Heal th Financia		OLLY MANOR CEN			u of Form CMS-2540-10
		20(b)). Failure to report can result in all interi eriod being deemed overpayments (42 USC 1395g).			OMB NO. 0938-0463
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315143	Period: From 01/01/2021 To 12/31/2021	Expires: 12/31/2021 Worksheet S Parts I, II & III Date/Time Prepared: 5/19/2022 1:16 pm
PART I - COST F	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost rep	port		Date: 5/19/20	22 Time: 1:16 pm
use only	2. [ ] Manually prepared cost report				
-	3. [0] If this is an amended report ent	ter the numbe	of times the provide	r resubmitted thi	s cost report
	3.01 [ ] No Medicare Utilization. Enter '				
Contractor	4. [ 1 ] Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[N]Firs	t Cost Report for this	Provider CCN	
-	(2) Settled without audit		Cost Report for this		
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened		ne 4, column 1 is "4"		times reenand
	(5) Amended				trilles reopened
			r Vendor Code	4	
	5. Date Received:		care Utilization. Ente	er "F" for full, '	'L" for low, or "N"
		for	no utilization.		

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 HOLLY MANOR CENTER (315143) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1		2	SI GNATURE STATEMENT	
1	Dia	ne Morris	Y Y	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	Diane Morris			2
3	Signatory Title	VP OF REIMBURSEMENT			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	-62, 083	1, 115	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
7.10	SNF - BASED CORF I	0		0		7.10
100.00	TOTAL	0	-62, 083	1, 115	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.

Heal th	Financial Systems	HOLLY	A MANOR CEN	TER		L	n Lie	u of Fori	n CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI					Peri od:		Workshe		
COMPLE	X INDENTIFICATION DATA					From 01/01/ To 12/31/		Part I Date/Ti	me Pre	nared
						10 12/31/	2021	5/19/20		
	1.00		. 00	<u> </u>	3.00					
	Skilled Nursing Facility and Skilled Nursing Street: 84 COLD HILL ROAD	PO Box:	Complex Ad	dress:						1.00
		State: NJ	I	Zip Code:	07945					2.00
	5	CBSA Code		Urban/Rui						3.00
3.01		CBSA Code								3. 01
			Compon	ent Name	Provi der	Date	Paym	ent Syste		
					CCN	Certified		0, or N		
		-	1	. 00	2.00	3.00	V 4.00	XVIII 5.00	XI X	
	SNF and SNF-Based Component Identification:		I	. 00	2.00	3.00	4.00	5   5.00	6.00	
	SNF		HOLLY MANOF	R CENTER	315143	01/01/1976	N	Р	Р	4.00
	Nursing Facility									5.00
6.00	ICF/IID									6.00
	SNF-Based HHA									7.00
	SNF-Based RHC SNF-Based FQHC									8.00 9.00
	SNF-Based CMHC									10.00
	SNF-Based OLTC									11.00
	SNF-Based HOSPICE									12.00
13.00	SNF-Based CORF									13.00
						From:		To:		
14.00	Cost Reporting Period (mm/dd/yyyy)					1.00	001	2.0 12/31/		14.00
	Type of Control (See Instructions)					01/01/2	JZ I 4	12/31/	2021	15.00
10.00								Y/I	V	10.00
								1.0		
	Type of Freestanding Skilled Nursing Facility							1		
	Is this a distinct part skilled nursing facil	ity that	meets the	requi remei	nts set forth	in 42 CFR		N		16.00
	section 483.5? Is this a composite distinct part skilled nur	sing faci	lity that	maats tha	roqui romonts	set forth i	n	N		17.00
17.00	42 CFR section 483.5?	Sing ruci	They char i	neets the	r equi r ellerres	Set for the				17.00
18.00	Are there any costs included in Worksheet A t	hat resul	ted from t	ransacti oi	ns with relate	ed		Y		18.00
	organizations as defined in CMS Pub. 15-1, ch	napter 10?	Plfyes,	complete \	Norksheet A-8-	1.				
	Miscellaneous Cost Reporting Information			- "\/"				NI.		10.00
	If this is a low Medicare utilization cost re If line 19 is yes, does this cost report meet						-	N N		19.00 19.01
17.01	utilization cost report, indicate with a "Y",				ion intring a r	ow mean cars	-			
	Depreciation - Enter the amount of depreciati				the method inc	dicated on	Li nes	20 - 22		
	Straight Line								20, 432	20.00
	Declining Balance								C	
	Sum of the Year's Digits Sum of line 20 through 22								20 423	22.00 23.00
	If depreciation is funded, enter the balance	as of th	e end of t	he neriod					20, 432	1
	Were there any disposal of capital assets dur			•				N		25.00
	Was accelerated depreciation claimed on any a	0	•	0.		orting peri	od?	N		26.00
	(Y/N)									
	Did you cease to participate in the Medicare	program a	at end of t	he period	to which this	cost repo	~t	N		27.00
	applies? (Y/N) Was there a substantial decrease in health ir	surance r	roportion	of allowa	hle cost from	nrior cost		N		28.00
20.00	reports? (Y/N)	isur unee p				prior cost				20.00
							Part	A Part B	0ther	
				11.0			1.00		3.00	
	If this facility contains a public or non-pub of the lower of the costs or charges enter "\									
	exemption.	i i or eac	ch componen	t and typ	e or service i	inat quallt	res I	or the		
29.00	Skilled Nursing Facility						N	N		29.00
30.00	Nursing Facility								Ν	30.00
31.00	ICF/IID								Ν	31.00
	SNF-Based HHA						N	N		32.00
	SNF-Based RHC							N		33.00
	SNF-Based FQHC SNF-Based CMHC							N N		34.00 35.00
	SNF-Based OLTC							IN IN		36.00
00.00						Y/N				00.00
						1.00		2.0	0	
37.00	Is the skilled nursing facility located in a				vider as a SNF	Y				37.00
30 00	regardless of the level of care given for Tit Are you legally-required to carry malpractice			s? (Y/N)		N				38.00
	Is the malpractice a "claims-made" or "occurr			e policy i	is	N 1				38.00
	"claims-made" enter 1. If the policy is "occu				-					
					Premiums	Paid Los	ses	SelfIns		
41.00	List malprostics promitime and paid large				1.00	2.00		3.0	J	41.00
4 I. UU	List malpractice premiums and paid losses:				1	I U		0		41.00

Health Financial Systems	HOLLY MANOR	CENTER		In Lie	eu of Form CMS	-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.:		Peri od:	Worksheet S-	2
COMPLEX INDENTIFICATION DATA				From 01/01/2021 To 12/31/2021		onorod.
				10 12/31/2021	5/19/2022 1:	
			I		Y/N	
					1.00	
42.00 Are malpractice premiums and paid loss	es reported in other t	han the Administra	ative and	General cost	N	42.00
center? Enter Y or N. If yes, check bo	x, and submit supporti	ng schedule listir	ng cost ce	nters and		
amounts.						
43.00 Are there any home office costs as def					Y	43.00
44.00 If line 43 is yes, enter the home office	ce chain number and en	ter the name and a	address of	the home	HB0067	44.00
office on lines 45, 46 and 47.						
1.00	2.00			3.00		
If this facility is part of a chain or	ganization, enter the	name and address o	of the hom	ne office on th	e lines	
bel ow.	1					
45.00 Name: GENESIS HEALTHCARE	Contractor's Name: NOV	'I TAS	Contracto	r's Number: 120	01	45.00
46.00 Street: 101 EAST STATE STREET	PO Box:					46.00
47.00 City: KENNETT SQUARE	State: PA		Zip Code:	193	48	47.00

MPLI	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2021 To 12/31/2021		epared
		I			Y/N	5/19/2022 1: 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" fo	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)				N		1.
				Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Progra	m?lf	1.00 N	2.00	3.00	2.
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.						
00	Is the provider involved in business transac contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or	the provider involved in business transactions, including management ntracts, with individuals or entities (e.g., chain home offices, dru- medical supply companies) that are related to the provider or its ficers, medical staff, management personnel, or members of the board directors through ownership, control, or family and other similar lationships? (see instructions)					3.
				Y/N	Туре	Date	
				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 comple available in column 3. (see instructions) If	" for Audited, "C" f te copy or enter dat	for Te	Y	С		4.
00	Are the cost report total expenses and total those on the filed financial statements? If a reconciliation.			N			5
					Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities						
00	Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2:	Is the	provider the	N	N	6.
00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during	s? (Y/N) see instruc	tions.		N N N	Ν	6. 7. 8.
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s? (Y/N) see instruc ng the cost reportin	tions.		N	Y/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 instruc ng the cost reportin	tions.		N		7
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 instruc ng the cost reportin ee instructions. d debts? (Y/N) see i	tions. ng period	for Nursing	NN	Y/N	7 8 9
)0 )0 )0 00	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 debt	s? (Y/N) see instruc ng the cost reportin <u>ee instructions.</u> d debts? (Y/N) see i t collection policy	nstructio	for Nursing ns. ring this cos	N N t reporting	Y/N 1.00 Y	7 8 9 10
00 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) 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 instruc ng the cost reportin ee instructions. d debts? (Y/N) see i t collection policy d/or coinsurance wai	tions. g period nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instr ", see instru	N N t reporting uctions. ctions.	Y/N 1.00 Y N N N	7. 8. 9. 10. 11.
00 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) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb 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 it collection policy d/or coinsurance wait	nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instr ", see instru Pa	N N t reporting uctions. ctions. rt A	Y/N 1.00 Y N N Part B	7 8 9 10 11
00 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) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	s? (Y/N) see instruc ng the cost reportin ee instructions. d debts? (Y/N) see i t collection policy d/or coinsurance wai	nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instr ", see instru	N N t reporting uctions. ctions.	Y/N 1.00 Y N N N	9 10 11
	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 deb 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	s? (Y/N) see instructing the cost reporting e instructions.	nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00	N N t reporting uctions. ctions. rt A Date	Y/N 1.00 Y N N Part B Y/N 3.00	9 10 11 12
0 0 0 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 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.)	s? (Y/N) see instructing the cost reporting e instructions.	nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instr ", see instru Pa Y/N 1.00 N	N N t reporting uctions. ctions. rt A Date	Y/N 1.00 Y N N Part B Y/N 3.00 N	9 10 11 12
	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 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 prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y"	s? (Y/N) see instructing the cost reporting einstructions.	nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00	N N t reporting uctions. ctions. rt A Date	Y/N 1.00 Y N N Part B Y/N 3.00	7 8 9 10 11 12 12 13
	Iegal operator of the program? (Y/N)         Were costs claimed for Allied Health Program:         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	s? (Y/N) see instructing the cost reporting einstructions.	nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instr ", see instru Pa Y/N 1.00 N	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 N	7.
	<pre>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) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&amp;R Data Was the cost report prepared using the PS&amp;R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&amp;R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&amp;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&amp;R used to prepare this cost report in cols. 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&amp;R data for additional claims that have been billed but are not included on the PS&amp;R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&amp;R Report information? If yes, see instructions.</pre>	s? (Y/N) see instructing the cost reporting einstructions.	nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instru Pa Y/N 1.00 N Y N N N	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 N Y N N	7.8. 9.9. 10. 11. 12. 13. 14. 15. 16.
	Iegal operator of the program? (Y/N)         Were costs claimed for Allied Health Program:         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 </td <td>s? (Y/N) see instructing the cost reporting einstructions.</td> <td>nstructio change du ved? If "</td> <td>for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00 N Y N</td> <td>N N t reporting uctions. ctions. rt A Date 2.00</td> <td>Y/N 1.00 Y N N Part B Y/N 3.00 N Y N</td> <td>7 8 9 10 11 12 13 13 14 15</td>	s? (Y/N) see instructing the cost reporting einstructions.	nstructio change du ved? If "	for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00 N Y N	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 N Y N	7 8 9 10 11 12 13 13 14 15

Health Financial Systems		HOLLY MANOF	R CENTER		In Lie	u of Form CMS-	2540-10
	AND SKILLED NURSING FACILITY	Y HEALTH CARE	Provi der		Period:	Worksheet S-2	
COMPLEX REIMBURSEMENT QU	IESTI ONNAI RE				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	nared
					10 12/31/2021	5/19/2022 1:1	6 pm
			1.	00	2.	00	
Cost Report Prepa	rer Contact Information						
19.00 Enter the first n	ame, last name and the title/	/position	JEAN		PRI CE		19.00
held by the cost	report preparer in columns 1,	2, and 3,					
respecti vel y.							
20.00 Enter the employe	r/company name of the cost re	eport (	GENESIS HEALTH	CARE			20.00
preparer.							
21.00 Enter the telepho	ne number and email address c	of the cost 4	4108044481		JEAN. PRI CE@GENI	ESI SHCC. COM	21.00
report preparer i	n columns 1 and 2, respective	el y.					

Heal th	Financial Systems	HOLLY MANOR	CENTER	In Lie	u of Form CMS-2	540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provider No.: 315143	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prep 5/19/2022 1:16	ared:
		Part B Date 4.00				
	PS&R Data	1.00				
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)					13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	03/19/2022				14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15.00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
			3.00			
	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		EIMBURSEMENT ANALYST			19. 00
20.00	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

al th	Financial Systems	HOLLY MANO	R CENTER		In Lieu	u of Form CMS-2	2540-
	D NURSING FACILITY AND SKILLED NURSI	NG FACILITY HEALTH CARE	Provi der		eriod: rom 01/01/2021	Worksheet S-3 Part I	
WPLE	X STATISTICAL DATA			T		Date/Time Prep	
				Inn	atient Days/Vis	5/19/2022 1:16	6 pm
				The	attent bays/vis	115	
	Component	Number of Beds	Bed Days Avai I abl e	Title V	Title XVIII	Title XIX	
	1	1.00	2.00	3.00	4.00	5.00	
00	SKILLED NURSING FACILITY	124	45, 260	0	2, 848	21, 590	1.
00 00	NURSING FACILITY	0	0	0		0	2. 3.
00	HOME HEALTH AGENCY COST	0	0	0	0	0	3. 4.
0	Other Long Term Care	0	0	0	0	0	5.
0	SNF-Based CMHC	Ū.	0				6.
0	SNF-Based CORF						6.
00	HOSPI CE	0	0	0	0	0	7.
00	Total (Sum of lines 1-7)	124	45, 260	0	1	21, 590	8.
		Inpatient D	ays/Visits		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
00	SKILLED NURSING FACILITY	5, 791	30, 229	0	73	37	1.
0 0	NURSING FACILITY	0	0	0		0	2. 3.
0	HOME HEALTH AGENCY COST	0	0			0	3. 4.
0	Other Long Term Care	0	0				5.
0	SNF-Based CMHC	_	-				6.
0	SNF-Based CORF						6.
0	HOSPICE	0	0	0	0	0	7.
00	Total (Sum of lines 1-7)	5, 791	30, 229	0	73 age Length of S	37	8.
		Discha	arges	Aver	age Length of s	stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
0		11.00	12.00	13.00	14.00	15.00	1
)0 )0	SKILLED NURSING FACILITY NURSING FACILITY	145	255 0	0.00 0.00	39.01	583. 51 0. 00	1. 2.
00	ICF/IID	0	0	0.00		0.00	3.
00	HOME HEALTH AGENCY COST	Ū.	0			01.00	4.
00	Other Long Term Care	0	0				5.
00	SNF-Based CMHC						6.
10	SNF-Based CORF						6.
00	HOSPICE	0	0	0.00	0.00	0.00	7.
00	Total (Sum of lines 1-7)	145 Average Length	255	0.00 Admis	39.01 si ons	583.51	8.
		of Stay			31 0113		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
0	SKILLED NURSING FACILITY	<u> </u>	17.00	18.00 98	<u>19.00</u> 12	20.00	1.
0	NURSING FACILITY	0.00	0	98	12	001	2.
0	ICF/IID	0.00	0		0	0	3.
0	HOME HEALTH AGENCY COST				-	-	4.
0	Other Long Term Care	0.00				0	5.
0	SNF-Based CMHC						6.
0	SNF-Based CORF	0.00					6.
0	HOSPICE Total (Sum of lines 1-7)	0. 00 118. 55	0	0 98	0 12	0 166	7. 8.
0		Admi ssi ons	Full Time		12	100	0.
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I 22.00	Workers 23.00			
0	SKILLED NURSING FACILITY	276	65.39	0.00			1.
0	NURSING FACILITY	0	0.00	0.00			2.
0	ICF/IID	0	0.00				3.
$\cap$	HOME HEALTH AGENCY COST		0.00	0.00			4.
	Other Long Term Care	0	0.00	0.00			5.
0	SNF-Based CMHC		0.00	0.00			6.
00 00				~ ~ ~ ~			
00 00 00 10	SNF-Based CORF		0.00	0.00			6. 7
00 00		0 276		0.00			6. 7. 8.

Heal th	Financial Systems	HOLLY MANC			In Li€	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION				Period: From 01/01/2021 To 12/31/2021		pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
			Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART I I – DI RECT SALARI ES			·			
	SALARI ES						
1.00	Total salaries (See Instructions)	3, 712, 032	0	3, 712, 03	2 136, 019. 00	27.29	1.00
2.00	Physician salaries-Part A	0	( C		0 0.00		2.00
3.00	Physician salaries-Part B	0	( C		0 0.00		3.00
4.00	Home office personnel	0	( C		0 0.00		4.00
5.00	Sum of lines 2 through 4	0	( C		0 0.00		5.00
6.00	Revised wages (line 1 minus line 5)	3, 712, 032	0	3, 712, 03			6.00
7.00	Other Long Term Care	0	0	D	0 0.00		7.00
8.00	HOME HEALTH AGENCY COST	0	0	D	0 0.00		
9.00	СМНС	0	C	D	0 0.00	0.00	9.00
9.10	CORF						9.10
10.00	HOSPI CE	0	C	D	0 0.00		
11.00	Other excluded areas	0	C	D	0 0.00		
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	C	)	0 0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line	3, 712, 032	( C	3, 712, 03	2 136, 019. 00	27.29	13.00
	12)						
	OTHER WAGES & RELATED COSTS			1			
14.00	Contract Labor: Patient Related & Mgmt	2, 270, 212					
15.00	Contract Labor: Physician services-Part A	30, 401					
16.00	Home office salaries & wage related costs	424, 974	(	424, 97	4 7,934.00	53.56	16.00
47 00	WAGE-RELATED COSTS						47 00
17.00	Wage-related costs core (See Part IV)	836, 266	C	836, 26	6		17.00
18.00	Wage-related costs other (See Part IV)	0	0	)	0		18.00
19.00	Wage related costs (excluded units)	0		2	0		19.00
20.00	Physician Part A - WRC	0			0		20.00
21.00	Physician Part B - WRC	0			U		21.00
22.00	Total Adjusted Wage Related cost (see	836, 266		836, 26	6		22.00
	instructions)		l	T	I	I	l

Heal th	Financial Systems	HOLLY MANO	R CENTER		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period: From 01/01/2021	Worksheet S-3	
					To 12/31/2021	Part III Date/Time Pre	pared:
					_	5/19/2022 1:1	<u>6 pm</u>
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	-	-		-1		
1.00	Employee Benefits	0	0		0.00		
2.00	Administrative & General	451, 116		451, 11			
3.00	Plant Operation, Maintenance & Repairs	78, 078	0	78, 07			
4.00	Laundry & Linen Service	0	0		0 0.00	0.00	4.00
5.00	Housekeepi ng	0	0		0 0.00	0.00	5.00
6.00	Dietary	0	0		0.00	0.00	6.00
7.00	Nursing Administration	385, 637	-44, 047	341, 59	0 7, 019. 00	48.67	7.00
8.00	Central Services and Supply	0	18, 974	18, 97	4 1, 128. 00	16. 82	8.00
9.00	Pharmacy	0	0		0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	25, 073	25, 07	3 1, 758. 00	14.26	10.00
11.00	Soci al Servi ce	134, 642	0	134, 64	2 4, 816. 00	27.96	11.00
12.00	Nursing and Allied Health Ed. Act.			1			12.00
13.00	Other General Service	94, 038	0	94, 03	5, 292. 00	17.77	13.00
14.00	Total (sum lines 1 thru 13)	1, 143, 511	0	1, 143, 51	1 37, 551. 00	30.45	14.00
	•						-

	Financial Systems	HOLLY MANOR CENTER		In Lie	u of Form CMS-2	2540-1
SNF WA	GE RELATED COSTS	Provi	der No.: 315143	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prep 5/19/2022 1:10	
					Amount Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				41, 019	1.0
2.00	Tax Sheltered Annuity (TSA) Employer Contr	i buti on			0	2.0
3.00	Qualified and Non-Qualified Pension Plan C	ost			0	3.0
4.00	Prior Year Pension Service Cost				0	4.0
	PLAN ADMINISTRATIVE COSTS (Paid to Externa	l Organi zati on)				
5.00	401K/TSA Plan Administration fees				0	5. C
o. 00	Legal /Accounting/Management Fees-Pension P	lan			0	6.0
. 00	Employee Managed Care Program Administrati	on Fees			0	7.0
	HEALTH AND INSURANCE COST					
. 00	Health Insurance (Purchased or Self Funded	)			373, 904	8. (
. 00	Prescription Drug Plan				0	9. (
0.00	Dental, Hearing and Vision Plan				0	10. (
1.00	Life Insurance (If employee is owner or be	nefi ci ary)			0	11. (
2.00	Accident Insurance (If employee is owner o	r beneficiary)			0	12.0
3.00	Disability Insurance (If employee is owner	or beneficiary)			0	13.0
4.00	Long-Term Care Insurance (If employee is o	wner or beneficiary)			0	14.
5.00	Workers' Compensation Insurance	57			98, 997	15.
6.00	Retirement Health Care Cost (Only current	year, not the extraordinary	accrual require	ed by FASB 106.	0	16.0
	Non cumulative portion)	<u> </u>		5		
	TAXES					
7.00	FICA-Employers Portion Only				272, 029	17.0
8.00	Medicare Taxes - Employers Portion Only				0	18. (
9.00	Unemployment Insurance				0	19. (
0. 00	State or Federal Unemployment Taxes				44, 197	20. (
	OTHER					
1.00	Executive Deferred Compensation				0	21. (
2.00	Day Care Cost and Allowances				0	22.0
3.00	Tuition Reimbursement				6, 120	23. (
4.00	Total Wage Related cost (Sum of lines 1 -	23)			836, 266	24. (
					Amount	
					Reported	
					1.00	
	Part B - Other than Core Related Cost					
5.00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.0

SNF REPORTING OF DIRECT CARE EXPENDITURES         Provider No.: 315143         Period: To 12/31/2021         Period: To 12/31/2021         Worksheet S-3 Part V Date/Time Prepared: 5/19/2022         Worksheet S-3 Part V Date/Time Prepared: 5/19/2022           Decupational Category         Amount Reported         Fringe Benefits         Adjusted Salary in col. 3         Average Hourly Wage (col. 4) Salary in col. 3         Wage (col. 4) Salary in col. 3           Direct Salaries         1.00         2.00         3.00         4.00         5.00           Direct Salaries         640, 350         70, 643         532, 393         11, 635.00         45.76           0.00         Cuensed Practical Nurses (LPNs)         604, 849         100, 947         705, 796         17, 653.00         32.75         4.00           3.00         Certified Nursing Assistant/Nursing         1, 501, 922         484, 784         1, 966, 706         69, 179.00         28.72         3.00           4.00         Physical Therapy Assistants         0         0         0.00         0.00         0.00         5.00           5.00         Physical Therapy Assistants         0         0         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00	Heal th	Financial Systems	HOLLY MANOF	R CENTER		In Lie	eu of Form CMS-2	2540-10
Occupational Category         Amount Reported         Fringe Benefits         Adjusted Salaries (col. 1 + col. 2)         Paid Hours Related to Salary in col.         Average Hourly Wage (col. 3 + col. 4)           Direct Salaries         1.00         2.00         3.00         4.00         5.00           Nursing Occupations         604,849         100,947         705,796         17,653.00         39.98         2.00           1.00         Registered Nurses (RNs)         604,849         100,947         705,796         17,653.00         39.98         2.00           0.00         Certified Nursing Assistant/Nursing         1,501,922         484,784         1.986,706         69,179.00         28.72         3.00           0.00         Physical Therapists         0         0         0         0.00						Period: From 01/01/2021	Worksheet S-3 Part V	
Reported         Benefits         Salaries         Col.         Related to Salary in col.         Wage (col. 3) col. 4)           Direct Salaries         1.00         2.00         3.00         4.00         5.00           Nursing Occupations         1         1.00         2.00         3.00         4.00         5.00           1.00         Registered Nurses (Ns)         461,750         70,643         532,393         11,635.00         45.76           2.00         Licensed Practical Nurses (LPNs)         604,849         100,947         705,796         17,653.00         39.98         2.00           0.00         Certified Nursing Assistant/Nursing Assistants/Aides         1,501,922         484,784         1,986,706         69,179.00         28.72         3.00           0.00         Physical Therapi Assistants         0         0         0.00<						To 12/31/2021	Date/Time Pre 5/19/2022 1:1	pared: 6 pm
Direct Salaries         Coi - 4)           Nursing Occupations         1         - 0         2.00         3.00         4.00         5.00           1.00         Registered Nurses (RNs)         461,750         70,643         532,393         11,635.00         45.76         1.00           2.00         Certified Nurses (LPNs)         604,849         100,947         705.796         17,653.00         39.98         2.00           3.00         Certified Nursing Assistant/Aursing         1.501,922         484,784         1,986,706         69,179.00         28.72         3.00           4.00         Total Nursing (sum of Lines 1 through 3)         2.568,521         656,374         3.224,895         98.467.00         32.75         4.00           0.00         Physical Therapists         0         0         0.00         0.00         5.00           0.00         Ccupational Therapy Assistants         0         0         0.00         0.00         6.00           0.00         Occupational Therapy Assistants         0         0         0         0.00         0.00         10.00           0.00         Occupational Therapy Assistants         0         0         0         0.00         0.00         10.00           0.00 </td <td></td> <td>Occupational Category</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		Occupational Category						
Direct Salaries         1.00         2.00         3.00         4.00         5.00           Nursing Occupations         1.00         2.00         3.00         4.00         5.00           1.00         Registered Nurses (RNs)         461,750         70.643         532,393         11,635.00         45.76         1.00           2.00         Licensed Practical Nurses (LPNs)         664,849         100.947         705.796         17,653.00         32.75         4.00           3.00         Certified Nursing Assistant/Nursing         1,501.922         484,784         1,966,706         69.179.00         28.72         3.00           4.00         Total Nursing (Sum of Lines 1 through 3)         2,568,521         656,374         3,224,895         98,467.00         32.75         4.00           5.00         Physical Therapy Assistants         0         0         0.00         0.00         0.00         5.00           6.00         Cocupational Therapy Assistants         0         0         0         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00 <t< td=""><td></td><td></td><td>Reported</td><td>Benefits</td><td></td><td></td><td></td><td></td></t<>			Reported	Benefits				
Direct Salaries         Direct Salaries           Nursing Occupations         600           1.00         2.00         3.00         4.00         5.00           1.00         Registered Nurses (RNs)         461,750         70.643         532,393         11.635.00         45.76         1.00           2.00         Licensed Practical Nurses (LPNs)         604,849         100,947         705.796         17.653.00         39.98         2.00           3.00         Certified Nursing (sum of lines 1 through 3)         2.568,521         656,374         3.24,895         98.467.00         32.75         4.00           5.00         Physical Therapists         0         0         0         0.00					I + COL 2)	<b>J</b>	COL. 4)	
Nursing Occupations           1.00         Registered Nurses (RNs)         461,750         70,643         532,393         11,635.00         45.76         1.00           2.00         Licensed Practical Nurses (LPNs)         604,849         100,947         705,796         17,653.00         39.98         2.00           3.00         Certified Nursing Assistant/Nursing         1,501,922         484,784         1,986,706         69,179.00         28.72         3.00           4.00         Total Nursing (sum of lines 1 through 3)         2,568,521         656,374         3,224,895         98,467.00         32.75         4.00           5.00         Physical Therapy Assistants         0         0         0         0.00         0.			1.00	2.00	3.00		5.00	
1.00       Registered Nurses (RNs)       461,750       70,643       532,393       11,635.00       45,76       1.00         2.00       Licensed Practical Nurses (LPNs)       604,849       100,947       705,796       17,653.00       39.98       2.00         Assistants/Aides       1,501,922       484,784       1,986,706       69,179.00       28.72       3.00         Assistants/Aides       0       0       0.00       0.00       0.00       0.00       5.00         5.00       Physical Therapists       0       0       0       0.00       0.00       5.00         6.00       Occupational Therapy Assistants       0       0       0       0.00       0.00       0.00       6.00         7.00       Physical Therapy Assistants       0       0       0       0.00								
2.00         Licensed Practical Nurses (LPNs)         604,849         100,947         705,796         17,653.00         39.98         2.00           3.00         Certified Nursing Assistant/Nursing         1,501,922         484,784         1,986,706         69,179.00         28.72         3.00           4.00         Total Nursing (sum of lines 1 through 3)         2,568,521         656,374         3,224,895         98,467.00         32.75         4.00           5.00         Physical Therapists         0         0         0.00         0.00         6.00         6.00         7.00         6.00         0.00         0.00         6.00         7.00         8.00         0.coupational Therapy Assistants         0         0         0         0.00         0.00         0.00         9.00         8.00         0.coupational Therapy Aides         0         0         0         0.00						1		
3.00       Certified Nursing Assistant/Nursing Assistants/Aides       1, 501, 922       484, 784       1, 986, 706       69, 179.00       28.72       3.00         4.00       Total Nursing (sum of lines 1 through 3)       2, 568, 521       656, 374       3, 224, 895       98, 467.00       32.75       4.00         5.00       Physical Therapy Assistants       0       0       0.00       0.00       0.00       5.00         6.00       Physical Therapy Assistants       0       0       0.00       0.00       0.00       7.00         8.00       Occupational Therapy Assistants       0       0       0.00       0.00       0.00       0.00       0.00         10.00       Cocupational Therapy Assistants       0       0       0.00								
Assistants/Ai des         Assistants         Assistants <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
5.00         Physical Therapists         0         0         0         0.00	3.00	Assi stants/Ai des	1, 501, 922	484, 784	1, 986, 70			3.00
6.00         Physical Therapy Assistants         0         0         0         0.00         0.00         6.00           7.00         Physical Therapy Asides         0         0         0.00         0.00         0.00         7.00           8.00         Occupational Therapy Assistants         0         0         0.00         0.00         9.00           9.00         Occupational Therapy Assistants         0         0         0.00         0.00         9.00           10.00         Occupational Therapy Asides         0         0         0         0.00         0.00         9.00           11.00         Speech Therapists         0         0         0         0.00         0.00         10.00           12.00         Respiratory Therapists         0         0         0         0.00         0.00         12.00           13.00         Other Medical Staff         0         0         0         0.00         0.00         13.00           14.00         Registered Nurses (RNs)         140,581         1,772.72         79.30         14.00           15.00         Licensed Practical Nurses (LPNs)         326.743         326.743         4.870.82         67.08         15.00           16.0			2, 568, 521	656, 374	3, 224, 89			
7.00         Physical Therapy Aides         0         0         0         0.00         0.00         7.00           8.00         Occupational Therapists         0         0         0.00         0.00         0.00         8.00           9.00         Occupational Therapy Asistants         0         0         0.00         0.00         0.00         9.00           0.00         Occupational Therapy Aides         0         0         0.00         0.00         9.00           10.00         Occupational Therapy Aides         0         0         0.00         0.00         10.00           11.00         Speech Therapists         0         0         0         0.00         0.00         10.00           12.00         Respiratory Therapists         0         0         0         0.00         0.00         12.00           13.00         Other Medical Staff         0         0         0         0.00         0.00         12.00           14.00         Registered Nurses (RNs)         140,581         1.772.72         79.30         14.00           15.00         Certified Nursing Assistant/Nursing         113,086         113,086         2.301.25         49.14         16.00           Assistant			0	0				
8.00         Occupational Therapists         0         0         0.00         0.00         8.00           9.00         Occupational Therapy Assistants         0         0         0         0.00         0.00         9.00           10.00         Occupational Therapy Assistants         0         0         0         0.00         0.00         9.00           11.00         Speech Therapists         0         0         0         0.00         0.00         0.00         10.00           12.00         Respiratory Therapists         0         0         0         0.00         0.00         11.00           13.00         Other Medical Staff         0         0         0         0.00         0.00         12.00           13.00         Certified Nurses (RNS)         140,581         1,772.72         79.30         14.00           15.00         Licensed Practical Nurses (LPNS)         326,743         326,743         4,870.82         67.93         15.00           16.00         Certified Nursing Assistant/Nursing         113,086         113,086         113,086         113,086         17.00           18.00         Physical Therapists         146,575         146,575         2,630.00         55.73         18.00 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0	0				
9.00         Occupational Therapy Assistants         0         0         0         0.00         0.00         9.00           10.00         Occupational Therapy Aides         0         0         0         0.00         0.00         10.00           11.00         Speech Therapists         0         0         0         0.00         0.00         11.00           12.00         Respiratory Therapists         0         0         0         0.00         0.00         11.00           13.00         Other Medical Staff         0         0         0         0.00         0.00         12.00           13.00         Other Medical Staff         0         0         0         0.00         0.00         13.00           Contract Labor           Versing Occupations           14.00         Certified Nursing Assistant/Nursing         140,581         1,772.72         79.30         14.00           15.00         Licensed Practical Nurses (LPNs)         326,743         326,743         4,870.82         67.08         15.00           16.00         Certified Nursing Assistant/Nursing         113,086         113,086         2,301.25         49.14         16.00           18.00         Physical T			0	0				
10.00       Occupational Therapy Aides       0       0       0       0.00       0.00       10.00         11.00       Speech Therapists       0       0       0       0.00       0.00       0.00       11.00         12.00       Respiratory Therapists       0       0       0       0.00       0.00       0.00       12.00         13.00       Other Medical Staff       0       0       0       0.00       0.00       13.00         Contract Labor         Nursing Occupations         14.00       Registered Nurses (RNs)       140,581       1,772.72       79.30       14.00         15.00       Li censed Practical Nurses (LPNs)       326,743       326,743       4,870.82       67.08       15.00         16.00       Certi fied Nursing Assistant/Nursing       113,086       113,086       2,301.25       49.14       16.00         Assistants/Aides       146,575       146,575       2,630.00       55.73       18.00         19.00       Physical Therapists       78,171       78,171       1,930.00       40.50       19.00         20.00       Physical Therapy Asistants       78,171       78,171       1,930.00       40.50       19.00 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0	0				
11.00       Speech Therapists       0       0       0       0.00       0.00       11.00         12.00       Respiratory Therapists       0       0       0       0.00       0.00       12.00         13.00       Other Medical Staff       0       0       0       0       0.00       0.00       12.00         13.00       Other Medical Staff       0       0       0       0.00       0.00       0.00       13.00         Contract Labor         Nursing Occupations         14.00       Registered Nurses (RNs)       140,581       1,772.72       79.30       14.00         15.00       Licensed Practical Nurses (LPNs)       326,743       326,743       4,870.82       67.08       15.00         16.00       Certified Nursing Assistant/Nursing       113,086       2,301.25       49.14       16.00         17.00       Total Nursing (sum of Lines 14 through 16)       580,410       8,944.79       64.89       17.00         18.00       Physical Therapy Assistants       78,171       78,171       1,930.00       40.50       19.00         19.00       Physical Therapy Aides       0       0       0.00       0.00       20.00         2			0	0				
12.00       Respiratory Therapists       0       0       0       0.00       0.00       0.00       12.00         13.00       Other Medical Staff       0       0       0       0.00 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<>			0	0				
13.00       Other Medical Staff       0       0       0       0.00       0.00       13.00         Contract Labor         Nursi ng Occupati ons         14.00       Regi stered Nurses (RNs)       140,581       1,772.72       79.30       14.00         15.00       Licensed Practical Nurses (LPNs)       326,743       4,870.82       67.08       15.00         16.00       Certified Nursing Assistant/Nursing       113,086       113,086       2,301.25       49.14       16.00         17.00       Total Nursing (sum of Lines 14 through 16)       580,410       580,410       8,944.79       64.89       17.00         18.00       Physical Therapists       146,575       2,630.00       55.73       18.00         19.00       Physical Therapy Assistants       78,171       78,171       1,930.00       40.50       19.00         20.00       Physical Therapy Assistants       142,053       142,053       2,526.00       56.24       21.00         22.00       Occupati onal Therapy Asisistants       106,002       106,002       3,157.00       33.58       22.00         23.00       Speech Therapi sts       92,734       92,734       1,672.00       55.46       24.00         24.			0	0				
Contract Labor           Nursi ng Occupati ons           14.00         Registered Nurses (RNs)         140,581         1,772.72         79.30         14.00           15.00         Li censed Practi cal Nurses (LPNs)         326,743         326,743         4,870.82         67.08         15.00           16.00         Certi fi ed Nursing Assi stant/Nursi ng Assi stants/Ai des         113,086         2,301.25         49.14         16.00           17.00         Total Nursi ng (sum of Li nes 14 through 16)         580,410         580,410         8,944.79         64.89         17.00           18.00         Physi cal Therapi sts         146,575         146,575         2,630.00         55.73         18.00           19.00         Physi cal Therapi sts         142,053         142,053         2,526.00         50.24         19.00           20.00         Physi cal Therapy Aides         0         0         0.00         0.00         20.00           21.00         Occupati onal Therapi sts         142,053         142,053         2,526.00         56.24         21.00           22.00         Occupati onal Therapy Asi stants         106,002         106,002         3,157.00         33.58         22.00           23.00         Occupati onal Therapy Aides			Ű	-				
Nursing Occupations           14.00         Registered Nurses (RNs)         140,581         140,581         1,772.72         79.30         14.00           15.00         Licensed Practical Nurses (LPNs)         326,743         326,743         4,870.82         67.08         15.00           16.00         Certified Nursing Assistant/Nursing Assistant/Nursing         113,086         113,086         2,301.25         49.14         16.00           77.00         Total Nursing (sum of lines 14 through 16)         580,410         580,410         8,944.79         64.89         17.00           18.00         Physical Therapists         146,575         146,575         2,630.00         55.73         18.00           19.00         Physical Therapy Assistants         78,171         78,171         1,930.00         40.50         19.00           20.00         Physical Therapy Aides         0         0         0.00         0.00         20.00           21.00         Occupational Therapists         142,053         142,053         2,526.00         56.24         21.00           22.00         Occupational Therapy Asistants         106,002         106,002         3,157.00         33.58         22.00           23.00         Occupational Therapy Aides         0	13.00		0	0		0 0.00	0.00	13.00
14.00       Registered Nurses (RNs)       140, 581       1, 772. 72       79. 30       14.00         15.00       Licensed Practical Nurses (LPNs)       326, 743       326, 743       4, 870. 82       67.08       15.00         16.00       Certified Nursing Assistant/Nursing Assistant/Nursing Introduction (Section 113, 086)       113, 086       2, 301. 25       49. 14       16.00         Assistants/Aides       0       Total Nursing (sum of lines 14 through 16)       580, 410       580, 410       8, 944. 79       64.89       17.00         18.00       Physical Therapists       146, 575       146, 575       2, 630.00       55. 73       18.00         19.00       Physical Therapy Assistants       78, 171       78, 171       1, 930.00       40.50       19.00         20.00       Physical Therapy Asistants       142, 053       142, 053       2, 526.00       56. 24       21.00         22.00       Occupational Therapy Asistants       106,002       106,002       315.8       22.00         23.00       Occupational Therapists       106,002       106,002       315.00       32.00         24.00       Speech Therapists       92, 734       92, 734       92, 734       22.00       55.00         25.00       Respiratory Therapists								
15.00       Li censed Practical Nurses (LPNs)       326,743       326,743       4,870.82       67.08       15.00         16.00       Certi fi ed Nursing Assistant/Nursing       113,086       113,086       2,301.25       49.14       16.00         Assistants/Ai des       113,086       2,301.25       49.14       16.00         17.00       Total Nursing (sum of Lines 14 through 16)       580,410       580,410       8,944.79       64.89       17.00         18.00       Physi cal Therapi sts       146,575       146,575       2,630.00       55.73       18.00         19.00       Physi cal Therapy Assistants       78,171       78,171       1,930.00       40.50       19.00         20.00       Physi cal Therapy Ai des       0       0       0.00       0.00       20.00         21.00       Occupati onal Therapi sts       142,053       142,053       2,526.00       56.24       21.00         22.00       Occupati onal Therapy Asi stants       106,002       106,002       3,157.00       33.58       22.00         23.00       Occupati onal Therapi sts       92,734       92,734       92,734       62.00       55.06         24.00       Speech Therapi sts       92,734       92,734       104			110 501		110.50	4 770 70	70.00	
16.00Certified Nursing Assistant/Nursing Assistants/Ai des113,086113,0862,301.2549.1416.0017.00Total Nursing (sum of Lines 14 through 16)580,410580,4108,944.7964.8917.0018.00Physical Therapists146,575146,5752,630.0055.7318.0019.00Physical Therapy Assistants78,17178,1711,930.0040.5019.0020.00Physical Therapy Aides000.000.0020.0021.00Occupational Therapists142,053142,0532,526.0056.2421.0022.00Occupational Therapy Asistants106,002106,00233.5822.0023.0023.00Occupational Therapists92,73492,7341,672.0055.4624.0024.00Speech Therapists1041042.0052.0025.00								
Assi stants/Ai desAssi stants/Ai desAssi stants/Ai des17. 00Total Nursing (sum of Lines 14 through 16)580, 410580, 4108, 944. 7964. 8917. 0018. 00Physi cal Therapi sts146, 575146, 5752, 630. 0055. 7318. 0019. 00Physi cal Therapy Assi stants78, 17178, 1711, 930. 0040. 5019. 0020. 00Physi cal Therapy Ai des000. 000. 0020. 0021. 00Occupati onal Therapi sts142, 053142, 0532, 526. 0056. 2421. 0022. 00Occupati onal Therapy Assi stants106, 002106, 0023, 157. 0033. 5822. 0023. 00Occupati onal Therapi sts92, 73492, 7341, 672. 0055. 4624. 0024. 00Speech Therapi sts1041042. 0052. 0025. 00								
17.00Total Nursing (sum of Lines 14 through 16)580, 410580, 4108, 944.7964.8917.0018.00Physical Therapists146, 575146, 5752, 630.0055.7318.0019.00Physical Therapy Assistants78, 17178, 1711, 930.0040.5019.0020.00Physical Therapy Aides000.000.0020.0021.00Occupational Therapists142, 053142, 0532, 526.0056.2421.0022.00Occupational Therapy Aides000.000.0020.0023.00Occupational Therapy Aides000.000.0020.0024.00Speech Therapists92, 73492, 7341, 672.0055.4624.0025.00Respiratory Therapists1041042.0052.0025.00	16.00		113, 086		113, 08	6 2,301.25	49.14	16.00
18.00Physical Therapists146, 5752, 630.0055.7318.0019.00Physical Therapy Assistants78, 17178, 1711, 930.0040.5019.0020.00Physical Therapy Aides0000.0020.0021.00Occupational Therapists142, 053142, 0532, 526.0056.2421.0022.00Occupational Therapy Assistants106, 002106, 0023, 157.0033.5822.0023.00Occupational Therapists000.000.0023.0024.00Speech Therapists92, 73492, 7341, 672.0055. 4624.0025.00Respiratory Therapists1041042.0052.0025.00	17 00		580 410		580 41	0 8 944 79	64 89	17 00
19.00Physical Therapy Assistants78,17178,1711,930.0040.5019.0020.00Physical Therapy Aides000.000.0020.0021.00Occupational Therapists142,053142,0532,526.0056.2421.0022.00Occupational Therapy Assistants106,002106,0023,157.0033.5822.0023.00Occupational Therapy Aides000.000.0023.0024.00Speech Therapists92,73492,73416,72.0055.4624.0025.00Respiratory Therapists1041042.0052.0025.00								
20. 00Physical Therapy Ai des000.000.0020.0021. 000ccupati onal Therapi sts142,053142,0532,526.0056.2421.0022. 000ccupati onal Therapy Assistants106,002106,0023,157.0033.5822.0023. 000ccupati onal Therapy Ai des000.000.0023.0024. 00Speech Therapi sts92,73492,7341,672.0055.4624.0025. 00Respi ratory Therapi sts1041042.0052.0025.00								
21.00Occupational Therapists142,053142,0532,526.0056.2421.0022.00Occupational Therapy Assistants106,002106,0023,157.0033.5822.0023.00Occupational Therapy Aides000.000.0023.0024.00Speech Therapists92,73492,7341,672.0055.4624.0025.00Respiratory Therapists1041042.0052.0025.00								
22.00Occupational Therapy Assistants106,002106,0023,157.0033.5822.0023.00Occupational Therapy Aides000.000.0023.0024.00Speech Therapists92,73492,7341,672.0055.4624.0025.00Respiratory Therapists1041042.0052.0025.00			Ŭ					
23.00       Occupational Therapy Aides       0       0.00       0.00       23.00         24.00       Speech Therapists       92,734       92,734       1,672.00       55.46       24.00         25.00       Respiratory Therapists       104       104       2.00       52.00       25.00								
24.00         Speech Therapi sts         92, 734         92, 734         1, 672.00         55.46         24.00           25.00         Respiratory Therapi sts         104         104         2.00         52.00         25.00								
25.00         Respiratory Therapists         104         104         2.00         52.00         25.00			92, 734		92.73			
26.00         Other Medical Staff         30,401         30,401         357.00         85.16         26.00	26.00	Other Medical Staff	30, 401		30, 40	1 357.00	85.16	26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	HOLLY MANOR CENTER Provider No.:	315143 Peri od:	eu of Form CMS-2540 Worksheet S-7	<u>+0-1(</u>
		From 01/01/2021 To 12/31/2021	Date/Time Prepar 5/19/2022 1:16 p	red:
		Group	Days	
1.00		1.00 RUX	2.00	1.00
2.00		RUL	2	2.00
3.00		RVX		3.00
4. 00 5. 00		RVL RHX		4.00 5.00
6.00		RHL		6.00
7.00		RMX		7. OC
3. 00		RML		8.00
9.00		RLX RUC		9.00 0.00
11.00		RUB		1.00
12.00		RUA		2.00
13.00 14.00		RVC RVB		3.00 4.00
15.00		RVA		4. 00 5. 00
16.00		RHC		6.00
17.00		RHB		7. OC
18.00		RHA		8.00
19.00 20.00		RMC RMB		9.00
21.00		RMA		1. OC
22. 00		RLB	22	2.00
23. 00		RLA		3.00
24.00 25.00		ES3 ES2		4.00 5.00
26.00		ES1		26. OC
27.00		HE2		7. OC
28.00		HE1		8.00
29.00 30.00		HD2 HD1		9. 00 0. 00
31.00		HC2		1. OC
32. 00		HC1		2.00
33. 00		HB2		3.00
34. 00 35. 00		HB1 LE2		4.00 5.00
36.00		LE1		6. OC
37. 00		LD2	37	7. OC
38. 00		LD1		8.00
39. 00 40. 00		LC2 LC1		9. 00
41.00		LB2		1. 00
42.00		LB1	42	2.00
43.00		CE2		3.00
14. 00 15. 00		CE1 CD2		4.00
46.00		CD1		6. 00
17.00		CC2		7.00
8.00		CC1		8.00
19.00 50.00		CB2 CB1	49	9. 00 0. 00
51.00		CA2		1. OC
52.00		CA1		2.00
3.00		SE3		3.00
64. 00 55. 00		SE2 SE1		4.00 5.00
6.00		SSC	56	6. 00
7.00		SSB	57	7.00
8.00		SSA		8.00
9.00 0.00		I B2 I B1		9. 00 0. 00
1.00		I A2	61	1.00
2.00		I A1	62	2.00
3. 00 4. 00		BB2 BB1		3. 00 4. 00
54. 00 55. 00		BB1 BA2		64. UC 5. OC
6. 00		BA1	66	6. OC
7.00		PE2	67	7.00
98. 00		PE1		8.00
99. 00 70. 00		PD2 PD1		9. 00 0. 00
71.00		PC2	71	1.00
72.00		PC1	72	2.00
73.00		PB2		3.00
74.00 75.00		PB1 PA2	72	4.00

Health Financial Systems	HOLLY MANOR CE	NTER		In Lie	eu of Form CMS	S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315143	Period:	Worksheet S	-7
				From 01/01/2021 To 12/31/2021		
				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 Vo payments beginning 10/01/2003. Congress expect expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" for with direct patient care and related expenses (See instructions)	cted this increase n column 1 the amou r each category to pr yes or "N" for n	to be used nt of the total SNF o if the s	l for direct expense for revenue from pending refl	batient care and each category. Er Worksheet G-2, F ects increases as	related hterin PartI, 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, II)	ne 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

CLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/19/2022 1:1	
	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 1					
00	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 677, 603			1, 677, 603	
00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		0		0 0	0	2.0
00	00300 EMPLOYEE BENEFITS	0	834, 503			834, 503	
00 00	00400 ADMINI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS	451, 116 78, 078	1, 584, 302 325, 668			2, 035, 418 403, 746	
00	00600 LAUNDRY & LINEN SERVICE	18,018	242, 526			242, 526	
00	00700 HOUSEKEEPING	0	189, 209			189, 209	
00	00800 DI ETARY	0	860, 607			860, 607	8.
00	00900 NURSI NG ADMI NI STRATI ON	385, 637	14, 052			355, 642	9.
. 00	01000 CENTRAL SERVICES & SUPPLY	0	34, 831	34, 83	1 18, 974	53, 805	10.
. 00	01100 PHARMACY	0	0		0 0	0	11.
. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0 25, 073	25, 073	
. 00	01300 SOCIAL SERVICE	134, 642	5, 678	140, 32		140, 320	
. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	111 00	0 0	0	14.
. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	94, 038	17, 261	111, 29	9 0	111, 299	15.
. 00	03000 SKILLED NURSING FACILITY	2, 568, 521	709, 140	3, 277, 66	1 0	3, 277, 661	30.
. 00	03100 NURSI NG FACILI TY	2, 500, 521	109, 140		0 0	0,277,001	31.
. 00	03200 I CF/I I D	0	0		0 0	0	
. 00	03300 OTHER LONG TERM CARE	0	0		0 0	0	
	ANCILLARY SERVICE COST CENTERS						
. 00	04000 RADI OLOGY	0	22, 067	22, 06	7 0	22, 067	40.
. 00	04100 LABORATORY	0	22, 245			22, 245	
. 00	04200 I NTRAVENOUS THERAPY	0	7, 770			7, 770	
. 00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
. 00	04400 PHYSI CAL THERAPY	0	203, 091			203, 091	44.
. 00 . 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	245, 585 122, 135			245, 585 122, 135	
. 00	04700 ELECTROCARDI OLOGY	0	122, 133		0 0	0	
. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
. 00	04900 DRUGS CHARGED TO PATIENTS	0	161, 384	161, 38	4 0	161, 384	49.
. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.
. 00	05100 SUPPORT SURFACES	0	34, 273	34, 27	3 0	34, 273	51.
. 00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	52.
	OUTPATIENT SERVICE COST CENTERS	-		1	-	-	
. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0		
. 00 . 00	06200 FQHC	0	0		0 0	0	61. 62.
. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		o o	0	
. 00	OTHER REIMBURSABLE COST CENTERS	0			<u> </u>	Ŭ	00.
. 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.
. 00	07100 AMBULANCE	0	0		0 0	0	
. 00	07200 CORF	0	0		0 0	0	72.
. 00	07300 CMHC	0	0		0 0	0	
. 00	07400 OTHER REIMBURSABLE COST	0	0		0 0	0	74.
~ ~	SPECIAL PURPOSE COST CENTERS	1		1			
. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80.
. 00 . 00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW		0			0	
. 00	08300 HOSPICE	0	0			0	
. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	
. 00	SUBTOTALS (sum of lines 1-84)	3, 712, 032	7, 313, 930	11, 025, 96	2 0	11, 025, 962	
-	NONREI MBURSABLE COST CENTERS						1
. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.
. 00	09100 BARBER AND BEAUTY SHOP	0	6, 418	6, 41	8 0	6, 418	
. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
. 00	09300 NONPAI D WORKERS	0	0		0 0	0	
. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	
. 00							

CLASSI FI	CATION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES	Provi der	No.: 315143	Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
	Cost Center Description	Adjustments to	Net Expenses			5/19/2022 1:1	o pr
	·	Expenses (Fr I					
		Wkst A-8)	(col. 5 +- col. 6)				
		6.00	7.00	-			
	RAL SERVICE COST CENTERS						
1	DO CAP REL COSTS - BLDGS & FIXTURES	0	1, 677, 603	•			1
	DO CAP REL COSTS - MOVABLE EQUI PMENT	0	0	•			2
	DO EMPLOYEE BENEFITS DO ADMINISTRATIVE & GENERAL	-48, 300 -527, 641	786, 203 1, 507, 777				
	DO PLANT OPERATION, MAINT. & REPAIRS	-527, 041	403, 746				5
1	DO LAUNDRY & LINEN SERVICE	0	242, 526				6
	DO HOUSEKEEPI NG	0	189, 209	1			
000000000000000000000000000000000000000	DO DI ETARY	0	860, 607				8
	DO NURSI NG ADMI NI STRATI ON	0	355, 642	1			9
	DO CENTRAL SERVICES & SUPPLY	0	53, 805				10
1		0	0				11
	DO MEDI CAL RECORDS & LI BRARY DO SOCI AL SERVI CE	0	25, 073	1			12
	DO NURSING AND ALLIED HEALTH EDUCATION	0	140, 320 0	1			14
	DO ACTIVITIES	-16, 315	94, 984	•			15
	ATIENT ROUTINE SERVICE COST CENTERS	10/010	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1			1
	DO SKILLED NURSING FACILITY	501	3, 278, 162				30
	DO NURSING FACILITY	0	0				3
	DO I CF/I I D	0	0				32
	DO OTHER LONG TERM CARE	0	0				3:
	LLARY SERVICE COST CENTERS						
	DO RADI OLOGY DO LABORATORY	0	22, 067				40
	DO I NTRAVENOUS THERAPY	0	22, 245 7, 770	1			4
	DO OXYGEN (INHALATION) THERAPY	0	,,,,0	1			4
	DO PHYSI CAL THERAPY	0	203, 091				4
	DO OCCUPATIONAL THERAPY	0	245, 585				45
00 0460	DO SPEECH PATHOLOGY	0	122, 135				40
	DO ELECTROCARDI OLOGY	0	0	•			4
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				48
	DO DRUGS CHARGED TO PATIENTS	0	161, 384				49
	DO DENTAL CARE – TITLE XIX ONLY DO SUPPORT SURFACES	0	0 34, 273				50 5
	00 OTHER ANCI LLARY SERVICE COST CENTERS	0	34, 273	1			5
	PATIENT SERVICE COST CENTERS		0	1			10.
	DO CLINIC	0	0				6
00 0610	DO RURAL HEALTH CLINIC	0	0				6
	DO FQHC						6
	00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	1			6
	ER REIMBURSABLE COST CENTERS	0	0				7
	DO AMBULANCE	0	0				7
	DO CORF	0	0	•			7
	оо смнс	0	0				7
	DO OTHER REIMBURSABLE COST	0	0	•			74
	CIAL PURPOSE COST CENTERS						
	DO MALPRACTICE PREMIUMS & PAID LOSSES	0	0				80
	DO INTEREST EXPENSE	0	0				8
	DO UTI LI ZATI ON REVI EW	0	0				82
	00 HOSPI CE 00 OTHER SPECIAL PURPOSE COST CENTERS	0	0				83
00 0840	SUBTOTALS (sum of lines 1-84)	-591, 755	10, 434, 207				80
	REIMBURSABLE COST CENTERS	071,700	.5, 104, 207	1			1
	OO GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				9
	DO BARBER AND BEAUTY SHOP	0	6, 418	•			9
	DO PHYSICIANS PRIVATE OFFICES	0	0				92
	DO NONPALD WORKERS	0	0	•			93
	DO PATIENTS LAUNDRY	0	0				94
00 0950	OO OTHER NONREI MBURSABLE COST CENTERS	0	0				95
1 1 1 1	TOTAL	-591, 755	10, 440, 625	1			100

Health Financial Systems	HOLLY MANOR CENTER			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2021	Worksheet A-6		
			To 12/31/2021	Date/Time Pre 5/19/2022 1:1	pared:		
			Increases		571972022 1.1		
	Cost Cente	r	Line #	Sal ary	Non Salary		
	2.00		3.00	4.00	5.00		
(1) A - DEFAULT							
1.00	CENTRAL SERVICES &	SUPPLY	10. (	0 18, 974	0	1.00	
2.00	MEDICAL RECORDS & L	I BRARY	12. (	0 25, 073	0	2.00	
TOTALS							
100.00	Total Reclassificat			44, 047	0	100.00	
	of columns 4 and 5						
	equal sum of columns 8 and						
	9)						

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

Health Financial Systems	HOLLY MANOR CENTER			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS				Period: From 01/01/2021	Worksheet A-6		
				To 12/31/2021	Date/Time Pre 5/19/2022 1:1		
	Decreases						
	Cost Cente	r	Line #	Sal ary	Non Salary		
	6.00		7.00	8.00	9.00		
(1) A - DEFAULT							
1.00	NURSING ADMINISTRAT	I ON	9. (	00 18, 974	0	1.00	
2.00	NURSING ADMINISTRAT	I ON	9. (	25, 073	0	2.00	
TOTALS							
100. 00				44, 047	0	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	HOLLY MANO	R CENTER		In Lie	eu of Form CMS-2	2540-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315143	Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021	Date/Time Prep 5/19/2022 1:10	
			÷	Acqui si ti on	S		
	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 BALANCES	S					
1.00	Land	0	0	I	0 0	0	1.00
2.00	Land Improvements	34, 813	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	24, 858	50, 770		0 50, 770	0	4.00
5.00	Fixed Equipment	2, 420	6, 220		0 6, 220	0	5.00
6.00	Movable Equipment	79, 125	15, 060		0 15, 060	0	6.00
7.00	Subtotal (sum of lines 1-6)	141, 216	72, 050		0 72, 050	0	7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	141, 216	72, 050		0 72, 050	0	9.00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
1.00	Land	0	0				1.00
2.00	Land Improvements	34, 813	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	75, 628	0				4.00
5.00	Fixed Equipment	8, 640	0				5.00
6.00	Movable Equipment	94, 185	0				6.00
7.00	Subtotal (sum of lines 1-6)	213, 266	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	213, 266	0				9.00

	Financial Systems	HOLLY MANOR		N= 045440		u of Form CMS-2	
DUUST	MENTS TO EXPENSES		Provi der	No.: 315143	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Date/Time Pre 5/19/2022 1:1	pare
					lassification on	Worksheet A	
				To/From Whic	ch the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
		Ádjustment					
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds (chapter 2)		0			0.00	1
00	Trade, quantity, and time discounts (chapter		0			0.00	2
00	8) Refunds and rebates of expenses (chapter 8)		0			0.00	3
00	Rental of provider space by suppliers (chapter 8)		0			0.00	
00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	5
00	Television and radio service (chapter 21)	А	-16, 315	ACTI VI TI ES		15.00	6
00	Parking lot (chapter 21)		0			0.00	
00	Remuneration applicable to provider-based physician adjustment	A-8-2	0				6
00	Home office cost (chapter 21)		0	)		0.00	9
. 00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
. 00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00	11
. 00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	178, 678				12
00	Laundry and linen service		0			0.00	13
. 00	Revenue - Employee meals		0			0.00	14
. 00	Cost of meals - Guests		0			0.00	15
. 00	Sale of medical supplies to other than		0	)		0.00	16
	patients						
00	Sale of drugs to other than patients		0			0.00	
. 00	Sale of medical records and abstracts		0			0.00	
. 00	Vendi ng machi nes		0			0.00	
. 00	Income from imposition of interest, finance		0			0.00	20
. 00	or penalty charges (chapter 21) Interest expense on Medicare overpayments		0			0.00	21
. 00	and borrowings to repay Medicare		0			0.00	
. 00	overpayments Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	REVIEW	82.00	22
	(chapter 21)						
. 00	Depreciationbuildings and fixtures			CAP REL COST FIXTURES		1.00	23
. 00	Depreciationmovable equipment		0	CAP REL COST EQUI PMENT	S - MOVABLE	2.00	24
. 00	MISC INCOME	В	-1, 096		VE & GENERAL	4.00	25
. 01	UNALLOWED A & G	A	-705, 223	ADMI NI STRATI	VE & GENERAL	4.00	25
. 02	WORKERS COMPENSATION	A	-48, 300	EMPLOYEE BEN	EFITS	3.00	25
	HEP/SALI NE	A	501	SKILLED NURS	ING FACILITY	30.00	25
0.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-591, 755				100

 to Worksheet 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 Fina	ancial Systems	HOLLY MANO	R CENTER		In Lie	u of Form CMS	-2540-10
STATEMENT OFFICE COS	OF COSTS OF SERVICES FROM RELATED ORGANIZ TS	ATIONS AND HOM	E Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet A- Parts I-II Date/Time Pr 5/19/2022 1:	epared:
		Line No.	Cost (	Center	Expense	e Items	
		1.00	2.	00	3.	00	
CLAI	I. COSTS INCURRED AND ADJUSTMENTS REQUID MED HOME OFFICE COSTS:						
1.00			ADMI NI STRATI VE		HOME OFFICE A&C		1.00
2.00			ADMI NI STRATI VE		HOME OFFICE CAR	PITAL	2.00
3.00		44.00	PHYSICAL THERA	PY	PT		3.00
4.00		45.00	OCCUPATI ONAL T	HERAPY	ОТ		4.00
5.00		46.00	SPEECH PATHOLO	GY	ST		5.00
6.00		30.00	SKILLED NURSIN	G FACILITY	NURSING PURCHAS	SED SERVICES	6.00
7.00		30.00	SKILLED NURSIN	G FACILITY	RT		7.00
8.00		4.00	ADMI NI STRATI VE	& GENERAL	MEDICAL DIRECTO	OR	8.00
9.00		0.00					9.00
10.00 TOT/	ALS (sum of lines 1-9). Transfer column						10.00
6, I 12.	ine 100 to Worksheet A-8, column 3, line						
		Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minus	5		
		Cost	Wkst. A, col.	col. 5)			
			5		_		
		4.00	5.00	6.00			_
CLAI	I. COSTS INCURRED AND ADJUSTMENTS REQUIN MED HOME OFFICE COSTS:			-		OR	
1.00		549, 741					1.00
2.00		33, 869		33, 86	9		2.00
3.00		200, 800			0		3.00
4.00		245, 240			0		4.00
5.00		121, 764			0		5.00
6.00		580, 410			0		6.00
7.00		5, 731	5, 731		0		7.00
8.00		30, 401	30, 401		0		8.00
9.00		0	0		0		9.00
10. 00 TOT/	ALS (sum of lines 1-9). Transfer column	1, 767, 956	1, 589, 278	178, 67	8		10.00
	ine 100 to Worksheet A-8, column 3, line						
12.							

Health Financial Systems	nancial Systems HOLLY MANOR CEN			In Lieu of Form CMS-2540-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ. OFFICE COSTS	ATIONS AND HOME	Provider No.: 315143	From 01/01/2021	Worksheet A-8- Parts I-II Date/Time Prep 5/19/2022 1:16	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	В	0.00	1.00
2.00	В	0.00	2.00
3.00	В	0.00	3.00
4.00	В	0.00	4.00
5.00	В	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		
	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	GENESIS HEALTHCARE	100.00 MANAGEMENT COMPANY	1.00
2.00	GRS	100.00PT OT ST	2.00
3.00	GSS	100.00 NURSING PURCHASED SERVICES	3.00
4.00	RHS	100.00 RT	4.00
5.00	GPS	100.00 MEDI CAL DI RECTOR	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.

Health Financial System COST ALLOCATION - GENE		HOLLY MANOR		No.: 315143	In Lie Period:	eu of Form CMS-: Worksheet B	2540-10
COST ALLOCATION - GENE	RAE SERVICE COSTS		FIOVIDEI	10 313143	From 01/01/2021	Part I	nored.
					To 12/31/2021	Date/Time Pre 5/19/2022 1:1	pared: 6 pm
			CAPI TAL REI	LATED COSTS			
Cost Cente	er Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		for Cost	<b>FI XTURES</b>	EQUI PMENT	BENEFI TS		
		Allocation (from Wkst A					
		col. 7)					
GENERAL SERVICE	COST CENTERS	0	1.00	2.00	3.00	3A	
	DSTS - BLDGS & FIXTURES	1, 677, 603	1, 677, 603				1.00
	STS - MOVABLE EQUI PMENT	0			0		2.00
3.00 00300 EMPLOYEE E		786, 203	22, 270		0 808, 473		3.00
4.00 00400 ADMI NI STRA 5.00 00500 PLANT OPER	ATION, MAINT. & REPAIRS	1, 507, 777 403, 746	319, 692 49, 877		0 98, 252 0 17, 005		4.00
6.00 00600 LAUNDRY &		242, 526	34, 847		0 0		•
7.00 00700 HOUSEKEEPI	NG	189, 209	17, 301		0 0		•
8.00 00800 DI ETARY 9.00 00900 NURSI NG AE		860, 607 355, 642	173, 067 25, 337		0 0 0 74, 398	.,	8.00 9.00
10.00 01000 CENTRAL SE		53,805	8, 712		0 4, 132		•
11.00 01100 PHARMACY		0	0		0 0	0	11.00
12.00 01200 MEDI CAL RE		25,073	9, 386		0 5,461		•
13.00 01300 SOCIAL SER 14.00 01400 NURSING AN	ND ALLIED HEALTH EDUCATION	140, 320	8, 221 0		0 29, 325 0 0		13.00
15.00 01500 ACTIVITIES		94, 984	0		0 20, 481		•
	NE SERVICE COST CENTERS	0.070.4(0)	055 500		0 550 440	4 700 4/4	
30. 00 03000 SKI LLED NU 31. 00 03100 NURSI NG FA		3, 278, 162 0	955, 580 0		0 559, 419 0 0		30.00
32.00 03200 I CF/I I D		0	0		0 0		32.00
33.00 03300 OTHER LONG		0	0		0 0	0	33.00
40.00 04000 RADI OLOGY	CE COST CENTERS	22,067	0		0 0	22,067	40.00
41. 00 04100 LABORATORY	(	22, 007	0		0 0		•
42.00 04200 I NTRAVENOL		7, 770	0		0 0	7, 770	•
43.00 04300 0XYGEN (IN 44.00 04400 PHYSICAL T	NHALATION) THERAPY	0	0 19 772			•	
45. 00 04500 0CCUPATION		203, 091 245, 585	18, 773 18, 773				•
46.00 04600 SPEECH PAT		122, 135	0	1	0 0		1
47.00 04700 ELECTROCAR		0	0		0 0	0	47.00
48.00 04800 MEDI CAL SU 49.00 04900 DRUGS CHAR	JPPLIES CHARGED TO PATIENTS	161, 384	12, 822 2, 945			12, 822 164, 329	•
	RE - TITLE XIX ONLY	0	2, 710		0 0		50.00
51.00 05100 SUPPORT SL		34, 273	0		0 0		•
	LLARY SERVICE COST CENTERS	0	0	1	0 0	0	52.00
60. 00 06000 CLINIC		0	0		0 0	0	60.00
61.00 06100 RURAL HEAL	TH CLINIC	0	0		0 0	0	61.00
62.00 06200 FQHC	PATIENT SERVICE COST CENTER	0	0		0 0	о	62.00 63.00
	BLE COST CENTERS	<u> </u>	0	1	0 0	0	03.00
70.00 07000 HOME HEALT	TH AGENCY COST	0	0		0 0		
71.00 07100 AMBULANCE 72.00 07200 CORF		0	0				•
72.00 07200 CORF 73.00 07300 CMHC		0	0			-	72.00
74.00 07400 OTHER REIN	IBURSABLE COST	0	0		0 0		74.00
SPECIAL PURPOSE				1		1	
80.00 08000 MALPRACTIC 81.00 08100 INTEREST E	CE PREMIUMS & PAID LOSSES						80.00 81.00
82. 00 08200 UTI LI ZATI 0							82.00
83. 00 08300 HOSPI CE		0	0		0 0	0	
	CIAL PURPOSE COST CENTERS	0	0		0 000 170	0	
89.00 SUBTOTALS NONREI MBURSABLE	(sum of lines 1-84) COST CENTERS	10, 434, 207	1, 677, 603		0 808, 473	10, 434, 207	89.00
	VER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00 09100 BARBER AND	) BEAUTY SHOP	6, 418	0		0 0	6, 418	91.00
92.00 09200 PHYSI CLANS 93.00 09300 NONPALD WC	S PRIVATE OFFICES	0	0		0 0	0	92.00 93.00
93.00 09300 NONPATE WC 94.00 09400 PATIENTS L		0	0		0 0	0	
95.00 09500 OTHER NONF	REIMBURSABLE COST CENTERS	0	0		0 0	0	95.00
	Adjustments	0	0		0 0	0	98.00
99.00         Negative 0           100.00         TOTAL	Cost Centers	10, 440, 625	0 1, 677, 603		0 0 0 808, 473	0 10, 440, 625	99.00 100.00
			.,,	1	1 300, 770	1	1.20.00

	Financial Systems	HOLLY MANO	R CENTER		In Lie	u of Form CMS-	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/19/2022 1:1	
	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	1		1			1 1 00
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.0$	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	1, 925, 721 106, 437 62, 730 46, 704 233, 775 102, 988 15, 073 0 9, 028 40, 226	577, 065 15, 640 7, 765 77, 674 11, 372 3, 910 0 4, 213 3, 690	355, 743 0 0 0 0 0 0 0 0 0 0 0	260, 979 36, 613 5, 360 1, 843 0 1, 986 1, 739	1, 381, 736 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0 26, 113	0		0	0	14.00 15.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	20, 113	0	0	0	0	10.00
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	1, 084, 016 0 0 0	428, 872 0 0 0	0	0	1, 381, 736 0 0 0	
40.00	ANCI LLARY SERVI CE COST CENTERS	4, 991	0	0	0	0	40.00
40.00	04100 LABORATORY	5, 031	0			0	40.00
42.00	04200 I NTRAVENOUS THERAPY	1, 757	0		0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	50, 177	8, 426	0	3, 972	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	59, 787	8, 426	0	3, 972	0	45.00
46.00	04600 SPEECH PATHOLOGY	27,622	0		0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 900	5, 755	0	2, 713	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	37, 164	1, 322	0	623	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	7, 751	0		0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS	Т Т		1			
60.00	06000 CLINIC	0	0			0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	
62.00		0	0			0	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	63.00
70 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	0	0	0	0	0	
72.00	07200 CORF	0	0	0	0	0	•
73.00	07300 CMHC	0	0	0	0	0	
	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	
	SPECIAL PURPOSE COST CENTERS	-					1
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW						82.00
83.00	08300 HOSPI CE	0	0	0	0	0	•
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	1, 924, 270	577, 065	355, 743	260, 979	1, 381, 736	89.00
00.00	NONREI MBURSABLE COST CENTERS		~				00.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 1, 451	0		0	0	90.00 91.00
	09200 PHYSICIANS PRIVATE OFFICES	1,431	0	0	0	0	91.00
92.00 93.00	09300 NONPALD WORKERS	0	0	0	0	0	92.00
93.00 94.00	09400 PATIENTS LAUNDRY		0	0	0	0	94.00
94.00 95.00	09500 OTHER NONREIMBURSABLE COST CENTERS		0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	0	
99.00	Negative Cost Centers	0	0	0	Ő	0	99.00
100.00		1, 925, 721	577,065	355, 743	260, 979		
	· · ·		,				•

Heal th	n Financial Systems	HOLLY MANO	R CENTER			In Lie	u of Form CMS-2	2540-10
	ALLOCATION - GENERAL SERVICE COSTS			No.: 315143		iod: m 01/01/2021	Worksheet B Part I	
					To	12/31/2021	Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		MEDI CAL	5/19/2022 1:10 SOCI AL SERVI CE	5 pm
		ADMI NI STRATI ON	SERVICES &			RECORDS &		
		9.00	SUPPLY 10.00	11.00		LI BRARY 12.00	13.00	
	GENERAL SERVICE COST CENTERS			1				
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT							1.00 2.00
3.00	00300 EMPLOYEE BENEFITS							3.00
4.00	00400 ADMI NI STRATI VE & GENERAL							4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE							5.00 6.00
7.00	00700 HOUSEKEEPI NG							7.00
8.00	00800 DI ETARY							8.00
9.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	575, 097	87, 475					9.00 10.00
11.00	01100 PHARMACY	0	07,473		0			11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0	55, 147		12.00
13.00 14.00		0	0		0	0 0	223, 521 0	13.00 14.00
14.00		0	0		0	0	0	14.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1				
30.00 31.00		575, 097	87, 475		0 0	47, 433		30.00
31.00		0	0		0	0 0	0	31.00 32.00
33.00		0	0		0	0	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS			1		105	0	40.00
40.00 41.00		0	0		0	135 313		40. 00 41. 00
42.00		0	0		0	36		42.00
43.00		0	0		0	0	0	43.00
44.00 45.00		0	0		0	2, 328 2, 828		44.00 45.00
46.00		0	0		0	1, 429		46.00
47.00		0	0		0	0	0	47.00
48.00 49.00		0	0		0	0 643	0	48.00 49.00
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	043	0	49.00 50.00
51.00	05100 SUPPORT SURFACES	0	0		0	2	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	52.00
60.00		0	0		0	0	0	60.00
61.00		0	0		0	0	0	61.00
62.00 63.00		0	0		0	0	0	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0		U	0	0	63.00
	07000 HOME HEALTH AGENCY COST	0	0		0	0		70.00
	07100 AMBULANCE 07200 CORF	0	0		0	0	0	71.00
	07300 CMHC	0	0		0	0	0	72.00 73.00
	07400 OTHER REIMBURSABLE COST	0	0		0	0	-	74.00
00.00	SPECIAL PURPOSE COST CENTERS	1 1		1				00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE							80. 00 81. 00
82.00								82.00
83.00		0	0		0	0	0	83.00
84.00 89.00		0 575, 097	0 87, 475		0 0	0 55, 147	0 223, 521	84.00 89.00
07.00	NONREI MBURSABLE COST CENTERS				<u> </u>			07.00
90.00		0	0		0	0	0	90.00
91.00 92.00		0	0		0	0	0	91.00 92.00
92.00 93.00		0	0		0	0	0	92.00 93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	0	94.00
95.00 98.00		0	0		0	0	0	95.00 98.00
98.00 99.00	5	0	0		0	0	0	98.00 99.00
100.00	S S	575, 097	87, 475		0	55, 147	223, 521	100. 00

,031 A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HOLLY MANC			Period: From 01/01/2021	u of Form CMS-: Worksheet B Part I	
					To 12/31/2021	Date/Time Pre 5/19/2022 1:1	
			OTHER GENERAL				
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	SERVICE ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
. 00	00300 EMPLOYEE BENEFITS						3.00
. 00	00400 ADMINISTRATIVE & GENERAL						4.00
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
o. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						6.00
. 00 3. 00	00800 DI ETARY						8.00
0.00	00900 NURSI NG ADMI NI STRATI ON						9.00
0.00	01000 CENTRAL SERVICES & SUPPLY						10.00
1.00	01100 PHARMACY						11.00
	01200 MEDI CAL RECORDS & LI BRARY						12.00
	01300 SOCIAL SERVICE						13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	141 570				14.00
5.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	141, 578	5 <u></u>			15.00
0.00	03000 SKI LLED NURSI NG FACI LI TY	0	141, 578	9, 320, 79	0 0	9, 320, 790	30.00
	03100 NURSING FACILITY	0	C		0 0	0	
	03200   CF/I   D	0	C		0 0	0	32.00
3.00	03300 OTHER LONG TERM CARE	0	C		0 0	0	33.00
0 00	ANCI LLARY SERVI CE COST CENTERS			07.40		07.400	1 10 0
	04000 RADI OLOGY 04100 LABORATORY	0				27, 193	
	04200 I NTRAVENOUS THERAPY	0		) 27, 58 9, 56		27, 589 9, 563	
	04300 OXYGEN (INHALATION) THERAPY	0			0 0	, 503	
	04400 PHYSI CAL THERAPY	0	C	286, 76	7 0	286, 767	
5.00	04500 OCCUPATI ONAL THERAPY	0	c c	339, 37	1 0	339, 371	45.00
	04600 SPEECH PATHOLOGY	0	C	) 151, 18	6 0	151, 186	
	04700 ELECTROCARDI OLOGY	0	C		0 0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0		24, 19		24, 190	
	05000 DENTAL CARE - TITLE XIX ONLY	0		204,08	0 0	204, 081 0	
	05100 SUPPORT SURFACES	0		42, 02		42,026	
	05200 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
	06000 CLI NI C	0			0 0	0	
	06100 RURAL HEALTH CLINIC	0	C	0	0 0	0	
2.00 3.00	06200 FQHC 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0 0	0	62.0 63.0
5.00	OTHER REIMBURSABLE COST CENTERS	0		/	0 0	0	03.00
0. 00	07000 HOME HEALTH AGENCY COST	0	C		0 0	0	70.00
	07100 AMBULANCE	0	C		0 0	0	1
	07200 CORF	0	C	)	0 0	0	
	07300 CMHC	0	C		0 0	0	
4.00	07400 OTHER REIMBURSABLE COST	0	C		0 0	0	74.00
00 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			1			80. 0
	08100 I NTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW						82.0
3.00	08300 HOSPI CE	0	C		0 0	0	83.00
	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	C	)	0 0	0	
9.00	SUBTOTALS (sum of lines 1-84)	0	141, 578	10, 432, 75	6 0	10, 432, 756	89.00
	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN					0	90.00
0 00	09000 BARBER AND BEAUTY SHOP			7,86	0 0 9 0	7, 869	
		0		, , 80	Ó n	7,809	
1.00		1 1		1	- I		
1.00 2.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	c c		0 0	0	93.0
91.00 92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES	0	C C		0 0 0 0	0	
<ol> <li>01.00</li> <li>02.00</li> <li>03.00</li> <li>04.00</li> <li>05.00</li> </ol>	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0			0 0 0 0 0 0	0 0	94. 00 95. 00
91.00 92.00 93.00 94.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY					0	94.0 95.0 98.0

	Financial Systems	HOLLY MANOR		N 045440			u of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315143		iod: m 01/01/2021 12/31/2021	Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS			5/19/2022 1:1	6 pm
	Cost Center Description	Directly Assigned New	BLDGS & FI XTURES	MOVABLE EQUI PMENT		Subtotal	EMPLOYEE BENEFI TS	
		Capital Related Costs						
		0	1.00	2.00		2A	3.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	T T		[				1.00
2.00	00200 CAP REL COSTS - BEDGS & FIXTORES							2.00
3.00	00300 EMPLOYEE BENEFITS	0	22, 270		0	22, 270	22, 270	3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	319, 692 49, 877		0	319, 692 49, 877	2, 706 468	4.00 5.00
5.00 6.00	00600 LAUNDRY & LINEN SERVICE	0	49, 877 34, 847		0	49, 877 34, 847	400	6.00
7.00	00700 HOUSEKEEPI NG	0	17, 301		0	17, 301	0	7.00
8.00	00800 DI ETARY	0	173, 067		0	173, 067	0	8.00
9.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0	25, 337 8, 712		0	25, 337 8, 712	2, 049 114	9.00 10.00
11.00	01100 PHARMACY	0	0, 712		o	0, 712	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	9, 386		0	9, 386	150	12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	8, 221 0		0	8, 221 0	808	13.00 14.00
14.00	01500 ACTIVITIES	0	0		0	0	0 564	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1				
30.00	03000 SKILLED NURSING FACILITY	0	955, 580		0	955, 580	15, 411	30.00
31.00 32.00	03100 NURSING FACILITY 03200 ICF/IID	0	0		0 0	0	0	31.00 32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	0	33.00
	ANCI LLARY SERVICE COST CENTERS			I				
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0		0 0	0	0	40.00
41.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	18, 773		0	18, 773	0	44.00
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	18, 773 0		0	18, 773 0	0	45.00 46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 822		0	12, 822	0	48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	2, 945 0		0	2, 945 0	0	49.00 50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	0	52.00
(0.00	OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	0	60.00 61.00
62.00	06200 FQHC		-		-	-	-	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
	07100 AMBULANCE	0	0		0	0	0	71.00
72.00	07200 CORF	0	0		0	0	0	72.00
73.00 74.00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0		0	0	0	73.00
74.00	SPECIAL PURPOSE COST CENTERS	0	0			0	0	/ 4. 00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES							80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW							81.00 82.00
82.00 83.00	08300 HOSPI CE	0	0		0	0	0	82.00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1, 677, 603		0	1, 677, 603	22, 270	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	О	0	92.00
93.00	09300 NONPALD WORKERS	0	0		0	0	0	93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	0	94.00 95.00
98. 00	Cross Foot Adjustments		0			0	0	98.00
99.00	Negative Cost Centers		0		0	0	0	99.00
100.00	TOTAL	0	1, 677, 603	I	0	1, 677, 603	22, 270	100.00

	TION OF CAPITAL RELATED COSTS				eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre	
	Cast Canton Deparienti an					5/19/2022 1:10	
	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		[	I		1.00
2.00 3.00 4.00 5.00 6.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	322, 398 17, 819 10, 502	68, 164 1, 847	47, 196			2.00 3.00 4.00 5.00 6.00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY	7,819	917 9, 175		26, 037	225 022	7.00
8.00 9.00	00900 NURSI NG ADMI NI STRATI ON	39, 138 17, 242	9, 175		3, 653 535	225, 033 0	8.00 9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	2, 524	462		184	0	10.00
11.00	01100 PHARMACY	0	0	-	0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	1, 511	498	0	198	0	12.00
13.00	01300 SOCIAL SERVICE	6, 735	436	0	174	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14.00
15.00	01500 ACTI VI TI ES	4, 372	0	0	0	0	15.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	101.100		17.10/			
30.00	03000 SKI LLED NURSI NG FACI LI TY	181, 483	50, 660			225, 033	30.00
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D	0	0 0		0	0	31.00 32.00
32.00	03300 OTHER LONG TERM CARE	0	0	0		0	
55.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	<u> </u>	0	33.00
40.00	04000 RADI OLOGY	836	0	0	0	0	40.00
41.00	04100 LABORATORY	842	0			0	41.00
42.00	04200 I NTRAVENOUS THERAPY	294	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43.00
44.00	04400 PHYSI CAL THERAPY	8,400	995		396	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	10,009	995		396	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	4, 624	0		0	0	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	485	680		271	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	6, 222	156		62	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	1, 298	0	0	0	0	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
( 0   00	OUTPATIENT SERVICE COST CENTERS						1 / 0 . 00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0			0	60.00 61.00
62.00	06200 FQHC	0	0	0	0	0	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	
	OTHER REIMBURSABLE COST CENTERS			-	1	-	1
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0		70.00
71.00	07100 AMBULANCE	0	0	0	0	0	71.00
72.00	07200 CORF	0	0	0	0	0	
73.00	07300 CMHC	0	0	0	-	0	
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW						82.00
83.00	08300 HOSPI CE	0	0	0	0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	322, 155	68, 164	47, 196	26, 037	225, 033	89.00
00.00	NONREI MBURSABLE COST CENTERS						00.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 243	0		-	0	90.00 91.00
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	243	0	0		0	91.00
	09300 NONPAI D WORKERS	0	0	0	0	0	93.00
93.00	09400 PATIENTS LAUNDRY	0	0	0	Ő	0	94.00
93.00 94.00	e i le la						
94. 00 95. 00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	95.00
94.00 95.00 98.00	09500 OTHER NONREI MBURSABLE COST CENTERS Cross Foot Adjustments	0	0	0 0	0 0	0	98.00
94. 00 95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	0 0 322, 398	0 0 68, 164	0 0 0 47, 196	0 0 26, 037	-	98.00 99.00

Cost Center Description         NURSING ALM STRATUN         CINIKAL SUPPLY         Pulsikan RUMMACY         Pulsikan RUMMACY         Pulsikan RUCORDS & ULL 00         SOCIAL SUPPLY         SUPPLY         Pulsikan RUCORDS & ULL 00         SOCIAL SUPPLY         SOCIAL SUPPLY         SUPPLY         Pulsikan RUCORDS & ULL 00         SOCIAL SUPPLY         SUPPLY         RUCORDS & ULL 00         SOCIAL SUPPLY         SUPPLY         RUCORDS & ULL 00         SOCIAL SUPPLY         SUPPLY         SOCIAL SUPPLY         SUPPLY         SOCIAL SUPPLY         SUPPLY         SOCIAL SUPPLY         SUPPLY         SOCIAL SUPPLY         SUPPLY		Financial Systems TION OF CAPITAL RELATED COSTS	HOLLY MANOR		No.: 315143	De	In Lie eriod:	eu of Form CMS-2 Worksheet B	2540-10
ADM IN STRATION         SERVICES &         ILBRAY           00000         CAP RELORDS A         ILBRAY         13.00           10000         CAP RELORDS - NUMBER ADDIVENT         13.00         13.00           10000         CAP RELORDS - NUMBER ADDIVENT         14.00         14.00           10000         CAP RELORDS - NUMBER ADDIVENT         0         0         11.00           10000         CAP RELORDS - NUMBER ADDIVENT         0         0         0         11.743           11000         CHAP RELORDS - NUMBER ADDIVENT         0	ALLUCA	TION OF CAPITAL RELATED COSTS		FIONDER	NO 313143	Fr	rom 01/01/2021	Part II	pared: 6 pm
CHERAL SLEWICE COST CENTERS           1.00         ODDO CAP REL COSTS - BUOSA & FUTURES           2.00         ODDO CAP REL COSTS - BUOSA & FUTURES           2.00         ODDO CAP REL COSTS - BUOSA & FUTURES           3.00         ODDO CAP REL COSTS - BUOSA & FUTURES           0.00         ODDO CAP REL COSTS - BUOSA & FUTURES           0.00         ODDO CAP REL COSTS - BUOSA & FUTURES           0.00         ODDO CAP REL COSTS - BUOSA & FUTURES           0.00         ODDO CONDUMESING AS ADMINISTRATION           10.00         OTOD ONUMESING AS ADMINISTRATION           10.00         OTOD ONUMESING AS ALLED HEALTH EDUCATION         0           10.00         OTOD ONUMESING		Cost Center Description		SERVICES &	PHARMACY		RECORDS &	SOCIAL SERVICE	
1.00         DOTOD (AP RFL COSTS - BLOS A FLXTURES           2.00         DOZOD (AP RFL COSTS - MOXABLE EURIPHENT           3.00         DOZOD (APR NEL COSTS - MOXABLE EURIPHENT           3.00         DOZOD (ANN STRATUR & GENERAL           5.00         DOGOD (ANN STRATUR & GENERAL           7.00         DOZOD (AUNEY) & LINE SERVICE           7.00         DOZOD (AUNEY) & LINE SERVICE           7.00         DOZOD (AUNEY) & LINE SERVICE           7.00         DOZOD (AUNEY) & LINEARY           10.00         DIZOD (AUNEY) & LINEARY			9.00	10.00	11.00		12.00	13.00	
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 3.00 00300 CAP REL COSTS - MOVABLE EQUIPMENT 4.00 00400 ADM IN STRATIVE & GENERAL 5.00 00500 CHAIN OPERATION, MAINT & REPAIRS 6.00 00500 CHAIN OPERATION, MAINT & REPAIRS 6.00 00400 ADM INSTRATIVE & GENERAL 8.00 00400 DETARY 9.00 00400 UNESING ADMINISTRATION 9.00 00400 00 9.00					1				1
3.00         00300         LMI LOVER ENLER ITS									1.00
4.00         00400 ADM IN STRATIVE & GENERAL									3.00
5.00 00500 PLANT OPERATION, MAINT: & REPAIRS 6.00 00600 (LANDRY & LINEN SERVICE 7.00 00700 HOUSEKEEPI NG 7.00 00700 HURSI NG ADM IN STRATION 46, 506 11, 996 0.00 00 0110, 743 10.00 10100 HIRAMACY 0.0 0.0 0110, 743 10.00 10100 HIRAMACY 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.									4.00
6.00 00600 LAUNDRY & LINEN SERVICE 7.00 0070 MURSING ANDIN STRATION 4.0.500 11.990 00000 MURSING ANDIN STRATION 46.500 0.01000 CENTRAL SERVICES & SUPPLY 0 11.990 0.01000 CENTRAL SERVICES & SUPPLY 0 0 0 0 11.743 0.00 01000 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 11.743 0.00 01000 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1								5.00
7.00         00700         HOUSERVEPT INS         0           9.00         00900         NURSI NG ADMI NI STRATION         46, 506           9.00         00900         NURSI NG ADMI NI STRATION         46, 506           11.00         01000         PHARMACY         0         0           12.00         01200         PHARMACY         0         0         0           13.00         01300         SICIAL SERVICE         0         0         0         0           13.00         01300         NENIS NG AND ALLED HEALTH EDUCATION         0         0         0         0         0           14.00         01400         NIRSING KAND K FACILITY         46, 500         11, 996         0         10, 100         16, 374           20.00         03000         OTF/LIED UNKS FERVICE COST CENTERS         0									6.00
9.000 0000 NURSI NG ADMINISTRATION 46.506 111.996 0110.00 1000 CENTRAL SERVICES & SUPPLY 0 110.00 0 0 0 0110, PHARMACY 0 0 0 0110, PHARMACY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									7.00
10.00         01000 CENTRAL SERVICES & SUPPLY         0         11.996           12.00         01200 MEDICAL RECORDS & LIBRARY         0         0         0           12.00         01200 MEDICAL RECORDS & LIBRARY         0         0         0         0           13.00         01300 MEDICAL RECORDS & LIBRARY         0	3.00	00800 DI ETARY							8.00
11.00       01100       PHARMACY       0       0       0         12.00       01200       NECICAL SERVICE       0       0       0       10.743         13.00       01300       SOCIAL SERVICE       0			46, 506						9.00
12.00         01300         MEDICAL         RECORDS & LIBRARY         0         0         11, 743           14.00         01400         NURSING AND ALLIED HEALTH EDUCATION         0			0						10.00
13. 00         01300 SOCIALS SERVICE         0         0         0         0         16.372           14. 00         01400 NURSING AND ALLIED HEALTH EDUCATION         0			0	0		0	11 740		11.00
14. 00         01400         NUMBERSING AND ALLIED HEALTH EDUCATION         0			0	0		0	_		12.00
15.00         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         015000         01			0	0		-	-		
INPATE INT ROUTI NE SERVICE COST CENTERS           00         03000 SKILLED NUESING FACILITY         46, 506         11, 996         0         10, 100         16, 372           31:00         03100 NUESING FACILITY         46, 506         11, 996         0			0	0		-	-		•
31.00       03100       NURSI NG FACILITY       0       0       0       0       0         32.00       03300       ICFA ILD       0<				-	1	-	-	-	1
32.00         03200 (TF/L ID)         0	30.00	03000 SKILLED NURSING FACILITY	46, 506	11, 996	1	0	10, 100	16, 374	30.00
33.00         O3300         OTHER LONG TERM CARE         O         O         O         O           ANCILLARY SERVICE COST CENTERS			0	C		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS         Image: Control of Control Contenter Control Control Control Control Contrel Conter			-				-		
40. 00         Q40000         RAD IOLOGY         0         0         0         29         C           41. 00         Q4200         INTRAVENOUS THERAPY         0         0         0         67         C           42. 00         Q4200         INTRAVENOUS THERAPY         0         0         0         8         C           43. 00         Q4300         DYGEN (INHALATION) THERAPY         0			0	0		0	0	0	33.00
11.00       04100       LABORATORY       0       0       67       0         200       04200       0100       LABORATORY       0       0       0       67       0         43.00       04300       DXYGEN (I NHALATION) THERAPY       0					1				1 10 00
42 00         04200         INTRAVENOUS THERAPY         0         0         8         0           43.00         04300         OXYGEN (INHALATION) THERAPY         0			-						•
43.00         04300         0XYGEN (1NHALATION) THERAPY         0         0         0         0         0           44.00         04400         PHYSI CAL THERAPY         0         0         0         0         496         0           44.00         04500         OCCUPATIONAL THERAPY         0         0         0         0         602         0           46.00         04600         SPECH PATHOLOGY         0         0         0         304         0           47.00         04700         ELCTROCARDIOLOGY         0			0	0		0		-	
44.00         04400         PHYSI CAL THERAPY         0         0         0         4460         C           45.00         04500         OCCUPATI ONAL THERAPY         0			0	0		0		0	
45:00         04500         0CCUPATI ONAL THERAPY         0		· · ·	0	Ő		0	-	-	
47.00         04700         ELECTROCARDIOLOGY         0 <td></td> <td></td> <td>0</td> <td>C</td> <td></td> <td>0</td> <td></td> <td></td> <td></td>			0	C		0			
48.00         04800         MEDICAL SUPPLIES CHARGED TO PATIENTS         0 <td>46.00</td> <td>04600 SPEECH PATHOLOGY</td> <td>0</td> <td>C</td> <td></td> <td>0</td> <td>304</td> <td>0</td> <td>46.00</td>	46.00	04600 SPEECH PATHOLOGY	0	C		0	304	0	46.00
49.00       04900       DRUGS CHARGED TO PATIENTS       0       0       137       0         50.00       05000       DENTAL CARE - TITLE XIX ONLY       0       0       0       0       0         51.00       05100       SUPPORT SURFACES       0 <t< td=""><td></td><td>04700 ELECTROCARDI OLOGY</td><td>0</td><td>C</td><td></td><td>0</td><td>0</td><td>0</td><td>47.00</td></t<>		04700 ELECTROCARDI OLOGY	0	C		0	0	0	47.00
50.00         05000         DENTAL CARE - TITLE XIX ONLY         0			0	C		0	-	0	
51.00         OS100         SUPPORT SURFACES         O <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td>			0	0		0		0	
52.00         OFACOL OTHER ANCI LLARY SERVICE COST CENTERS         0         0         0         0         0           0UTPATI ENT SERVICE COST CENTERS         0			0	0		0	-	-	50.00
OUTPATIENT SERVICE COST CENTERS           60.00         06000 CLINIC         0<			-	-		-	-		•
60.00         06000         CLINIC         0			0			0	0	0	52.00
61.00       06100       RURAL HEALTH CLINIC       0       0       0       0       0         62.00       06200       FOHC       0 <td></td> <td></td> <td>0</td> <td>C</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>60.00</td>			0	C		0	0	0	60.00
63.00         OG300         OTHER OUTPATIENT SERVICE COST CENTER         O <td></td> <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td>0</td> <td>0</td> <td>•</td>			0	C			0	0	•
OTHER         REI MBURSABLE         COST         CENTERS           70.00         07000         HOME         HEALTH         AGENCY         OST         O <td< td=""><td>52.00</td><td>06200 FQHC</td><td></td><td></td><td></td><td></td><td></td><td></td><td>62.00</td></td<>	52.00	06200 FQHC							62.00
70.00       07000       HOME HEALTH AGENCY COST       0			0	0		0	0	0	63.00
71.00       07100       AMBULANCE       0			-1		1	-	-	-	
72.00       07200       CORF       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
73.00       07300       CMHC       0 <t< td=""><td></td><td></td><td>Ŭ</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>71.00</td></t<>			Ŭ	0		0	0	0	71.00
74.00         07400         OTHER REIMBURSABLE COST         0 <t< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td>0</td><td>0</td><td></td></t<>			-				0	0	
SPECIAL PURPOSE COST CENTERS           80.00         08000         MALPRACTICE PREMIUMS & PAID LOSSES           81.00         08100         INTEREST EXPENSE           82.00         08200         UTILIZATION REVIEW           83.00         08300         HOSPICE           0         0         0           84.00         08400         OTHER SPECIAL PURPOSE COST CENTERS           0         08400         OTHER SPECIAL PURPOSE COST CENTERS           0         0         0           0         0         0           0         0         0           0         0         0           0         0         0           0         0         0           0         0         0           0         0         0           0         0         0           0         0         0           0         0         0         0           0         0         0         0           0         0         0         0         0           0         0         0         0         0           90.00         GIFT, FLOWER, COFFEE SHOPS & CANTEEN			-				0		
80.00         08000         MALPRACTICE PREMIUMS & PAID LOSSES <td< td=""><td></td><td></td><td></td><td></td><td>1</td><td></td><td>0</td><td></td><td>1</td></td<>					1		0		1
82.00         08200         UTILIZATION REVIEW         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>80.00</td>									80.00
83.00         08300         HOSPICE         0	31.00	08100 INTEREST EXPENSE							81.00
84.00         08400         OTHER SPECIAL PURPOSE COST CENTERS         0									82.00
89.00         SUBTOTALS (sum of lines 1-84)         46,506         11,996         0         11,743         16,374           NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         0			0	C		0	0	0	•
NONREI MBURSABLE COST CENTERS           90. 00         09000         GI FT, FLOWER, COFFEE SHOPS & CANTEEN         0         0         0         0           91. 00         09100         BARBER AND BEAUTY SHOP         0         0         0         0         0           92. 00         09200         PHYSI CI ANS PRI VATE OFFI CES         0         0         0         0         0           93. 00         09300         NONPAI D WORKERS         0         0         0         0         0			0				0	0	•
90.00         09000         GIFT, FLOWER, COFFEE SHOPS & CANTEEN         0 <td></td> <td></td> <td>46, 506</td> <td>11, 996</td> <td></td> <td>0</td> <td>11, 743</td> <td>16, 374</td> <td>89.00</td>			46, 506	11, 996		0	11, 743	16, 374	89.00
91.00         09100         BARBER AND BEAUTY SHOP         0 <th< td=""><td></td><td></td><td></td><td>0</td><td></td><td>0</td><td></td><td>0</td><td>90.00</td></th<>				0		0		0	90.00
92.00         09200         PHYSI CLANS PRI VATE OFFICES         0			-						1
93. 00 09300 NONPAI D WORKERS 0 0 0 0 0			0	0		õ	0	0	1
94.00 09400 PATIENTS LAUNDRY I OI OI OI O			0	C		0	0	0	•
		09400 PATIENTS LAUNDRY	0	C		0	0	0	•
			0	C		0	0	0	
98.00         Cross Foot Adjustments         0         0         0			0	0		0			98.00
			0	11 00/			11 740	0	
100. 00           TOTAL         46, 506         11, 996         0         11, 743         16, 374	100.00	TOTAL	46, 506	11, 996	1	U	11, 743	16, 374	1100.00

	Financial Systems TION OF CAPITAL RELATED COSTS	HOLLY MANO	Provi der	F	Period: From 01/01/2021 To 12/31/2021	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/19/2022 1:1	pared:
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVI CE ACTI VI TI ES	Subtotal	Post Step-Down Adjustments		
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	18.00	
12. 00 13. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						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
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	4, 936				14.00 15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	4, 930	<u>א</u>			15.00
31. 00 32. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0 0	4, 936 C C C		0 0 0 0	1, 585, 443 0 0 0	31.00 32.00
41. 00 42. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	000000000000000000000000000000000000000	( ( (	909 302	9 0 2 0	865 909 302	41.00 42.00
44.00 45.00 46.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY			0 ( 29, 060 0 30, 775 0 4, 928	0 5 0 3	0 29, 060 30, 775 4, 928	44.00 45.00 46.00
48.00 49.00 50.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES			) ( ) 14, 258 ) 9, 522 ) ( ) 1, 298	3 O 2 O 0 O	0 14, 258 9, 522 0 1, 298	48.00 49.00 50.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS 0017PATIENT SERVICE COST CENTERS 06000 CLINIC	0	( (	) (	00	0	52.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC 06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	С		0	0	61.00 62.00
71.00 72.00 73.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07200 CORF 07300 CMHC 07400 OTHER REIMBURSABLE COST	0 0 0 0 0	( ( ( ( ( (			0 0 0 0 0	71.00 72.00 73.00
81.00 82.00 83.00 84.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST CENTERS	00000	( ( ( (			0000	84.00
91.00 92.00 93.00	SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		4, 936 C C C C C C	1,677,360           0         ()           0         243           0         ()           0         ()	D O 3 O	1, 677, 360 0 243 0 0	90. 00 91. 00 92. 00 93. 00
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers TOTAL	0 0 0 0 0	0 0 0 4, 936	) () ) () ) () ) () 5 1,677,603	0         0           0         0           0         0           0         0           3         0	0 0 0 1, 677, 603	95.00 98.00 99.00

	Financial Systems ALLOCATION - STATISTICAL BASIS	HOLLY MANC		F	Period: From 01/01/2021	u of Form CMS-2 Worksheet B-1	
				T	o 12/31/2021	Date/Time Pre 5/19/2022 1:1	
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE FEET)		(GROSS		(ACCUM. COST)	
		1.00	2.00	SALARIES) 3.00	4A	4.00	
~~	GENERAL SERVICE COST CENTERS	27.245					
00 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT	27, 345	27, 345				1
00	00300 EMPLOYEE BENEFITS	363					3
00	00400 ADMINISTRATIVE & GENERAL	5, 211				8, 514, 904	4
00	00500 PLANT OPERATION, MAINT. & REPAIRS	813				470, 628	5
00 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	568 282				277, 373 206, 510	
00	00800 DI ETARY	2,821			-	1, 033, 674	8
00	00900 NURSI NG ADMI NI STRATI ON	413				455, 377	9
. 00	01000 CENTRAL SERVICES & SUPPLY	142	142	18, 974	0	66, 649	10
. 00	01100 PHARMACY	0			-	0	11
. 00	01200 MEDICAL RECORDS & LIBRARY	153				39, 920	
. 00 . 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	134				177, 866	13
. 00	01500 ACTIVITIES	0	-			115, 465	
	INPATIENT ROUTINE SERVICE COST CENTERS			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· · · ·	110,100	1.0
. 00	03000 SKILLED NURSING FACILITY	15, 576	15, 576	2, 568, 521	0	4, 793, 161	30
. 00	03100 NURSING FACILITY	0	-		-	0	31
. 00		0	-			0	32
. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	C	0 0	0	33
. 00	04000 RADI OLOGY	0	0	C	0	22, 067	40
. 00	04100 LABORATORY	0	0		-	22, 245	
. 00	04200 I NTRAVENOUS THERAPY	0	0	C	0 0	7, 770	42
. 00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43
. 00	04400 PHYSI CAL THERAPY	306			0	221, 864	
5.00 5.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	306 0			-	264, 358 122, 135	
. 00 . 00	04700 ELECTROCARDI OLOGY	0	0		, s	122, 133	47
3.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	209	-	-	0	12, 822	
9.00	04900 DRUGS CHARGED TO PATIENTS	48	48	c c	0 0	164, 329	49
). 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	-	0	50
. 00	05100 SUPPORT SURFACES	0			-	34, 273	
2.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS OUTPATI ENT SERVICE COST CENTERS	0	0	C	0 0	0	52
). 00	06000 CLINIC	0	0	C	0	0	60
. 00	06100 RURAL HEALTH CLINIC	0	0			0	61
2.00	06200 FQHC						62
8.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	C	0	0	63
	OTHER REIMBURSABLE COST CENTERS					0	1 70
). 00 . 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0			-	0	70   71
2.00	07200 CORF				, s	0	
8.00	07300 CMHC	0	0		-	0	73
. 00	07400 OTHER REIMBURSABLE COST	0	0	c	0 0	0	74
	SPECIAL PURPOSE COST CENTERS	Γ	1	1			
0.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80
. 00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						81
. 00 . 00	08300 HOSPI CE	0	0		0	0	
I. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	84
. 00	SUBTOTALS (sum of lines 1-84)	27, 345	27, 345	3, 712, 032	-1, 925, 721	8, 508, 486	89
	NONREI MBURSABLE COST CENTERS		1	1	1		
. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	90
. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0		C	0	6, 418 0	91 92
. 00	09300 NONPAID WORKERS					0	93
. 00	09400 PATIENTS LAUNDRY	0	0		0	0	94
. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	c	0	0	95
8. 00	Cross Foot Adjustments						98
. 00	Negative Cost Centers						99
02.00		1, 677, 603	0	808, 473		1, 925, 721	102
03.00	Part I) Unit cost multiplier (Wkst. B, Part I)	61. 349534	0. 000000	0. 217798		0. 226159	103
)3.00 )4.00		01. 347334	0.00000	22, 270		322, 398	
	Part II)			22,2/0		522, 570	.54
05.00				0.005999		0. 037863	105
							1

OST A	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2021	Worksheet B-1	
				Τ.		Date/Time Prep 5/19/2022 1:10	
	Cost Center Description	PLANT OPERATI ON, MAI NT. & REPAI RS (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (TOTAL PATI ENT DAYS)		DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (TOTAL PATI ENT DAYS)	
		5.00	6.00	7.00	8.00	9.00	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		1				1.0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 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 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	20, 958 568 282 2, 821 413 142 0 153 134 0 0	30, 229 0 0 0 0 0 0 0 0 0 0 0 0	20, 108	90, 687 0 0 0 0 0 0 0 0	30, 229 0 0 0 0 0 0 0 0	2. 3. 4. 5. 6. 7. 8.
D. 00	03000 SKI LLED NURSI NG FACI LI TY	15, 576	30, 229	15, 576	90, 687	30, 229	30.
1.00	03100 NURSING FACILITY	C	-	0	0	0	31.0
2.00 3.00	03200 ICF/IID 03300 OTHER LONG TERM CARE			0	0	0	32.
3.00	ANCI LLARY SERVICE COST CENTERS		0	0	0	0	33.1
0. OO	04000 RADI OLOGY	C	0	0	0	0	40.
1.00	04100 LABORATORY	C			0	0	41.
2.00 3.00	04200 INTRAVENOUS THERAPY			0	0	0	42. 43.
4.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	306		306	0	0	43.
5.00	04500 OCCUPATI ONAL THERAPY	306		306	0	0	45.
6. 00	04600 SPEECH PATHOLOGY	C	-	0	0	0	46.
7.00	04700 ELECTROCARDI OLOGY	209		0 209	0	0	47.
B. 00 9. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	48		48	0	0	48. 49.
). 00 ). 00	05000 DENTAL CARE - TITLE XIX ONLY	C		0	0	0	50.
1.00	05100 SUPPORT SURFACES	C		0	0	0	51.
2. 00	05200 OTHER ANCI LLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	C	0	0	0	0	52.
D. 00	06000 CLINIC	C	0	0		0	60.
1.00	06100 RURAL HEALTH CLINIC	C			0	0	61.
2.00	06200 FQHC						62.
3. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	C	0	0	0	0	63.
D. 00	07000 HOME HEALTH AGENCY COST	C	0	0	0	0	70.
1.00	07100 AMBULANCE	C		0	0	0	71.
2.00	07200 CORF	C	0	0	0	0	72.
3.00 4.00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0	0	0	0	73.
4.00	SPECIAL PURPOSE COST CENTERS		0	0	0	0	, 4.
0. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.
1.00	08100 I NTEREST EXPENSE						81.
2.00 3.00	08200 UTILIZATION REVIEW 08300 HOSPICE		0	0	0	0	82. 83.
4.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	84.
9. 00	SUBTOTALS (sum of lines 1-84)	20, 958	30, 229	20, 108	90, 687	30, 229	89.
	NONREI MBURSABLE COST CENTERS					0	
). 00 1. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP				0	0	
2.00	09200 PHYSI CLANS PRI VATE OFFI CES	C	0	0	0	0	92.
3.00	09300 NONPAI D WORKERS	C	0	0	0	0	93.
4.00 5.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS		0	0	0	0	94. 95.
3.00 3.00	Cross Foot Adjustments		0	0	0	0	93.
9.00	Negative Cost Centers						99.
02.00	Cost to be allocated (per Wkst. B, Part I)	577,065	355, 743	260, 979	1, 381, 736	575, 097	102.
03. OC 04. OC	Unit cost multiplier (Wkst. B, Part I)	27. 534354 68, 164			15. 236318 225, 033	19. 024678 46, 506	
	Part II)	3. 252410					
05. OC							

	Financial Systems LLOCATION - STATISTICAL BASIS	HOLLY MANOR		No.: 315143 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
0001 /			Trovider	F	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/19/2022 1:1	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 10.00	PHARMACY (COSTED REQUI S. ) 11.00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 12.00	SOCIAL SERVICE (TOTAL PATIENT DAYS) 13.00	NURSING AND ALLIED HEALTH	
	GENERAL SERVICE COST CENTERS	10100	11100	12100	101.00	11100	
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 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	33, 389 0 0 0 0 0	0 0 0 0 0 0	-	30, 229	0	
30.00	03000 SKILLED NURSING FACILITY	33, 389	0	14, 401, 545	30, 229	0	30.00
	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0	000000000000000000000000000000000000000		0	0 0 0	31.00 32.00
40.00	04000 RADI OLOGY	0	0	40, 979	0	0	40.00
41.00	04100 LABORATORY	0	0	101010		0	41.00
	04200 I NTRAVENOUS THERAPY	0	0	10, 974		0	42.00
43.00 44.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0	0	0 706, 867	-	0	43.00 44.00
44.00	04500 OCCUPATI ONAL THERAPY	0	0	858, 407		0	44.00
46.00	04600 SPEECH PATHOLOGY	o	0	433, 724		0	46.00
47.00	04700 ELECTROCARDI OLOGY	o	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	0	195, 187	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0		0	50.00
51.00	05100 SUPPORT SURFACES	0	0	495	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS	I		1			
60.00	06000 CLINIC	0	_	0		0	
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC		0		0	0	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0 0	0	0	63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100 AMBULANCE	o	0		0	0	71.00
	07200 CORF	0	0	0	0	0	
73.00	07300 CMHC	0	0	0	0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS	r		1			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						81.00 82.00
83.00	08300 HOSPI CE	0	0	0	0	0	
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	
89.00	SUBTOTALS (sum of lines 1-84)	33, 389	0	16, 743, 273	30, 229	0	
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	
	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	
93.00 94.00	09300 NONPALD WORKERS 09400 PATLENTS LAUNDRY	0	0		0	0	
94.00 95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	
98.00	Cross Foot Adjustments	U U	0		0	Ŭ	98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B,	87, 475	0	55, 147	223, 521	0	102.00
	Part I)						
103.00		2. 619875	0. 000000			0.000000	
104.00		11, 996	0	11, 743	16, 374	0	104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 359280	0.00000	0. 000701	0. 541665	0. 000000	105 00
100.00		0.007200	0.000000	3.000701	0.041000	0.00000	
	· · · ·	. 1					•

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS	HOLLY MANOR (	Provi der No. : 315143	Peri od:	u of Form CMS- Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	
		OTHER GENERAL		I	5/19/2022 1:1	<u>16 pm</u>
		SERVI CE				
	Cost Center Description	ACTIVITIES (TOTAL PATIENT				
		DAYS)				
		15.00				
4 00	GENERAL SERVICE COST CENTERS					1 4 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT					1.00
3.00	00300 EMPLOYEE BENEFITS					3.00
4.00	00400 ADMINISTRATIVE & GENERAL					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600 LAUNDRY & LINEN SERVICE					6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY					7.00
9.00	00900 NURSI NG ADMI NI STRATI ON					9.00
10. 00	01000 CENTRAL SERVICES & SUPPLY					10.00
11.00						11.00
12.00 13.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE					12.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION					14.00
15.00	01500 ACTI VI TI ES	30, 229				15.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	30, 229				30.00
32.00	03200 I CF/I I D	0				32.00
33.00	03300 OTHER LONG TERM CARE	0				33.00
	ANCILLARY SERVICE COST CENTERS	1				
40.00	04000 RADI OLOGY	0				40.00
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0				41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0				43.00
44.00	04400 PHYSI CAL THERAPY	0				44. OC
45.00	04500 OCCUPATI ONAL THERAPY	0				45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0				46.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				47.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0				49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0				50.00
51.00 52.00	05100 SUPPORT SURFACES	0				51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS OUTPATI ENT SERVICE COST CENTERS					52.00
60.00		0				60.00
61.00	06100 RURAL HEALTH CLINIC	0				61.00
62.00	06200 FQHC					62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0				63.00
70.00		0				70.00
71.00	07100 AMBULANCE	0				71.00
72.00	07200 CORF	0				72.00
73.00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0				73.00
00	SPECIAL PURPOSE COST CENTERS					- / 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES					80. 00
81.00						81.00
82.00 83.00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE					82.00 83.00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0				84.00
89.00	SUBTOTALS (sum of lines 1-84)	30, 229				89.00
	NONREI MBURSABLE COST CENTERS	1				-
90.00		0				90.00
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0				91.00
93.00		o o				93.00
94.00	09400 PATIENTS LAUNDRY	0				94.00
95.00	09500 OTHER NONREI MBURSABLE COST CENTERS	0				95.00
98.00 99.00	Cross Foot Adjustments					98.00 99.00
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	141, 578				102.00
	Part I)					
103.00	Unit cost multiplier (Wkst. B, Part I)	4. 683516				103.00
104.00		4, 936				104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 163287				105.00
	, IVIII COSCILUI LI DI LE UNNOL, D. FALL	0.10320/1				1100.00

Health Financial Systems	HOLLY MANOR CEN	ITER		In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT	COST CENTERS	Provi der		Period:	Worksheet C	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
					5/19/2022 1:1	
Cost Center Description			Total (from	Total Charges		
			Wkst. B, Pt I	1	di vi ded by	
			col . 18)		col . 2	
			1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS			07.40	40.070	0 ((0504	40.00
40. 00 04000 RADI OLOGY			27, 19			
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY			27, 58			
			9, 56			
43. 00 04300 0XYGEN (INHALATION) THERAPY 44. 00 04400 PHYSICAL THERAPY			286, 76	0 0 7 706,867	0.000000 0.405687	
45. 00 04500 OCCUPATI ONAL THERAPY			286, 76			
46. 00 04600 SPEECH PATHOLOGY			151, 18			
47. 00 04700 ELECTROCARDI OLOGY			151, 10	0 433,724	0. 000000	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			24, 19		0.000000	
49. 00 04900 DRUGS CHARGED TO PATIENTS			204, 08			
50. 00 05000 DENTAL CARE - TITLE XIX ONLY			204,00	0 0	0. 000000	•
51. 00 05100 SUPPORT SURFACES			42, 02	6 495	84. 901010	•
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS			12/02	0 0	0. 000000	•
OUTPATIENT SERVICE COST CENTERS				-1 -		
60. 00 06000 CLINIC				0 0	0.00000	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER				0 0	0. 000000	63.00
71. 00 07100 AMBULANCE				0 0	0. 000000	71.00
100. 00 Total			1, 111, 96	6 2, 341, 728		100.00

lealth Financial Systems	HOLLY MANO				eu of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2021 To 12/31/2021		
		Title	XVIII (1)	Skilled Nursing	PPS	
		Health Care Pr	Charge	Facility	Program Cost	
Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
ANCI LLARY SERVICE COST CENTERS			1			
40. 00 04000 RADI OLOGY	0. 663584			0 7,600		
41. 00 04100 LABORATORY	0. 290120			0 676		
42. 00 04200 I NTRAVENOUS THERAPY	0. 871423			0 1, 619		
43. 00 04300 OXYGEN (INHALATION) THERAPY	0.00000			0 0	0	1 101 00
44. 00 04400 PHYSI CAL THERAPY	0. 405687			0 103, 402		1 111 00
45. 00 04500 OCCUPATIONAL THERAPY	0. 395350			0 129, 798		1 101 00
46. 00 04600 SPEECH PATHOLOGY	0. 348577			0 63, 018		1 101 00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS	0.00000				0	
49.00 04900 DRUGS CHARGED TO PATIENTS 50.00 05000 DENTAL CARE - TITLE XIX ONLY	1. 045567 0. 000000	70, 654		0 73, 873	0	50.00
51.00 05100 SUPPORT SURFACES	84. 901010	0		0 5 2(4		
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 5,264		
OUTPATIENT SERVICE COST CENTERS	0.00000	0		0 0	0	52.00
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.000000	0		0	0	61.00
62. 00 06200 FQHC						62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0, 000000	0		0 0	0	
71.00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of Lines 40 - 71)	0.00000	850, 334		0 385, 250	-	100.00

(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	HOLLY MANO	R CENTER		In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315143	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/19/2022 1:1	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description						
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of co	st to charges	(From Workshoo	t C colump 2	line (0)	1. 045567	1.00
2.00 Program vacci ne charges (From your reco			t C, COTUMITS	, IIIIe 49)	2, 787	2.00
3.00 Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet	2, 914	3.00
E, Part I, Line 18)	Aviii, ii 5 pio			t to worksheet	2, 714	5.00
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	(From Wkst. B,			Cost (From	& Allied	
	Part I, Col.	(From Wkst. B,	Allied Healt	h Wkst. D Part	Health Costs	
	18	Part I, Col.	Costs to Tota		for Pass	
		14)	Costs - Part		Through (Col.	
			(Col. 2 / Col 1)		3 x Col. 4)	
	1.00	2.00	3.00	4,00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS			0.00	1.00	0.00	
ANCI LLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	27, 193	C	0.0000	7,600	0	40.00
41. 00 04100 LABORATORY	27, 589	C	0.0000	00 676	0	41.00
42.00 04200 INTRAVENOUS THERAPY	9, 563	C	0.0000	00 1, 619	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	C	0.0000		0	43.00
44. 00 04400 PHYSI CAL THERAPY	286, 767	0	0.0000		0	44.00
45.00 04500 OCCUPATI ONAL THERAPY	339, 371	0	0.0000			45.00
46.00 04600 SPEECH PATHOLOGY	151, 186	C	0.0000			46.00
47. 00 04700 ELECTROCARDI OLOGY	0	C	0.0000		0	47.00
48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	24, 190	0	0.0000		0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	204, 081	0	0.0000		0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	12 02(	0	0.0000		0	50.00
51.00 05100 SUPPORT SURFACES 52.00 05200 OTHER ANCI LLARY SERVICE COST CENTERS	42, 026	0	0.0000		0	51.00 52.00
100.00 Total (Sum of lines 40 - 52)	1, 111, 966			385, 250	-	52.00 100.00
	1, 111, 900	0	1	505, 250	0	1.00.00

Title XVIII         Skilled Nursing Facility         PPS           Impatient days including private room days         1.00           Impatient days including private room days         30.229           1         1           00         Inpatient days including private room days applicable to the Program         2.848           00         Hongeneral inpatient routine service cost         9.320,790           01         Total general inpatient routine service cost         9.320,790           02         Fixe room charges from your records         13.996.816           03         General inpatient routine service cost/charge ratio (Line 5 divided by private room days, line 2)         516.516           04         Average private room charges from your records         13.996.816           05         Owerage semi-private room charges from your records         13.480.300           10.00         Average per diem private room cost differential (Line 9 minus line 10, divided by semi-private room cost differential (Line 7 times line 12)         65.93           10.00         Average per diem private room cost differential (Line 2 times line 13)         60.919           10.00         Private room cost differential (Line 2 times line 13)         60.919           10.00         Average per diem private room cost differential (Line 7 times line 13)         60.919           10.00	UNIPUI	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315143	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 5/19/2022 1:1	pared
PART 1 CALCULATION OF INPATIENT ROUTINE COSTS           INPATIENT DAYS           00         Inpatient days including private room days         30.229         1           00         Private room days         924         2           00         Private room days         924         2           01         Inpatient days including private room days applicable to the Program         9.44           01         Unpatient applient routine service cost         9.320,790           02         PRIVATE ROOM DIFFERENTIAL ADJUSTRENT         9.320,790           03         General inpatient routine service cost /charge ratio (Line 5 divided by private room days, line         516,516           04         Overage private room charges from your records         13,480,300         10           04         Average semi-private room charge dim charge (Semi-private room charges line 10, divided by         460.00         11           05         Semi-private room days         13,480,300         10           04         Verage per diem private room charge differential (Line 9 minus line 11)         99.00         12           06         Average per diem private room cost differential (Line 7 times line 12)         65.93         13           1.00         Average per diem private room cost differential (Line 7 times line 13)         60.91         14			Title XVIII	5		
INPATIENT DAYS           00         Inpatient days including private room days         30,229         1           01         Inpatient days including private room days applicable to the Program         2,848           01         Inpatient days including private room days applicable to the Program         0           02         Inpatient days including private room days applicable to the Program         0           03         Medically necessary private room days applicable to the Program         9,320,790           04         General inpatient routine service cost/charge ratio (Line 5 divided by line 6)         13,996,816           04         General inpatient routine service cost/charge ratio (Line 5 divided by private room days, line         559,00           00         Enter semi-private room charges from your records         13,480,300         10           10.0         Average private room days         13,480,300         12           10.0         Average per diem private room charge differential (Line 7 times line 12)         450,31           10.0         Average per diem private room cost differential (Line 7 times line 12)         453,31           10.0         Private room cost differential diustment (Line 15 divided by line 1)         90,012           10.0         Average per diem private room cost differential (Line 7 times line 13)         90,011           10.0					1.00	
100       Inpatient days including private room days       30, 229       1         000       Private room days       924       2       2, 848       3         001       Medically necessary private room days applicable to the Program       0       4         001       Total general inpatient routine service cost       9, 320, 790       5         001       General inpatient routine service cost/charge ratio (Line 5 divided by line 6)       13, 996, 816       6         001       General inpatient routine service cost/charge ratio (Line 5 divided by private room days, line       516, 516       8         002       Average private room charges from your records       13, 480, 300       10         003       Enter semi-private room charge differential (Line 9 minus line 11)       99, 00       12         014       Overage per diem private room cost differential (Line 7 times line 12)       66, 919       14         004       Verage per diem private room cost differential (Line 7 times line 13)       60, 919       14         015       Overage per diem private room cost pervice cost net of private room cost differential (Line 5 minus line 14)       9, 229, 391       15         015       Private room cost differential (Line 7 times line 13)       60, 919       14       160, 919       160, 919       160, 919       160, 919       160, 91						
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7.00Program routine service cost (Line 3 times line 16)872,399178.00Medically necessary private room cost applicable to program (line 4 times line 13)0189.00Total program general inpatient routine service cost (Line 17 plus line 18)872,399190.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)1,585,443201.00Per diem capital related costs (Line 20 divided by line 1)52.45212.00Program capital related cost (Line 3 times line 21)149,378223.00Inpatient routine service cost (Line 19 minus line 22)723,021234.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service cost limitation (1)27287.00Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)278.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28						
8.00Medically necessary private room cost applicable to program (line 4 times line 13)0189.00Total program general inpatient routine service cost (Line 17 plus line 18)872, 399190.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)1,585, 443201.00Per diem capital related costs (Line 20 divided by line 1)52.45212.00Program capital related cost (Line 3 times line 21)149, 378223.00Inpatient routine service cost for excess costs (From provider records)0245.00Total program routine service cost s for comparison to the cost limitation (Line 23 minus line 24)723, 021236.00Enter the per diem limitation (1)262626277.00Inpatient routine service cost s (Line 3 times the per diem limitation line 26) (1)27288.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	6.00				306.32	16. (
9.00Total program general inpatient routine service cost (Line 17 plus line 18)872,399190.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)1,585,443201.00Per diem capital related costs (Line 20 divided by line 1)52.45212.00Program capital related cost (Line 19 minus line 21)52.45213.00Inpatient routine service cost (Line 19 minus line 22)723,021234.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service cost for comparison to the cost limitation (Line 23 minus line 24)723,021256.00Enter the per diem limitation (1)2728207.00Inpatient routine service cost (Line 2 times the per diem limitation line 26) (1)278.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	7.00				872, 399	
0.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)1,585,443201.00Per diem capital related costs (Line 20 divided by line 1)52.45212.00Program capital related cost (Line 3 times line 21)52.45213.00Inpatient routine service cost (Line 19 minus line 22)723,021234.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)723,021256.00Enter the per diem limitation (1)2728208.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	8.00					18.0
line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)1.00Per diem capital related costs (Line 20 divided by line 1)2.00Program capital related cost (Line 3 times line 21)3.003.00Inpatient routine service cost (Line 19 minus line 22)4.00Aggregate charges to beneficiaries for excess costs (From provider records)5.005.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)6.006.00Enter the per diem limitation (1)7.007.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	9.00					
2.00Program capital related cost (Line 3 times line 21)149,378223.00Inpatient routine service cost (Line 19 minus line 22)723,021234.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)723,021236.00Enter the per diem limitation (1)267.00Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)268.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	20.00			rt II column 18,	1, 585, 443	20. (
3.00Inpatient routine service cost(Line 19 minus line 22)723,021234.00Aggregate charges to beneficiaries for excess costs(From provider records)0245.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)723,021236.00Enter the per diem limitation (1)267.00Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)278.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	1.00	Per diem capital related costs (Line 20 divid	led by line 1)		52.45	21.
4.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)723,021256.00Enter the per diem limitation (1)2626247.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)27288.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	2.00	Program capital related cost (Line 3 times li	ne 21)		149, 378	22.
5.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)723,021256.00Enter the per diem limitation (1)267.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)278.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	3.00	Inpatient routine service cost (Line 19 minus	s line 22)		723, 021	23.
6.00Enter the per diem limitation (1)267.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)278.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	4.00				-	24.
7.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)278.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	5.00		ison to the cost limitation (Line 23 m	inus line 24)	723, 021	
8.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) 28	6. 00					26.
	7.00					27.
	8.00			line 27)		28.0

	1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
Total SNF inpatient days	30, 229	1.00
Program inpatient days (see instructions)	2, 848	2.00
Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
Nursing & allied health ratio. (line 2 divided by line 1)	0.094214	4.00
Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00
	Total SNF inpatient days Program inpatient days (see instructions)	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH       30,229         Total SNF inpatient days       2,848         Program inpatient days (see instructions)       2,848         Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)       0         Nursing & allied health ratio. (line 2 divided by line 1)       0.094214

	Financial Systems		OR CENTER		u of Form CMS-2	2540
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TIT	LE XVIII	Provider No.: 315143	Period: From 01/01/2021	Worksheet E Part I	
				To 12/31/2021	Date/Time Pre	
			Title XVIII	Skilled Nursing	5/19/2022 1:1 PPS	o pili
				Facility		_
				-	1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER C		MBURSEMENT		1.00	
00	Inpatient PPS amount (See Instructions)	JOWI OTATION OF REL	MDORSEMENT		1, 731, 542	1 1
00	Nursing and Allied Health Education Activ	/ities (pass throu	ugh payments)		0	
00	Subtotal (Sum of lines 1 and 2)	(1	9 F=J		1, 731, 542	
00	Primary payor amounts				0	
00	Coinsurance				291,050	
00	Allowable bad debts (From your records)				49, 296	6
00	Allowable Bad debts for dual eligible ber	neficiaries (See i	nstructions)		39, 798	7
00	Adjusted reimbursable bad debts. (See in	nstructions)			32, 042	8
00	Recovery of bad debts - for statistical r	records only			0	9
0. 00	Utilization review				0	10
. 00	Subtotal (See instructions)				1, 472, 534	11
2.00	Interim payments (See instructions)				1, 534, 617	12
8.00	Tentati ve adjustment				0	13
. 00	OTHER adjustment (See instructions)				0	14
1.50	Demonstration payment adjustment amount &				0	
4.55	Demonstration payment adjustment amount a	after sequestratio	n		0	
1.75	Sequestration for non-claims based amount	ts (see instructio	ons)		0	
1. 99	Sequestration amount (see instructions)				0	14
5.00	Balance due provider/program (see Instruc	ctions)			-62, 083	15
b. 00	Protested amounts (Nonallowable cost repo				0	16
7 00	PART B - ANCILLARY SERVICE COMPUTATION OF	REIMBURSEMENT LE	SSER OF COST OR CHARGES - I	IILE XVIII ONLY	0	1 17
	Ancillary services Part B	2)			0	
3.00 9.00	Vaccine cost (From Wkst D, Part II, line Total reasonable costs (Sum of lines 17 a				2, 914 2, 914	
). 00	Medicare Part B ancillary charges (See in				2, 914	
. 00	Cost of covered services (Lesser of Line				2, 787	
2.00	Primary payor amounts	17 01 11110 20)			2, 787	
	Coinsurance and deductibles				0	
I. 00	Allowable bad debts (From your records)				0	
	Allowable Bad debts for dual eligible ber	neficiaries (see i	nstructions)		0	
	Adjusted reimbursable bad debts (see ins				0	1
	Subtotal (Sum of Lines 21 and 24, minus I				2, 787	
b. 00	Interim payments (See instructions)				1, 672	
7.00	Tentati ve adj ustment				0	
3.00	Other Adjustments (See instructions) Spe	eci fy			0	
3.50	Demonstration payment adjustment amount b	2	on		0	
3.55	Demonstration payment adjustment amount a				0	28
8.99	Sequestration amount (see instructions)				0	28
	Balance due provider/program (see instruc	ctions)			1, 115	
	Protested amounts (Nonallowable cost repo		rdanco with CMS Dub 15 2 c	ection 115 2	0	

eal th	Financial Systems					
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT TITLE	V and TITLE XIX ONLY	Provider No.: 315143	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part II Date/Time Pre 5/19/2022 1:1	
			Title XIX	Skilled Nursing Facility		•
				i doi i ty	1.00	
	COMPUTATION OF NET COST OF COVERED SER	/I CES			1.00	
	Inpatient ancillary services (see Inst				C	1.
	Nursing & Allied Health Cost (From Wo		ne 5)		C	
	Outpatient services				C	
	Inpatient routine services (see instru	ctions)			C	-
	Utilization reviewphysicians' compen		ecords)		C	
00	Cost of covered services (Sum of Lines				C	-
	Differential in charges between semipr		d less than semi-private	accommodations	C	-
00	SUBTOTAL (Line 6 minus line 7)				C	
	Primary payor amounts				C	-
	Total Reasonable Cost (Line 8 minus li	ne 9)			C	
	REASONABLE CHARGES				- C	1 10
	Inpatient ancillary service charges					1 11
	Outpatient service charges				C	
	Inpatient routine service charges				0	
	Differential in charges between semipr	ivato accommodations and	d loss than comincivato	accommodations	0	
	Total reasonable charges	I vate accommodations and	a ress than semprivate		C	
	CUSTOMARY CHARGES				C	1 13
	Aggregate amount actually collected fr	om pationts liable for u	anymont for convicos on	a chargo basis	C	16
	Amounts that would have been realized				C	
. 00	had such payment been made in accordan			n a charge basis	L.	'l ''
3. 00	Ratio of line 16 to line 17 (not to ex		)		0.00000	18
	Total customary charges (see instructi	-			0. 000000	
	COMPUTATION OF REIMBURSEMENT SETTLEMEN					4 17
	Cost of covered services (see Instruct				C	20
	Deducti bl es	i ons)			0	
	Subtotal (Line 20 minus line 21)				0	
	Coi nsurance				C	
	Subtotal (Line 22 minus line 23)				0	
	Allowable bad debts (from your records				C	
	Subtotal (sum of lines 24 and 25)	)			0	
	Unrefunded charges to beneficiaries fo	r aveass casts arrange	sly collected based on a	orroction of	C	
. 00	cost limit	excess costs el l'olleous	siy corrected based on c		L. L.	'  <i>21</i>
3. 00	Recovery of excess depreciation result	ing from provider termi	nation or a decrease in	nrogram	C	28
. 00	utilization	ing from provider termin		pi ogi alli	C	/ 20
9.00	Other Adjustments (see instructions)	Specify			C	29
	Amounts applicable to prior cost repor		from disposition of depr	eciable assets (	C	
. 00	if minus, enter amount in parentheses)	the periods resulting	i on ar sposi ti on or depr		C.	1 30
1.00	Subtotal (Line 26 plus or minus lines	29 and 30 minus lines	s 27 and 28)		C	31
	Interim payments		$5 \ge i$ und $\ge 0$		C	
	Balance due provider/program (Line 31	minus line 32) (indicat	e overnavments in paront	heses) (see	0	
	Darance due provider/program (LINE 31	minus iine szj (inuitati	s overpayments in parent	10303) (300	L	1 22

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315143	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Prep 5/19/2022 1:16	bare
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	5 pm
		Inpatien	it Part A		t 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		1, 501, 3	33 0	1, 672 0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER	05/28/2021	33, 2	01	0	3.
02		00/20/2021	33,2	0	0	3.
03				0	0	3
)4				0	0	3
05				0	0	3
	Provider to Program					
0	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		33, 2	84	0	3
~~	- 3.98)		1 504 /	17	1 (70	
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		1, 534, 6	17	1, 672	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			
)1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program		1			
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0	0	5
00	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
01	PROGRAM TO PROVIDER			0	1, 115	6
)2	PROVIDER TO PROGRAM		62, 0	83	0	6
00	Total Medicare program liability (see instructions)		1, 472, 5		2, 787	7
				actor Name	Contractor	
					Number	
					Number	_

 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.

	SHEET (If you are nonproprietary and do not maintain be accounting records, complete the "General Fund" column	Provi der		Period: From 01/01/2021	Worksheet G	
l y)				To 12/31/2021	Date/Time Pre 5/19/2022 1:1	:pare 6 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
0		1.00	2.00	3.00	4.00	_
	ssets URRENT ASSETS					-
	Cash on hand and in banks	4, 161	(	0 0	0	1.
	emporary investments	0		o c	0	
	lotes receivable	0	(	0 0	0	
	Accounts recei vabl e Other recei vabl es	1, 490, 433 -63, 526			0	
	ess: allowances for uncollectible notes and accounts	-233, 481			0	
	recei vabl e	2007 101			Ū	
	nventory	29, 188		0 C	0	
	Prepaid expenses	0		0 0	0	
	Other current assets	551			0	
	Due from other funds TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 227, 326			0	
	I XED ASSETS	1,227,320	<u> </u>	0	0	1.1
	and	0	(	0 C	0	12
	and improvements	34, 813		0 0	0	
	ess: Accumulated depreciation	-6, 654	(	0 0	0	
	Buildings Less Accumulated depreciation	0			0	
	easehold improvements	75, 628			0	
	ess: Accumulated Amortization	-4, 290		0	0	
	ixed equipment	8, 640	(		0	
00 L	ess: Accumulated depreciation	-1, 976	(	0 C	0	20
1	Automobiles and trucks	0		0 C	0	
	ess: Accumulated depreciation	0	(	0 0	0	
	lajor movable equipment	94, 185		0 0	0	
	ess: Accumulated depreciation linor equipment – Depreciable	-21, 654			0	
	li nor equipment nondepreciable	0			0	
	other fixed assets	0	(	0 0	0	
00 T	OTAL FIXED ASSETS (Sum of lines 12 - 27)	178, 692	(	0 0	0	28
	THER ASSETS					
	nvestments Deposits on Leases	0			0	
	Due from owners/officers	-6, 836, 032			0	
	other assets	0	(	0 0	0	
00 T	OTAL OTHER ASSETS (Sum of lines 29 - 32)	-6, 836, 032	(	0 0	0	33
	OTAL ASSETS (Sum of Lines 11, 28, and 33)	-5, 430, 014	(	0 0	0	) 34
	iabilities and Fund Balances URRENT LIABILITIES					1
	Accounts payable	535, 256		0 0	0	3
	Salaries, wages, and fees payable	0		0 0	0	
	Payroll taxes payable	0	(	o c	0	37
	lotes & Loans payable (Short term)	0		0 0	0	
	Deferred income	0	(	0 0	0	
	Accelerated payments Due to other funds	11, 218			0	40
	)ther current liabilities	1, 091, 207			0	
	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 637, 681		0 0	0	
	ONG TERM LIABILITIES					
	lortgage payabl e	0		0 C	0	
	lotes payable	0	(	0 0	0	
	Insecured Loans	0			0	
	Loans from owners: Other long term liabilities				0	
	APIC DISTRIBUTIONS; R/E EARNINGS	-6, 158, 616		- 0 0	0	
	OTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-6, 158, 616	(	0 0	0	
	OTAL LIABILITIES (Sum of lines 43 and 50)	-4, 520, 935	(	0 0	0	<u>5</u>
	API TAL ACCOUNTS					4
	General fund balance	-909, 079				52
	Specific purpose fund Donor created - endowment fund balance - restricted					53
	Nonor created - endowment fund balance - restricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion				-	
	OTAL FUND BALANCES (Sum of lines 52 thru 58) OTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-909, 079 -5, 430, 014		0 0	0	-
00 T						

Heal th	Financial Systems	HOLLY MANOR	CENTER		In Lie	eu of Form CMS-2	2540-10
	ENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315143	Peri od: From 01/01/2021 To 12/31/2021	Worksheet G-1 Date/Time Pre 5/19/2022 1:1	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1 00	Fund halances at beginning of pariod	1.00	2.00	3.00	4.00	5.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	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	0 0 0 0 0 0 0 0 0 0 0 0 0	0 -909, 079 -909, 079 0 -909, 079 0 -909, 079			0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$
	sheet (Line 11 - Line 18)						
		Endowment Fund	Pl ant	Funa			
		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 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 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		9.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00

Heal th	Financial Systems HOLLY MANOR	CENTER			In Lie	eu of Form CMS-2	2540-10		
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315143		riod: om 01/01/2021 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/19/2022 1:1	pared:		
	Cost Center Description		I npati ent		Outpati ent	Total			
			1.00		2.00	3.00			
	PART I – PATIENT REVENUES								
	General Inpatient Routi ne Care Services								
1.00	SKILLED NURSING FACILITY			45		14, 401, 545	1.00		
2.00	IURSING 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 lines 1 - 4)		14, 401, 5	45		14, 401, 545	5.00		
0.00	All Other Care Services		11,101,0	10		11, 101, 010	0.00		
6.00	ANCI LLARY SERVICES		2, 350, 6	28	0	2, 350, 628	6.00		
7.00	CLINIC		2, 330, 0	20	0		7.00		
8.00	HOME HEALTH AGENCY COST				0	0	8.00		
9.00	AMBULANCE				0	0	9.00		
9.00 10.00	RURAL HEALTH CLINIC				0		10.00		
	FORAL HEALTH CLINIC				0				
10.10					0	0	10.10		
11.00	CMHC				0	0	11.00		
11.10	CORF				0	0	11.10		
12.00	HOSPICE			0	0	0	12.00		
13.00	OTHER (SPECIFY)			0	0	0	13.00		
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column	3 to	16, 752, 1	73	0	16, 752, 173	14.00		
	Worksheet G-3, Line 1)			_					
	Cost Center Description								
	1				1.00	2.00			
	PART II - OPERATING EXPENSES								
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					11, 032, 380	1.00		
2.00	Add (Specify)				0		2.00		
3.00					0		3.00		
4.00					0		4.00		
5.00					0		5.00		
6.00					0		6.00		
7.00					0		7.00		
8.00	Total Additions (Sum of lines 2 - 7)					0	8.00		
9.00	Deduct (Specify)				0		9.00		
10.00					0		10.00		
11.00					0		11.00		
12.00					0		12.00		
13.00					0		13.00		
14.00	Total Deductions (Sum of lines 9 - 13)				0	0			
	Total Operating Expenses (Sum of Lines 1 and 8, minus Line 14	)				11, 032, 380			
15.00	Tiotal operating Expenses (sum of times rained, millius time 14	)		1		11,032,300	15.00		

Heal th	ancial Systems HOLLY MANOR CENTER In L		In Lie	u of Form CMS-2	2540-10	
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315143 Pe		Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/19/2022 1:16 pm			
	· · · · · · · · · · · · · · · · · · ·				0/1//2022 1.10	5 pm
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,	16, 752, 173	1.00			
2.00	Less: contractual allowances and discounts on pa	6, 641, 271	2.00			
3.00	Net patient revenues (Line 1 minus line 2)	10, 110, 902	3.00			
4.00	Less: total operating expenses (From Worksheet (	G-2, Part II, lii	ne 15)		11, 032, 380	4.00
5.00	Net income from service to patients (Line 3 minuted	us 4)			-921, 478	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from communications ( Telephone and In-	ternet service)			0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and guests				0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical suppli	ies to other tha	n patients		0	16.00
17.00	Revenue from sale of drugs to other than patien	ts			0	17.00
18.00	Revenue from sale of medical records and abstrac	cts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.	.)			0	19.00
20.00	Revenue from gifts, flower, coffee shops, canter	en			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of skilled nursing space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	MISC INCOME				12, 399	24.00
24.50	COVI D-19 PHE Funding				0	24.50
25.00	Total other income (Sum of lines 6 - 24)				12, 399	25.00
26.00	Total (Line 5 plus line 25)				-909, 079	26.00
27.00	Other expenses (specify)				0	27.00
28.00					0	28.00
29.00					0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)				0	30.00
31.00	Net income (or loss) for the period (Line 26 min	nus line 30)			-909, 079	31.00