This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315243

Period:
From 01/01/2021
To 12/31/2021

Worksheet S
Parts I, II & III
Date/Time Prepared:
5/19/2022 1:32 pm

				3/ 1	7/2UZZ I	. ZZ PIII
PART I - COST	REPORT STATUS					
Provi der use only	1. [ X ] Electronically prepared cost report 2. [ ] Manually prepared cost report	ort		Date: 5/19/2022	Ti me:	1: 22 p
use only	3. [ 0 ] If this is an amended report end 3. 01 [ ] No Medicare Utilization. Enter '			resubmitted this co	st repor	t
Contractor use only	4. [ 1 ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended  5. Date Received:	8.[ N ] Last 9. NPR Date: 10.[ 0 ]If I 11.Contracto 12.[ F ] Medi	No. t Cost Report for this Cost Report for this Fine 4, column 1 is "4": r Vendor Code care Utilization. Enter	Provider CCN Enter number of tim 4		

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MILLVILLE CENTER ( 315243 ) 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	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1	Dia	ne Morris	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	
F	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-102, 985	2, 514	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	-102, 985	2, 514	0	100.00

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

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

Health Financial Systems MILLVILLE CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315243 Peri od: Worksheet S-2 From 01/01/2021 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2021 5/19/2022 1:22 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 54 SHARP STREET PO Box: 1.00 2.00 City: MILLVILLE State: NJ Zi p Code: 08332 2.00 3.00 County: CUMBERLAND CBSA Code: 47220 Urban/Rural: U 3.00 3. 01 CBSA Code: 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4.00 5.00 6.00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF MILLVILLE CENTER 315243 04/01/1987 N Р Р 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 43, 926 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 43, 926 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) Ν 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility N 30.00 31.00 | ICF/IID Ν 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 N 34.00 SNF-Based FQHC Ν 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38.00 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00

Health Financial Systems	MILLVILLE CEN	TER	In Lie	u of Form CMS-2	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE   Provider No.: 315243   Period:   W					
COMPLEX INDENTIFICATION DATA			From 01/01/2021	Part I	
			To 12/31/2021	Date/Time Prep 5/19/2022 1: 2:	
				Y/N	z piii
				.,	
				1.00	
42.00 Are malpractice premiums and paid loss				N	42.00
center? Enter Y or N. If yes, check bo	ox, and submit supporting	schedule listing cost	centers and		
amounts.					
43.00 Are there any home office costs as def	ined in CMS Pub. 15-1, Ch	apter 10?		Υ	43.00
44.00 If line 43 is yes, enter the home offi	ce chain number and enter	the name and 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 nam	e and address of the	home office on the	lines	
bel ow.					
45. 00 Name: GENESIS HEALTHCARE	Contractor's Name: NOVITA	S Contra	ctor's Number: 1200	)1	45. 00
46.00 Street: 101 EAST STATE STREET	PO Box:				46. 00
47.00 City: KENNETT SQUARE	State: PA	Zi p Co	de: 1934	0	47. 00

	Financial Systems	MILLVILLE CENTER			eu of Form CMS-	
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE   Provi		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre	epared:
				Y/N	5/19/2022 1:2 Date	22 pm
			THE COLUMN HAND	1.00	2. 00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column i, "Y	" for yes or "N"	TOT NO. FOT ALL	the date	
1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)			N		1.00
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in	the Medicare Program? If	1. 00 N	2. 00	3. 00	2. 00
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and in col	umn			
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personner of directors through ownership, control, or relationships? (see instructions)	., chain home offices, dr d to the provider or its I, or members of the boar	rug			3.00
	Teratronsings. (See That dottons)		Y/N	Туре	Date	
	Financial Data and Reports		1. 00	2. 00	3. 00	
4.00	Column 1: Were the financial statements preparcountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" for te copy or enter date	С	С		4. 00
5. 00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If reconciliation.	revenues different from	N			5. 00
	T COSHOTT TUTTON.		<b>'</b>	Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	ool? (Y/N) Column 2: Is	the provider the	N	N	6. 00
7. 00 8. 00	Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so	ng the cost reporting per		N N		7. 00 8. 00
	()				Y/N 1.00	
0.00	Bad Debts	1 1 1 1 0 ()////				0.00
9. 00 10. 00	Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	t collection policy chang	e during this cos		Y N	9.00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance waived?	If "Y", see instr	ucti ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting period? I			N	12. 00
		Description	Y/N	Date	Part B Y/N	
	DCAD D.	0	1.00	2. 00	3. 00	
13. 00	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.)		N		N	13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		Y	03/19/2022	Y	14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were		N		N	16. 00
16.00	adjustments made to PS&R data for corrections of other PS&R Report information? If we see instructions					
17. 00	"		N		N	17. 00

Heal th	Financial Systems MILLVILL	E CEN	TER		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE		Provi der No.: 315243		eriod: com 01/01/2021	Worksheet S-2 Part II	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To		Date/Time Pre	pared:
		_		Ц,		5/19/2022 1: 2	2 pm
			1. 00		2.	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/position	JEAN		F	PRI CE		19. 00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
20.00	Enter the employer/company name of the cost report	GENE	SIS HEALTHCARE				20. 00
	preparer.						
21.00	Enter the telephone number and email address of the cost	4108	044481	L	JEAN. PRI CE@GENE	ESI SHCC. COM	21. 00
	report preparer in columns 1 and 2, respectively.						

 
 Heal th Financial
 Systems
 MILLVILLE

 SKILLED NURSING
 FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 MILLVILLE CENTER Provi der No.: 315243

| In Lieu of Form CMS-2540-10 | Period: | Worksheet S-2 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/19/2022 1:22 pm COMPLEX REIMBURSEMENT QUESTIONNAIRE

				5/19/2022 1:	22 pm
		Part B			
		Date			
		4. 00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R				13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and				
	4. (see Instructions.)				
14.00	Was the cost report prepared using the PS&R	03/19/2022			14. 00
	for total and the provider's records for				
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
45.00	4.				45.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that				15. 00
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
	see Instructions.				
16. 00	If line 13 or 14 is "Y", then were				16, 00
10.00	adjustments made to PS&R data for				10.00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17.00	If line 13 or 14 is "Y", then were				17. 00
	adjustments made to PS&R data for Other?				
	Describe the other adjustments:				
18.00	Was the cost report prepared only using the				18. 00
	provider's records? If "Y" see Instructions.				
			3. 00		
	Cost Report Preparer Contact Information				
19. 00	Enter the first name, last name and the title		REIMBURSEMENT ANALYST		19. 00
	held by the cost report preparer in columns 1	, 2, and 3,			
00.00	respecti vel y.				00.00
20. 00	Enter the employer/company name of the cost r	report			20. 00
21 00	preparer.	of the cost			21.00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respective				21. 00
	Treport preparer in corumns rand 2, respectiv	rei y.	I		I

MILLVILLE CENTER In Lieu of Form CMS-2540-10

Health Financial Systems MILLVILLE SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared: 5/19/2022 1:22 pm Provi der No.: 315243 Peri od:

						5/19/2022 1: 22	2 pm
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	167	60, 955	0	5, 863	28, 844	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4. 00	HOME HEALTH AGENCY COST			0	0	0	4. 00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	1/7	(0.055	0	U 5 0/3	0 044	7. 00
8. 00	Total (Sum of lines 1-7)	167	60, 955 Days/Vi si ts	0	5, 863 Di scharges	28, 844	8. 00
		Tripatricité E	Says/ VI SI tS		Di Schai ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	I	6. 00	7. 00	8. 00	9. 00	10.00	
1.00	SKILLED NURSING FACILITY	7, 865		0	193	60	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3. 00 4. 00	ICF/IID   HOME HEALTH AGENCY COST	0	0			0	3. 00 4. 00
5. 00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0	o	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	7, 865	42, 572	0	193	60	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	300		0. 00	30. 38	480. 73	1. 00
2.00	NURSING FACILITY	0	0	0. 00		0. 00	2. 00
3.00	ICF/IID	0	0			0. 00	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	U				5. 00 6. 00
6. 10	SNF-Based CORF						6. 00 6. 10
7. 00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	300	553	0.00	30. 38	480. 73	8. 00
0.00	Total (Sam of Titles 1 7)	Average Length		Admi s		100. 70	0.00
		of Stay					
	Component	Total	Title V	Title XVIII	Title XIX	0ther	
	T	16. 00	17. 00	18. 00	19. 00	20. 00	
1.00	SKILLED NURSING FACILITY	76. 98		228	28	302	1. 00
2.00	NURSING FACILITY	0.00			0	0	2. 00
3. 00 4. 00	ICF/IID   HOME HEALTH AGENCY COST	0.00			0	0	3. 00 4. 00
5. 00	Other Long Term Care	0.00				0	5. 00
6. 00	SNF-Based CMHC	0.00				o <sub>l</sub>	6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0.00	o	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	76. 98			28	302	8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
			Payrol I	Workers			
1 00	SKILLED MUDSING EACHLEY	21.00	22.00	23. 00			1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	558 0	92. 50 0. 00	0. 00 0. 00			1. 00 2. 00
3. 00	ICF/IID	0	0.00	0.00			2. 00 3. 00
4.00	HOME HEALTH AGENCY COST		0.00	0.00			4. 00
5. 00	Other Long Term Care	0	0.00	0.00			5. 00
6.00	SNF-Based CMHC		0.00	0.00			6. 00
6. 10	SNF-Based CORF		0.00	0.00			6. 10
7.00	HOSPI CE	0	0.00	0. 00			7. 00
8. 00	Total (Sum of lines 1-7)	558	92. 50	0. 00			8. 00

				T	0 12/31/2021	Date/Time Prep 5/19/2022 1:2	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	5, 104, 745	0	5, 104, 745	i i		
2.00	Physician salaries-Part A	0	0	0	0.00		
3.00	Physician salaries-Part B	0	0	0	0.00		
4.00	Home office personnel	0	0	0	0.00	0. 00	
5.00	Sum of lines 2 through 4	0	0	0	0.00	0. 00	5. 00
6.00	Revised wages (line 1 minus line 5)	5, 104, 745	0	5, 104, 745	192, 393. 00	26. 53	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	5, 104, 745	0	5, 104, 745	192, 393. 00	26. 53	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	2, 834, 859	0	2, 834, 859	38, 589. 34	73. 46	14.00
15.00	Contract Labor: Physician services-Part A	30, 114	0	30, 114	354.00	85. 07	15.00
16.00	Home office salaries & wage related costs	622, 203	0	622, 203	11, 616. 00	53. 56	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1, 294, 206	O	1, 294, 206			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19.00	Wage related costs (excluded units)	0		0			19. 00
20.00	Physician Part A - WRC	0		0			20. 00
21.00	Physician Part B - WRC	0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 294, 206	0	1, 294, 206			22. 00
	instructions)						
		•	•	•	•		

In Lieu of Form CMS-2540-10 Health Financial Systems MILLVILLE CENTER Provi der No.: 315243 Peri od:

SNF WAGE INDEX INFORMATION

Worksheet S-3 Part III Date/Time Prepared: From 01/01/2021 To 12/31/2021 5/19/2022 1:22 pm Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 ÷ Reported col . 4) Worksheet A-6  $1 \pm col. 2$ Salary in col 5.00 1.00 2.00 3.00 4.00 PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0.00 0.00 1.00 2.00 Administrative & General 13, 666. 00 4, 069. 00 410, 844 0 410, 844 30.06 2.00 3.00 Plant Operation, Maintenance & Repairs 102, 803 0 102, 803 25. 26 3.00 4.00 Laundry & Linen Service 0.00 0.00 4.00 5.00 Housekeepi ng 0 0 0.00 0.00 5.00 0.00 Di etary 0.00 6.00 6.00 0 Nursing Administration 580, 353 -64, 752 515, 601 14, 085. 00 7.00 7.00 36. 61 8.00 Central Services and Supply 0 18, 323 18, 323 1, 020. 00 17.96 8.00 9.00 Pharmacy 0 0.00 0.00 9. 00 21.44 Medical Records & Medical Records Library 46, 429 10.00 46, 429 2, 166. 00 10.00 Social Service 11.00 168, 723 168, 723 6,043.00 27.92 11.00 12.00 Nursing and Allied Health Ed. Act. 12.00 7, 920. 00 17. 99 13.00 Other General Service 142, 455 0 142, 455 13.00 14.00 Total (sum lines 1 thru 13) 28. 70 14. 00

1, 405, 178

1, 405, 178

48, 969. 00

Health Financial Systems	MILLVILLE CENTER	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315243	Peri od: Worksheet S-3
		From 01/01/2021   Part IV
		T- 10/01/0001 D-+-/T: D

	To 12/31/202		pared: 2 pm
		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	230, 276	
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00		579, 234	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	377, 349	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	88, 210	20. 00
	OTHER		
21.00	Executive Deferred Compensation	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	19, 137	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 294, 206	24. 00
		Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Provi der No.: 315243

					0 12/31/2021	Date/Time Prep 5/19/2022 1:2	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	
	obsupational satisfiery	Reported		Salaries (col.		Wage (col. 3 ÷	
		,			Salary in col.	col . 4)	
				,	3		
		1.00	2.00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	756, 819	74, 748		18, 330. 00	45. 37	1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 252, 548	290, 444	1, 542, 992			2. 00
3.00	Certified Nursing Assistant/Nursing	1, 690, 200	679, 143	2, 369, 343	83, 451. 00	28. 39	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 699, 567	1, 044, 335	4, 743, 902	· ·		4. 00
5.00	Physical Therapists	0	0	0	0.00		
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6. 00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7. 00
8.00	Occupational Therapists	0	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 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	Respi ratory Therapi sts	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						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	47, 835		47, 835	678. 79	70. 47	14. 00
15.00	Licensed Practical Nurses (LPNs)	160, 536		160, 536	2, 535. 43	63. 32	15. 00
16.00	Certified Nursing Assistant/Nursing	264, 696		264, 696	6, 359. 02	41. 63	16. 00
	Assi stants/Ai des						
17. 00		473, 067		473, 067	· ·		17. 00
18. 00	Physi cal Therapists	355, 957		355, 957			
19. 00		112, 382		112, 382			
20. 00	Physical Therapy Aides	0		0	0.00		
21. 00	1 '	273, 221		273, 221			
22. 00		276, 118		276, 118			
23. 00		0		0			23. 00
24.00		108, 563		108, 563			
25. 00	, , , , ,	423		423			25. 00
26. 00	Other Medical Staff	30, 114		30, 114	354.00	85. 07	26. 00

Provi der No.: 315243 

	10 12/31/20	21   Date/lime Prepared:   5/19/2022 1:22 pm
	Group	Days
1.00	1. 00 RUX	2. 00
2.00	RUL	2.00
3.00	RVX	3.00
4. 00	RVL	4.00
5. 00	RHX	5. 00
6.00	RHL	6. 00
7. 00 8. 00	RMX RML	8.00
9. 00	RLX	9.00
10. 00	RUC	10.00
11. 00	RUB	11.00
12.00	RUA	12.00
13. 00 14. 00	RVC RVB	13. 00 14. 00
15. 00	RVA	15. 00
16. 00	RHC	16. 00
17. 00	RHB	17. 00
18.00	RHA	18.00
19. 00   20. 00	RMC RMB	19. 00 20. 00
21. 00	RMA	21. 00
22. 00	RLB	22. 00
23. 00	RLA	23. 00
24. 00	ES3	24.00
25. 00   26. 00	ES2 ES1	25. 00 26. 00
27. 00	HE2	27. 00
28. 00	HE1	28. 00
29. 00	HD2	29. 00
30.00	HD1	30.00
31. 00 32. 00	HC2 HC1	31. 00 32. 00
33. 00	HB2	33.00
34. 00	HB1	34.00
35. 00	LE2	35. 00
36.00	LE1	36.00
37. 00 38. 00	LD2 LD1	37. 00 38. 00
39. 00	LC2	39.00
40.00	LC1	40.00
41. 00	LB2	41. 00
42.00	LB1	42.00
43. 00 44. 00	CE2 CE1	43. 00 44. 00
45. 00	CD2	45.00
46. 00	CD1	46. 00
47. 00	CC2	47. 00
48.00	CC1	48.00
49. 00 50. 00	CB2 CB1	49. 00 50. 00
51. 00	CA2	51. 00
52. 00	CA1	52.00
53. 00	SE3	53.00
54. 00   55. 00	SE2 SE1	54. 00 55. 00
56. 00	SSC	56. 00
57. 00	SSB	57. 00
58. 00	SSA	58.00
59. 00	I B2	59.00
60. 00 61. 00	I B1 I A2	60. 00
62. 00	I A1	62. 00
63. 00	BB2	63. 00
64. 00	BB1	64. 00
65. 00	BA2	65.00
66.00	BA1	66.00
67. 00 68. 00	PE2 PE1	67. 00 68. 00
69. 00	PD2	69.00
70. 00	PD1	70.00
71.00	PC2	71.00
72. 00 73. 00	PC1 PB2	72. 00 73. 00
73.00	PB2	73.00
75. 00	PA2	75. 00
· · · · · · · · · · · · · · · · · · ·	,	, , , , , , , , , , , , , , , , , , , ,

Health Financial Systems	MILLVILLE CENTER	R		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	P	rovi der	No.: 315243	Peri od:	Worksheet S-7	7
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/19/2022 1:2	
				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 expec 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" fo with direct patient care and related expenses (See instructions)	ted this increase to column 1 the amount each category to tot r yes or "N" for no i	be used of the tal SNF if the s	for direct pexpense for erevenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
101. 00 Staffi ng						101. 00
102.00 Recrui tment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105.00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, lin	e 1, column 3)					106. 00

Health Financial Systems	MILLVILLE C	ENTER		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/19/2022 1:2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	z piii
'			+ col . 2)	ons	Trial Balance	
				I ncrease/Decre	(col. 3 +-	
				ase (Fr Wkst	col. 4)	
	1.00	2. 00	3. 00	A-6) 4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES		3, 754, 184	3, 754, 18	4 0	3, 754, 184	1. 00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT		0	(	0	0	2. 00
3.00   00300   EMPLOYEE BENEFITS	0	1, 280, 368	1, 280, 36		1, 280, 368	3. 00
4. 00   00400   ADMI NI STRATI VE & GENERAL	410, 844	2, 055, 047	2, 465, 89		2, 465, 891	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	102, 803	470, 455	573, 25	1	573, 258	5. 00
6.00   00600   LAUNDRY & LI NEN SERVI CE 7.00   00700   HOUSEKEEPI NG		246, 845 282, 853	246, 84! 282, 85:	1	246, 845 282, 853	6. 00 7. 00
8. 00   00800 DI ETARY		936, 088	936, 08	1	936, 088	8. 00
9. 00 00900 NURSING ADMINISTRATION	580, 353	75, 148		1	590, 749	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	0	36, 981	36, 98		55, 304	10. 00
11. 00   01100   PHARMACY	0	0		0	0	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	0	(	46, 429	46, 429	12. 00
13. 00 01300 SOCIAL SERVICE	168, 723	142	168, 86	0	168, 865	13.00
14.00   01400   NURSING AND ALLIED HEALTH EDUCATION 15.00   01500   ACTIVITIES	142 455	22 (0)	17/ 15:	0	17/ 151	14. 00 15. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	142, 455	33, 696	176, 15	ij oj	176, 151	13.00
30. 00 03000 SKILLED NURSING FACILITY	3, 699, 567	637, 473	4, 337, 040	0 0	4, 337, 040	30. 00
31.00 03100 NURSING FACILITY	0	0		0	0	31.00
32. 00   03200   I CF/I I D	0	0	(	0	0	32. 00
33. 00 03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
ANCI LLARY SERVI CE COST CENTERS  40. 00 04000 RADI 0LOGY	0	19, 236	19, 23	6	19, 236	40. 00
41. 00   04100   LABORATORY		43, 770	43, 770	1	43, 770	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	l ő	85, 382	85, 38:	1	85, 382	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	O	0	(	o o	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0	407, 817	407, 81	7 0	407, 817	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	549, 824	549, 82	1	549, 824	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	171, 803	171, 80	3 0	171, 803 0	46. 00
47. 00   04700   ELECTROCARDI OLOGY 48. 00   04800   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0	1		0	47. 00 48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS		258, 454	258, 45	4 0	258, 454	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	(	o o	0	50.00
51.00 05100 SUPPORT SURFACES	0	4, 552	4, 55	2 0	4, 552	51. 00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0	0	52. 00
60.00 OCTOPATIENT SERVICE COST CENTERS	l ol	0		o lo	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC		0			0	61. 00
62. 00   06200   FQHC		J			Ü	62. 00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70. 00 07000 HOME HEALTH AGENCY COST	0	0	(	0	0	
71. 00   07100   AMBULANCE 72. 00   07200   CORF		0			0	71. 00 72. 00
73. 00 07300 CMHC		0			0	73. 00
74. 00 07400 OTHER REIMBURSABLE COST	o	Ö			0	74. 00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	(	0	0	80. 00
81. 00 08100 I NTEREST EXPENSE		0	(	0	0	81.00
82. 00   08200   UTI LI ZATI ON REVI EW 83. 00   08300   HOSPI CE		0			0	82. 00 83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS		0			0	84. 00
89. 00 SUBTOTALS (sum of lines 1-84)	5, 104, 745	11, 350, 118	16, 454, 86	3 0	16, 454, 863	89. 00
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(	0	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	0	1, 405	1, 40	0	1, 405	91.00
92. 00   O9200   PHYSICIANS PRIVATE OFFICES 93. 00   O9300   NONPAID   WORKERS	U	0			0	92. 00 93. 00
94. 00   09400   PATI ENTS LAUNDRY		0			0	93.00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS		0		ol ol	0	95. 00
100. 00 TOTAL	5, 104, 745	11, 351, 523	16, 456, 26	3  o	16, 456, 268	

MILLVILLE CENTER In Lieu of Form CMS-2540-10

Health Financial Systems MILLY RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES 

				To 12/31/2021 Date/Time Pre	
	Cost Center Description	Adjustments to	Net Expenses	37 177 2022 1.2	.z piii
		Expenses (Fr	For Allocation		
		Wkst A-8)	(col. 5 +-		
		6. 00	col . 6) 7.00	-	
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	C	3, 754, 184	1	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	C	0		2. 00
3.00	00300 EMPLOYEE BENEFITS	-261, 461		•	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-517, 708			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS		573, 258	•	5. 00
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG		246, 845 282, 853	•	6. 00 7. 00
8. 00	00800 DI ETARY		936, 088	•	8.00
9. 00	00900 NURSING ADMINISTRATION		590, 749	•	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	C	55, 304	1	10.00
11.00	01100 PHARMACY		0		11. 00
	01200 MEDICAL RECORDS & LIBRARY	C	46, 429		12. 00
13. 00	01300 SOCIAL SERVICE	C	168, 865	1	13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	2/ 001	150 150		14.00
15. 00	01500   ACTIVITIES   INPATIENT ROUTINE SERVICE COST CENTERS	-26, 001	150, 150	J	15. 00
30. 00	03000 SKILLED NURSING FACILITY	1, 585	4, 338, 625	5	30.00
	03100 NURSING FACILITY	1,000		l .	31. 00
32.00	03200   CF/IID	C	0		32. 00
33. 00	03300 OTHER LONG TERM CARE	C	0	)	33. 00
	ANCILLARY SERVICE COST CENTERS				
40. 00	04000 RADI OLOGY	C	1,	l .	40. 00
41. 00	04100 LABORATORY	C	43, 770		41. 00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY		85, 382		42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		407, 817	1	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		549, 824	l .	45. 00
46. 00	04600 SPEECH PATHOLOGY		171, 803	1	46. 00
47.00	04700 ELECTROCARDI OLOGY	C	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	C	258, 454	1	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0		50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCI LLARY SERVICE COST CENTERS		4, 552	•	51. 00 52. 00
32.00	OUTPATIENT SERVICE COST CENTERS		,	<u>/ </u>	32.00
60.00	06000 CLINIC	C	0		60.00
61.00	06100 RURAL HEALTH CLINIC	C	0		61. 00
62. 00	06200 FQHC				62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	C	0		63. 00
70.00	OTHER REIMBURSABLE COST CENTERS		\		70.00
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE			l .	70. 00 71. 00
72. 00	07200 CORF				72.00
	07300 CMHC				73. 00
	07400 OTHER REIMBURSABLE COST	C	0		74. 00
	SPECIAL PURPOSE COST CENTERS				
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	C	0		80. 00
81. 00	08100   I NTEREST EXPENSE	C	0		81. 00
82. 00	08200 UTILIZATION REVIEW				82.00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS				83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-803, 585	15, 651, 278	3	89. 00
07.00	NONREI MBURSABLE COST CENTERS	000,000	10,001,270	<b>,</b>	37.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0		90.00
91. 00	09100 BARBER AND BEAUTY SHOP		1, 405	5	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	C	0		92. 00
	09300 NONPALD WORKERS	C			93. 00
94.00	09400 PATIENTS LAUNDRY				94. 00 95. 00
95. 00 100. 00	O9500 OTHER NONREIMBURSABLE COST CENTERS   TOTAL	-803, 585	15, 652, 683	3	100.00
100.00	1.01/12	000, 000	10,002,000	1	1.00.00

Health Financial Systems	MILLVILLE CENTER		In Lie	eu of Form CMS-	2540-10
RECLASSI FI CATI ONS	Provid	er No.: 315243	Peri od: From 01/01/2021	Worksheet A-6	
			To 12/31/2021	Date/Time Pre	pared:
				5/19/2022 1:2	2 pm
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2. 00	3.00	4. 00	5. 00	
(1) A - DEFAULT					
1.00	CENTRAL SERVICES & SUPPLY	10.	00 18, 323	0	1. 00
2. 00	MEDICAL RECORDS & LIBRARY	12.	00 46, 429	0	2. 00
TOTALS					1
100. 00	Total Reclassifications (	Sum	64, 752	0	100. 00
	of columns 4 and 5 must				
	equal sum of columns 8 and	ı			1
	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	MILLVILLE CENTE	ER		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od: From 01/01/2021	Worksheet A-6	
				To 12/31/2021	Date/Time Pre 5/19/2022 1:2	
			Decreases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
(1) A - DEFAULT						
1. 00	NURSING ADMINISTRATI	ON	9. 0	0 18, 323	0	1. 00
2. 00	NURSING ADMINISTRATI	ON	9. 0	0 46, 429	0	2. 00
TOTALS						
100. 00				64, 752	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS In Lieu of Form CMS-2540-10
Worksheet A-7 MILLVILLE CENTER Provi der No.: 315243

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/19/2022 1:22 pm Acqui si ti ons Donati on Begi nni ng Bal ances Disposals and Retirements Description Purchases Total

		1.00	2.00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	S					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	1, 134	0	1, 134	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	329, 198	117, 402	0	117, 402	0	4. 00
5.00	Fixed Equipment	7, 580	9, 468	0	9, 468	0	5. 00
6.00	Movable Equipment	95, 022	16, 444	0	16, 444	0	6. 00
7.00	Subtotal (sum of lines 1-6)	431, 800	144, 448	0	144, 448	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9.00	Total (line 7 minus line 8)	431, 800	144, 448	0	144, 448	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	S					
1.00	Land	0	0				1. 00
2.00	Land Improvements	1, 134	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	446, 600	0				4. 00
5.00	Fixed Equipment	17, 048	0				5. 00
6.00	Movable Equipment	111, 466	0				6. 00
7.00	Subtotal (sum of lines 1-6)	576, 248	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	576, 248	0				9. 00
		•		•			

Provi der No.: 315243

Peri od: Worksheet A-8 From 01/01/2021 | Worksheet A-8 | To 12/31/2021 | Date/Time Prepared:

				10 12/31/2021	5/19/2022 1:2	
				Expense Classification on		Z DIII
				To/From Which the Amount is		
				To Troin will on the fundaments	to be maj astea	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	bescription (1)	Adjustment	Amount	COST CENTER	LITIC NO.	
		1.00	2.00	3.00	4. 00	
1. 00	Investment income on restricted funds	1.00	2.00		0.00	1. 00
1.00	(chapter 2)		0		0.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2.00
2.00	8)		0		0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4. 00	Rental of provider space by suppliers		0		0.00	4. 00
4.00	(chapter 8)		0		0.00	4.00
5. 00	Telephone services (pay stations excluded)		0		0.00	5. 00
3.00	(chapter 21)		0		0.00	3.00
6. 00	Television and radio service (chapter 21)	A	-26 001	ACTI VI TI ES	15.00	6. 00
7. 00	Parking Lot (chapter 21)		20,001	non vines	0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2	0		0.00	8.00
8.00	physician adjustment	A-0-2	U			0.00
9. 00	Home office cost (chapter 21)		0		0.00	9. 00
10. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
11.00	Capital expenditures (chapter 24)		U		0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	284, 033			12. 00
12.00	related organizations (chapter 10)	A-0-1	204, 033			12.00
13. 00	Laundry and linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals		0			14. 00
15. 00	Cost of meals - Guests		0	1	0.00	
16. 00			-		0.00	
16.00	Sale of medical supplies to other than patients		0		0.00	16.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	
19. 00			0		0.00	19.00
	Vending machines		U		l .	
20. 00	Income from imposition of interest, finance		U	,	0.00	20. 00
21. 00	or penalty charges (chapter 21) Interest expense on Medicare overpayments		0		0.00	21. 00
21.00	and borrowings to repay Medicare		U		0.00	21.00
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW	82.00	22. 00
22.00	(chapter 21)		U	OTTETZATION REVIEW	02.00	22.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
23.00	beprecrationburidings and fratures		U	FIXTURES	1.00	23.00
24. 00	Danraciation mayable aguinment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
∠4. ∪∪	Depreciationmovable equipment		U	EQUIPMENT	2.00	∠4. UU
25. 00	MISC INCOME	D D	ס דד כ		4 00	25. 00
25. 00 25. 01	UNALLOWED A & G	B A		ADMINISTRATIVE & GENERAL	4. 00 4. 00	
				ADMINISTRATIVE & GENERAL		
25. 02	WORKERS COMPENSATION	A		EMPLOYEE BENEFITS	3.00	25. 02
25. 03	HEP/SALINE	A		SKILLED NURSING FACILITY	30.00	25. 03
100.00	Total (sum of lines 1 through 99) (Transfer		-803, 585			100. 00
	to Worksheet A, col. 6, line 100)			l	I	

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

MILLVILLE CENTER

Health Financial Systems MILLVILLE OF STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS TER In Lieu of Form CMS-2540-10
Provider No.: 315243 Period: Worksheet A-8-1
From 01/01/2021 Parts I-II

OFFIC	E COSTS				rom 01/01/2021 o 12/31/2021	Parts I-II Date/Time Pr 5/19/2022 1:	
		Li ne No.	Cost (	Center	Expense		ZZ piii
		1.00	2.		3.		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	4. 00 44. 00 45. 00 46. 00 30. 00 30. 00	ADMI NI STRATI VE ADMI NI STRATI VE PHYSI CAL THERA OCCUPATI ONAL T SPEECH PATHOLO SKILLED NURSI N SKILLED NURSI N ADMI NI STRATI VE	& GENERAL PY HERAPY GY G FACILITY G FACILITY	HOME OFFICE A&( HOME OFFICE CAMPT OT ST NURSING PURCHAS RT MEDICAL DIRECTO	PITAL SED SERVICES	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)			
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	S OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	808, 910 49, 795 407, 466 549, 372 171, 803 473, 067 10, 788 30, 114 0 2, 501, 315	0 407, 466 549, 372 171, 803 473, 067 10, 788 30, 114	49, 795 C C C C C C C			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315243 Peri od: Worksheet A-8-1 From 01/01/2021 OFFICE COSTS Parts I-II 12/31/2021 Date/Time Prepared:

				5/19/2022 1: 22	2 pm
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/O	R 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
spe	eci 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 rel ated 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	Related Organization(s) and/or Home Office					
Name	Percentage of	Type of Business				
1.5	Ownershi p	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
4.00	5.00	6. 00	1			

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

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

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

1.00		GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2. 00		GRS	100.00	PT 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	MEDICAL DIRECTOR	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 (fin	ancial or non-financial)		0.00		100. 00
speci fy:					

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

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Cost Center Description				To	o 12/31/2021	Date/Time Pre	
Fig. 2   F			CAPI TAL REL	ATED COSTS		5/19/2022 1: 2	2 pm
COLING   CAP WILL COSTS - BLIES A FLYRIMS   COST   CAP WILL COST   CAP WIL	Cost Center Description	for Cost Allocation				Subtotal	
SIN MAIL STRUCT COST - BLOOS ATTURES   1.00   2.00   3.00   3A   1.00							
0.000   CAP REL COSTS - BLODGS & FIXTURES   3, 754, 184   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000			1. 00	2.00	3. 00	3A	
0.0000   CAP REL COSTS - MANABE FOULPRINT   1,018,907   1119,249   0   1,138,156   3,00   0.0000   CERLIFOVE BENEFIX   1,018,907   1119,249   0   1,138,156   3,00   0.0000   CERLIFOVE BENEFIX   1,018,907   1119,249   0   1,138,156   3,00   0.0000   CERLIFOVE BENEFIX   1,018,907   1119,249   0   0   0,000   2,139,046   4,00   0.00000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		2 754 104	2 754 104				1 00
0.000   0.00		3, 754, 164	3, 754, 164	0			
0.000   0.000   PLANT OPERATION, IJAINT. & REPAIRS   573, 228   223, 226   0   22. 921   899, 435   5.00		1, 018, 907	119, 249	0	1, 138, 156		
0.000   0.000   LANDRY & LINEN SERVICE   246, 845   122, 429   0   0   3.99, 274   0.00   0.000   0.		1		0			
1.00   00700   MUSENECEPING   292, 853   94, 036   0   0   376, 889   7 0   0   0   0   0   0   0   0   0		1		0	22, 921		
0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		1		0	o		
10.00   01000   CENTRAL SERVICES & SUPPLY   55, 304   0   0   4,085   59,389   10.00		1		0	0		
11.00   01100   PHARMACY   0   0   0   0   0   11.00     12.00   01200   MEDICAL RECORDS & LIBRARY   46,429   36,115   0   10,352   27,896   12.00     13.00   01300   SOCIAL SERVICE   168,865   46,791   0   37,618   253,274   13.00     15.00   01500   ACTIVITIES   15.0   15.0   80,294   0   31,762   262,206   15.00		1	160, 589	0			
12.00   01200   MEDICAL RECORDS & LIBRARY   46, 429   36, 115   0   10.352   92, 896   12.00   14.00   10.00   10.00   10.00   0.00   0   0   0   0   0   0   0		55, 304	0	0	4, 085		
14. 00   01400 NURSING AND ALLIED HEALTH EDUCATION   0   0   0   0   0   0   13,762   226,200   15. 00	· · · · · · · · · · · · · · · · · · ·	46, 429	36, 115	0	10, 352		
15.00   01500   ACTIVITIES		1	46, 791	0	37, 618		
INPATIENT ROUTH NE SERVICE COST CENTERS		1 9	90 204		21 742	-	
30.00		150, 150	00, 294	U	31, 702	202, 200	13.00
32.00   03200   CIFF I D   0   0   0   0   0   32.00	30.00 03000 SKILLED NURSING FACILITY	4, 338, 625	2, 011, 900	0	824, 858	7, 175, 383	
33. 00   03300   OTHER LONG TENI CARE   0   0   0   0   33. 00		0	0	0	0		
ANCILLARY SERVICE COST CENTERS			0	-	0	-	
41. 00		<u> </u>	<u> </u>	<u> </u>	<u> </u>		33.00
42.00   04200   INTRAVENOUS THERAPY   85.382   0   0   0   85.382   42.00     43.00   04300   0XYGEN (INHALATION) THERAPY   0   0   0   0   0   545.919     44.00   04400   PHYSICAL THERAPY   407, 817   138, 102   0   0   545.919     44.00   04400   O4400   PHYSICAL THERAPY   549, 824   115, 160   0   0   654.94     45.00   04500   OCCUPATIONAL THERAPY   549, 824   115, 160   0   0   0   654.94     45.00   04500   OCCUPATIONAL THERAPY   70   0   0   0   0   0     47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   0     47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   0     47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   0     49.00   04900   MEDICAL SUPPLIES CHARGED TO PATIENTS   258, 454   60, 533   0   0   318, 907   49   00     49.00   04900   DENTAL CARRED TO PATIENTS   258, 454   60, 533   0   0   318, 907   49   00     51.00   05000   DENTAL CARRED TO PATIENTS   258, 454   60, 533   0   0   318, 907   49   00     51.00   05100   DENTAL CARRED TO PATIENTS   258, 454   60, 533   0   0   0   0   4, 552   51   00     51.00   05100   DENTAL CARRED TO PATIENTS   4, 552   0   0   0   0   4, 552   51   00     51.00   05100   DENTAL CARRED TO PATIENTS   4, 552   0   0   0   0   0   4, 552   51   00     51.00   05100   DENTAL CARRED TO PATIENTS   4, 552   0   0   0   0   0   4, 552   51   00     51.00   05100   DENTAL CARRED TO PATIENTS   4, 552   0   0   0   0   0   0   0   5     51.00   05100   DENTAL CARRED TO PATIENTS   4, 552   0   0   0   0   0   0   0   0   0		1	ĭ	_	-	•	
43. 00 04300 OXYGEN (INHALATION) THERAPY		1	0	_	0		
44. 00 04400 PHYSI CAL THERAPY		00, 302	0	0	0		
44. 00   04400   SPEECH PATHOLOGY   171, 803   26, 462   0   0   198, 265   46, 00   047, 00   477, 00   4		407, 817	138, 102	0	O		
47.00   04700   CLECTROCARDIOLOGY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		0	0		
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   22, 828   0   0   0   22, 828   48.00   49.00   04900   DRUGS CHARGED TO PATIENTS   258, 454   60, 533   0   0   0   318, 987   50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   51.00   05100   SUPPORT SURFACES   4, 552   0   0   0   0   4, 552   52.00   05200   OTHER RAINCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   60.00   06000   CLINIC   COST CENTERS   0   0   0   0   0   0   61.00   06000   CLINIC   COST CENTERS   0   0   0   0   0   0   0   62.00   06000   CLINIC   COST CENTERS   0   0   0   0   0   0   0   63.00   06300   OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   0   0   0   0   63.00   06300   OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   0   0   0   0   0   63.00   06300   OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   0   0   0   0   0   63.00   06300   OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   0   0   0   0   0   63.00   0700   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0   63.00   07100   AMBULANCE   0   0   0   0   0   0   0   0   0		1	26, 462	0	0		
49.00   04900   DRUGS CHARGED TO PATIENTS   258, 454   60, 533   0   0   318, 987   49, 00			22, 828	0	0		
51.00   05100   SUPPORT SURFACES   4,552   0   0   0   4,552   51.00   05200   OTHER ARCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   52.00   05200   OTHER ARCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0	49.00 04900 DRUGS CHARGED TO PATIENTS	258, 454		0	0		
52. 00		0	0	-	0	-	
OUTPATLENT SERVICE COST CENTERS		1	0		0		
61. 00	OUTPATIENT SERVICE COST CENTERS		۷۱	<u> </u>	91	<u> </u>	02.00
62. 00   63.00   FOHC   O   O   O   O   O   O   O   O   O		- 1	0	_	0		
63.00   06300  OTHER OUTPATIENT SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0			O	O	O <sub>1</sub>	0	
70.00	· ·	O	0	0	0	0	
71. 00							
72.00		0	0		0		
73. 00			0	_	o		
SPECIAL PURPOSE COST CENTERS   80.00	73. 00 07300 CMHC	0	0	0	0		73. 00
80. 00 81. 00 81. 00 82. 00 82. 00 82. 00 83. 00 83. 00 83. 00 83. 00 84. 00 85. 00 85. 00 86. 00 86. 00 86. 00 87. 00 88. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0	0	74. 00
81. 00			I				80. 00
83. 00 08300 HOSPI CE 0 0 0 0 0 0 0 0 83. 00 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 84. 00 89. 00 SUBTOTALS (sum of lines 1-84) 15, 651, 278 3, 754, 184 0 1, 138, 156 15, 651, 278 89. 00  NONREI MBURSABLE COST CENTERS  90. 00 09100 BARBER AND BEAUTY SHOP 1, 405 0 0 0 0 0 0 91. 00 91. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 92.00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 95. 00 98. 00 Cross Foot Adjustments 0 0 0 0 0 0 99. 00 99. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 99. 00							
84. 00				0		0	
89. 00   SUBTOTALS (sum of lines 1-84)   15,651,278   3,754,184   0   1,138,156   15,651,278   89. 00			0	0	0		
NONREI MBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0		15, 651, 278	3, 754, 184	_	1, 138, 156	-	
91. 00   09100   BARBER AND BEAUTY SHOP   1,405   0   0   0   1,405   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   0   0   0   93. 00   94. 00   94. 00   94. 00   09400   PATI ENTS LAUNDRY   0   0   0   0   0   0   95. 00   09500   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   95. 00   98. 00   0   0   0   0   0   0   0   0   98. 00   99. 00   Negative Cost Centers   0   0   0   0   0   0   99. 00							
92. 00     09200     PHYSI CI ANS PRI VATE OFFI CES     0     0     0     0     0     92. 00       93. 00     09300     NONPAI D WORKERS     0     0     0     0     0     93. 00       94. 00     09400     PATI ENTS LAUNDRY     0     0     0     0     0     94. 00       95. 00     09500     OTHER NONREI MBURSABLE COST CENTERS     0     0     0     0     0     95. 00       98. 00     Negati ve Cost Centers     0     0     0     0     0     99. 00		1 405	0	O O	0	-	
93. 00   09300   NONPAI D WORKERS   0 0 0 0 0 0 93. 00   94. 00   95. 00   0 0 0 0 0 0 0 95. 00   95. 00   97. 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	0		
95. 00   09500   OTHER NONREIMBURSABLE COST CENTERS   0   0   0   0   0   95. 00   98. 00   99. 00   Negative Cost Centers   0   0   0   0   99. 00   0   0   99. 00   0   0   0   0   0   0   0   0   0	93. 00   09300   NONPALD   WORKERS		Ö	0	Ö	-	
98.00   Cross Foot Adjustments		0	0	0	0	-	
99.00   Negative Cost Centers   0   0   0   99.00	1 1	0	0	0	0	-	
100. 00   TOTAL   15, 652, 683  3, 754, 184  0  1, 138, 156  15, 652, 683   100. 00			o	0	o	-	
	100. 00   TOTAL	15, 652, 683	3, 754, 184	0	1, 138, 156	15, 652, 683	100. 00

COST Center Description						0 12/31/2021	Date/Time Pre	
DEPENTION   STRENG CE COST CENTERS		Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPING		2 pm
SEPREMAN   SERVICE COST   CENTERS   4.00   5.00   0.00   7.00   8.00   1.00		Cook conto. Decorrption				HOUGENEEL THE	51271111	
CONTROL   CONT								
ERICRAL SERVICE COST CENTERS  1 00 00100 (AP REL COSTS - BUGS & FIXTURES 2 00 00200 (AP REL COSTS - BUGS & FIXTURES 3 00 00200 (AP REL COSTS - BUGS & FIXTURES 3 00 00200 (AP REL COSTS - BUGS & FIXTURES 4 00 00200 (AP REL COSTS - BUGS & FIXTURES 5 00 00200 (AP REL COSTS - BUGS & FIXTURES 5 00 00200 (ARIONEY & LINES ESCREAL 6 00 00200 (ARIONEY & LINES ESCREAL 7 00 00200 (ARIONEY & LINES ESCREAL 7 00 00200 (ARIONEY & LINES ESCREAL 8 00 00200 (ARIONEY & LINES ESCREAL 9 00 00200 (ARIONEY & LINES ESCREAL 9 00 00200 (ARIONEY & LINES ESCREAL 137 124 48, 66 0 24, 43 0 1, 660, 97 8, 00 00200 (ARIONEY & LINES ESCREAL 137 124 48, 66 0 24, 43 0 1, 660, 97 8, 00 00200 (ARIONEY & LINES ESCREAL 12 00 00200 (ARIONEY & LINES ESCREAL 13 00 00200 (ARIONEY & LINES ESCREAL 14 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			4.00		4 00	7.00	0.00	
0.0100   CAP REL COSTS - BLOSS S FIXTURES   2.00   0.0000   0.00   REL COSTS - WOMABLE FOUNDAMENT   3.00   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000		GENERAL SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
2.00	1. 00							1.00
4. 00   0.00		l l						2. 00
5.00   00500   PLANT   OPERATION, MAINT: & REPAIRS   1.50, 0.08   995, 473   464, 969   6.00   00500   MINRY & LINEN SERVICE   59, 657   28, 666   40, 00   465, 155   7, 00	3.00	00300 EMPLOYEE BENEFITS						3. 00
0.000   LANDAY & LINEN SERVICE   58, 452   37, 243   464, 969   465, 152   70, 00   7070   MUSSELEPIN (MUSSELEPIN S) 9, 657   28, 606   0.00   465, 102   1, 660, 97   8. 00   900   0000   URSING ADMINISTRATION   137, 124   48, 891   0.00   24, 443   0.00   0.			1					•
7.00   0.0700   HUSEKEEPING   29, 667   28, 606   0   465, 192   7.00   9.00   9.00   0.000   UTARY   204, 709   108, 664   0   54, 367   1, 660, 977   8.00   9.00   0.000   URISS INC. ADMINISTRATION   137, 124   48, 851   0   0   24, 443   0, 60, 977   8.00   11.00   0.00   0.00   0   0   0   0   0		· ·	1		1			
B. DO   00800   DIETARY   204, 709   108, 694   0   54, 307   1, 600, 997   8, 00   10, 00   1000   010000   010000   010000   010000   010000   010000   010000   010000   010000   010000   010000   010000   010000   0100000   0100000   01000000   0100000000		· ·	1 ' 1		1	l		1
9.00   0.0900   MURSING ADMINISTRATION   137, 124   48, 851   0   0.4, 443   0   0.0   0.10   11.00   01000   CHYRTAL SERVICE OS SUPPLY   9, 401   1.0   0.0   0   0   0   0   0   0   11.00   01000   MEDICAL RECORDS & LIBRARY   14, 704   10, 986   0   5, 497   0.12   0.0   13.00   01300   SOLIAL SERVICE   40, 090   14, 234   0   7, 122   0.13, 00   15.00   13.00   01300   MURSING AND ALLED HEALTH EDUCATION   40, 090   14, 234   0   7, 122   0.13, 00   15.00   13.00   01300   SOLIAL SERVICE   COST CENTERS   12, 426   0   12, 222   0.15, 00   15.00   13.00   13.00   01300   SELLED MURSING REPORT   17, 135, 777   0.12, 022   0.40, 90   306, 234   1, 600, 997   30, 00   13.00   03300   SELLED MURSING FACILITY   1, 135, 777   0.12, 022   0.40, 90   306, 234   1, 600, 997   30, 00   13.00   03300   OTHER LONG TERN CARE   0   0   0   0   0   0   0   0   0		· ·			1		1 660 997	1
10.00   01000   CENTRAL SERVICES & SUPPLY   9, 401   0   0   0   0   0   0   11.00   11.00   11.00   11.00   01.00   PARAMACY   14, 704   14, 704   10, 986   0   5, 497   0   12.00   13.00   13.00   01300   SOCIAL SERVICE   40, 090   14, 223   0   7, 122   0   13.00   13.00   01300   SOCIAL SERVICE   40, 090   14, 223   0   7, 122   0   13.00   13.00   01300   SOCIAL SERVICE   COST CENTERS   41, 504   24, 426   0   72, 222   0   15.00   15.			1		1			1
12.00   01200 MEDICAL RECORDS & LIBRARY			1		i	0	0	1
13.00   01300  SOCIAL SERVICE   40.090   14.234   0   7.122   0   13.00     14.00   01500  ACTI VITTES   41.504   24.426   0   12.222   0   15.00     15.00   01500  ACTI VITTES   41.504   24.426   0   12.222   0   15.00     15.00   03000  SKILLED WIRSING FACILITY   1.135,777   612,022   464,969   306,234   1.660,997   30.00     22.00   03200  ICEPTILD WIRSING FACILITY   0   0   0   0   0   0   22.00     23.00   03300  OTHER LOW TERM CARE   0   0   0   0   0   0   33.00     23.00   03300  OTHER LOW TERM CARE   0   0   0   0   0   0   33.00     23.00   03300  OTHER LOW TERM CARE   0   0   0   0   0   0   33.00     23.00   03300  OTHER LOW TERM CARE   0   0   0   0   0   0   0   0     24.00   04000  OTHER LOW TERM CARE   0   0   0   0   0   0   0   0   0     25.00   04000  OTHER LOW TERM CARE   0   0   0   0   0   0   0   0   0	11. 00	01100 PHARMACY	0	0	0	o	0	11. 00
14. 00   01400 NURSING AND ALLIED HEALTH EDUCATION   0   0   0   12,222   0   15. 00			1	•				1
15. 00   01500   ACTIVITIES			1	14, 234	0	7, 122		
INPATIENT ROUTH NE SERVICE COST CENTERS			-1	24 426	0	12 222		
30. 00	13.00		41, 304	24, 420	<u> </u>	12, 222	0	15.00
31 00   03100   NURSING FACILITY	30. 00		1, 135, 777	612, 022	464, 969	306, 234	1, 660, 997	30.00
33. 00   03300   OTHER LONG TENI CARE   0   0   0   0   0   33. 00			0	0	0	0		•
ANCILLARY SERVICE COST CENTERS	32.00		O	0	0	0	0	32. 00
40.00   04000   04000   0400   0400   040   040   040   040   040   040   040	33. 00		0	0	0	0	0	33. 00
41.00   04100   LABORATORY   6,928   0   0   0   0   41.00   42.00   04200   INTRAVENDUS THERAPY   13,515   0   0   0   0   22.00   43.00   04300   OVYCEN (1 INHALATION) THERAPY   0   0   0   0   0   0   0   44.00   04400   PHYSI CAL THERAPY   105,259   35,032   0   17,529   0   45.00   45.00   04500   OCCUPATI ONAL THERAPY   105,259   35,032   0   17,529   0   45.00   46.00   04600   SPEECH PATHOLOGY   31,383   8,050   0   0   0   0   0   48.00   04600   SPEECH PATHOLOGY   31,383   8,050   0   0   0   0   0   48.00   04600   DEUGS CHARGED TO PATIENTS   3,613   6,944   0   3,475   0   48.00   48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   3,613   6,944   0   3,475   0   48.00   50.00   05000   DRUISC SHARGED TO PATIENTS   50,492   18,414   0   9,214   0   49.00   50.00   05000   DRUISC SHARGED TO PATIENTS   50,492   18,414   0   9,214   0   49.00   50.00   05000   DRUISC SHARGED TO PATIENTS   50,492   18,414   0   0   0   0   0   55.00   50.00   05000   DEUGS SHARGED TO PATIENTS   50,492   18,414   0   0   0   0   0   55.00   50.00   05000   DEUGS SHARGED TO PATIENTS   50,492   18,414   0   0   0   0   0   0   55.00   50.00   05000   DEUGS SHARGED TO PATIENTS   50,492   18,414   0   0   0   0   0   0   55.00   50.00   05000   DEUGS SHARGED TO PATIENTS   50,492   18,414   0   0   0   0   0   0   0   0   0   50.00   05000   DEUGS SHARGED TO PATIENTS   50,492   18,414   0   0   0   0   0   0   0   0   0			0.045		1	ام		
42 00   04200   INTRAVENDUS THERAPY			1	0	_	0		•
43. 00   04300   04500   04500   04500   04500   045			1	0	1	0		•
44. 00   04400   PHYSICAL THERAPY   86, 412   42, 011   0   21, 021   0   44, 00   45, 00   04500   020			1	0	0			•
46. 00   04600   SPECCH PATHOLOGY   31, 333   8, 050   0   4, 028   0   46, 00   07, 00   07, 00   0   0   0   0   0   0   0   0   0			-1	42, 011	l o	21, 021		
47.00	45.00	04500 OCCUPATI ONAL THERAPY	105, 259	35, 032	0	17, 529	0	45. 00
48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   3, 613   6, 944   0   3, 475   0   48. 00   49. 00   04900   DRUGS CHARGED TO PATIENTS   50, 492   18, 414   0   9, 214   0   49. 00   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   52. 00   05200   OTHER RAKE LLARY SERVICE COST CENTERS   0   0   0   0   0   0   00   05200   OTHER RAKE LLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   00   05200   OTHER RAKE LLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   01   05400   CILINIC   0   0   0   0   0   0   0   0   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   0   0   06200   OFACO		· ·	31, 383	8, 050	0	4, 028		•
49.00   04900   DRUGS CHARGED TO PATIENTS   50,492   18,414   0   9,214   0   49,00			0	0	0	0		1
50.00					1			
51.00		· ·	1	18, 414		9, 214		1
52.00			1	0	0		-	
60.00			1	0	Ō	Ö		1
61.00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   61.00   62.00   06200   FOHC   0   0   0   0   0   0   0   0   0   63.00   05300   OTHER OUTPATIENT SERVICE COST CENTERS   0   0   0   0   0   0   0   0    70.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   0    71.00   07100   AMBULANCE   0   0   0   0   0   0   0   0   0    72.00   07200   CORF   0   0   0   0   0   0   0   0   0    73.00   07300   CMHC   0   0   0   0   0   0   0   0   0    74.00   07400   OTHER REI MBURSABLE COST   0   0   0   0   0   0   0   0    74.00   07400   OTHER REI MBURSABLE COST   0   0   0   0   0   0   0    80.00   08000   MALPRACTICE PREMI LUMS & PAID LOSSES   81.00    81.00   08200   UTILIZATION REVIEW   82.00    82.00   08200   UTILIZATION REVIEW   82.00    83.00   08300   HOSPICE   0   0   0   0   0   0    84.00   08400   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   0    89.00   NONDEL MBURSABLE COST CENTERS   0   0   0   0   0    90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0    91.00   09100   BARBER AND BEAUTY SHOP   222   0   0   0   0   0   0    92.00   09200   PHYSICI ANS PRIVATE OFFICES   0   0   0   0   0   0    93.00   09300   NONPAID WORKERS   0   0   0   0   0   0    94.00   09400   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0    95.00   09500   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0    96.00   NONPAID WORKERS   0   0   0   0   0   0    97.00   09500   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0    98.00   NONPAID WORKERS   0   0   0   0   0    98.00   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0    99.00   NONPAID WORKERS   0   0   0   0    90.00   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0    90.00   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0    90.00   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0    90.00   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0    90.00   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0    90.00   OTHER NONREI MBURSABLE COST CENTERS   0		OUTPATIENT SERVICE COST CENTERS						
62.00   66.200   FOHC   FOHC   GASON   FOHC   GASON   FOHC   GASON   FOHC   GASON   GASON   FOHC   GASON   GAS		l l	1 - 1	0	0	0		1
63.00   OTHER OUTPATIENT SERVICE COST CENTERS   O O O O O O O O O O O O O O O O O O			0	0	0	0	0	1
OTHER REIMBURSABLE COST CENTERS   O				0			0	1
70. 00   07000   HOME   HEALTH   AGENCY COST   0   0   0   0   0   0   0   70. 00	03.00		l o	0	<u> </u>	l U	0	03.00
71. 00	70. 00		O	0	0	ol	0	70.00
73. 00			0	0	0	o	0	
74. 00			0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS   80.00			0	0	0	0		ı
80. 00   08000   MALPRACTI CE PREMI UMS & PAI D LOSSES   81. 00   08100   INTEREST EXPENSE   82. 00   08200   UTI LI ZATI ON REVI EW   82. 00   08300   HOSPI CE   0   0   0   0   0   0   0   0   0	74. 00		0	0	0	0	0	74.00
81. 00	90 00							00 00
82. 00   08200   UTILIZATION REVIEW     0   0   0   0   0   0   83. 00   08300   HOSPI CE   0   0   0   0   0   0   0   0   83. 00   084. 00   08400   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   0   0   0					•			
83. 00   08300   HOSPI CE   0   0   0   0   0   0   83. 00   84. 00   08400   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   0   89. 00   SUBTOTALS (sum of lines 1-84)   2,138,824   995,473   464,969   465,152   1,660,997   89. 00								
89. 00   SUBTOTALS (sum of lines 1-84)   2,138,824   995,473   464,969   465,152   1,660,997   89.00			o	0	0	О	0	•
NONRE   MBURSABLE   COST   CENTERS	84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	o	0	84. 00
90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   90. 00   91. 00   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   0   0   0   93. 00   94. 00   94. 00   94. 00   95. 00   0750	89. 00		2, 138, 824	995, 473	464, 969	465, 152	1, 660, 997	89. 00
91. 00   09100   BARBER AND BEAUTY SHOP   222   0   0   0   0   91. 00   92. 00   93. 00   09200   PHYSICIANS PRIVATE OFFICES   0   0   0   0   0   92. 00   93. 00   09300   NONPAID   WORKERS   0   0   0   0   0   0   93. 00   94. 00   94. 00   94. 00   95. 00   095. 00   071   071   072   073   074   074   074   075	00.00							00.00
92. 00   09200   PHYSICIANS PRIVATE OFFICES   0   0   0   0   92. 00   93. 00   09300   NONPAID   WORKERS   0   0   0   0   93. 00   94. 00   09400   PATIENTS LAUNDRY   0   0   0   0   0   94. 00   95. 00   09500   OTHER   NONREI   MBURSABLE   COST   CENTERS   0   0   0   0   0   95. 00   98. 00   09600   Negative   Cost   Centers   0   0   0   0   0   0   99. 00   09600   Negative   Cost   Centers   0   0   0   0   0   99. 00   09700   0   0   0   0   0   99. 00   0   0   0   0   0   99. 00   0   0   0   0   99. 00   0   0   0   0   99. 00   0   0   0   99. 00   0   0   0   99. 00   0   0   0   99. 00   0   0   0   99. 00   0   0   0   99. 00   0   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0			1	0	0	0		1
93. 00   09300   NONPAI D WORKERS   0 0 0 0 0 0 93. 00   94. 00   95. 00   09500   OTHER NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0 0 95. 00   98. 00   99. 00   Negative Cost Centers   0 0 0 0 0 0 0 0 99. 00   0 0 0 0 0 0 0 99. 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1 1	0	0			
94. 00   09400   PATIENTS LAUNDRY   0   0   0   0   94. 00   95. 00   09500   OTHER NONREIMBURSABLE COST CENTERS   0   0   0   0   95. 00   98. 00   Cross Foot Adjustments   0   0   0   0   98. 00   99. 00   Negative Cost Centers   0   0   0   0   99. 00				0	l ő	l ől		
98.00   Cross Foot Adjustments			0	0	Ō	o		
99.00   Negative Cost Centers   0   0   0   99.00		1	0	0	0	o		
		1 1	0	0	0	0		
100.00    101AL   2,134,040  440,404  404,404  405,152  1,660,997 100.00		1 9	2 120 044	005 473	144 040	0 44E 1E3		
	100.00	) IOIAL	2, 139, 040	770, 4/3	404, 909	400, 152	1, 000, 997	1100.00

Provi der No.: 315243

| Peri od: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Da

					10 12/31/2021	5/19/2022 1:2	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Z piii
		9.00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS	,					
1. 00 2. 00 3. 00 4. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						5. 00 6. 00 7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	1, 076, 714					8. 00 9. 00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	0	68, 790 0		0		10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0		0 124, 083		12.00
13. 00	01300 SOCIAL SERVICE	0	0		0	314, 720	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14.00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0  0	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	1, 076, 714	68, 790		0 99, 860	314, 720	30.00
31. 00	03100 NURSING FACILITY	0	00,770		0 77,000	011,720	31. 00
32.00	03200   CF/IID	0	0		0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	l ol	0		0 248	0	40. 00
41. 00	04100 LABORATORY		0		0 776		41.00
42. 00	04200 I NTRAVENOUS THERAPY	Ö	0		0 493		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0		0 7, 965		44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0 9, 755 0 2, 871		45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY		0		0 2,871	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		o o	ő	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 1, 758	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 357	0	51. 00 52. 00
32.00	OUTPATIENT SERVICE COST CENTERS	j oj	0		0  0	0	32.00
60.00	06000 CLINIC	0	0		0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	61. 00
62. 00	06200 FOHC						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	l	0		ol o	0	70.00
71. 00	07100 AMBULANCE	0	0		0	0	71. 00
72. 00	07200 CORF	0	0		0	0	72. 00
73.00	07300 CMHC	0	0		0	0	73.00
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	l d	0		<u>U</u>	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 UTILIZATION REVIEW	_	_			_	82. 00
83. 00 84. 00	08300 HOSPI CE	0	0		0 0	0	83.00
89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	1, 076, 714	68, 790		0 124, 083	0 314, 720	84. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	1,070,714	00, 170		0  124,000	314,720	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	91. 00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		0		0 0	0	93. 00 94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		0		ŏ o	0	95. 00
98. 00	Cross Foot Adjustments	0	0				98. 00
99. 00	Negative Cost Centers	0	0		0 0	0	99.00
100.00	D TOTAL	1, 076, 714	68, 790	l	0 124, 083	314, 720	1100.00

					o 12/31/2021		
			OTHER GENERAL			5/19/2022 1:2	2 pm
			SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATI ON			,		
	GENERAL SERVICE COST CENTERS	14.00	15. 00	16. 00	17. 00	18. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						6. 00 7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13.00	01300 SOCIAL SERVICE						13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	240 250				14.00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		340, 358	3			15. 00
30. 00	03000 SKILLED NURSING FACILITY	0	340, 358	13, 255, 824	0	13, 255, 824	30.00
31.00	03100 NURSING FACILITY	0	O	1 ' '	0	1	31.00
32.00	03200   CF/IID	0	0		0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
40.00	ANCILLARY SERVICE COST CENTERS	1		00.500		00.500	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	1	1			40.00
41.00	04200 I NTRAVENOUS THERAPY	0		51, 474 99, 390		51, 474 99, 390	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	ĺ	) //, 3/0	o o	77,370	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	Ö	703, 328	0	703, 328	1
45.00	04500 OCCUPATI ONAL THERAPY	0	o	832, 559	0	832, 559	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	244, 597	0	244, 597	1
	04700 ELECTROCARDI OLOGY	0	0	) (	0	0	
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	1		36, 860	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		398, 865	0	398, 865 0	1
51. 00	05100 SUPPORT SURFACES	0	ĺ	1	1		1
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0		1		l	1
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	l .		-	· -	
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	61.00
62. 00	06200 FOHC	0				_	62.00
63. 00	O6300 OTHER OUTPATIENT SERVICE COST CENTER   OTHER REIMBURSABLE COST CENTERS	0	0		) 0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
71. 00	07100 AMBULANCE	0	Ö		-	Ō	71. 00
72.00	07200 CORF	0	o		0	0	72. 00
	07300 CMHC	0	l e				1
74. 00	07400 OTHER REIMBURSABLE COST	0	0		0	0	74. 00
90 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100   NTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW						82. 00
	08300 H0SPI CE	0	O		0	0	1
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	) (	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	340, 358	15, 651, 056	0	15, 651, 056	89. 00
00.00	NONREI MBURSABLE COST CENTERS	T -		\			00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	1	1	0	1	
	09200 PHYSI CLANS PRI VATE OFFI CES	0	l	1, 62 /	0	1, 627 0	1
93. 00	09300 NONPAID WORKERS				0	0	1
94. 00	09400 PATIENTS LAUNDRY	0			Ö	Ö	1
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	) (	0	0	
98. 00	Cross Foot Adjustments	0	_		0	0	
99.00	Negative Cost Centers   TOTAL	0	1	15 452 403		0	
100.00	/ IUIAL	0	340, 358	15, 652, 683	0	15, 652, 683	1100.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315243

				1	0 12/31/2021	Date/lime Pre 5/19/2022 1:2	
			CAPI TAL REL	ATED COSTS		1071772022 112	<u> </u>
	Cost Center Description	Di rectly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	FIXTURES	EQUI PMENT	Subtotal	BENEFI TS	
		Capi tal					
		Related Costs 0	1. 00	2.00	2A	3. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	3.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			_			2. 00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	0	119, 249 99, 261	0		119, 249 9, 597	3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	263, 256	_	263, 256		5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	122, 429	Ō			6. 00
7. 00	00700 HOUSEKEEPI NG	0	94, 036		94, 036		7. 00
8.00	00800 DI ETARY	0	357, 179				8.00
9. 00 10. 00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	0	160, 589	0	160, 589	12, 044 428	1
11. 00	01100 PHARMACY	0	0	Ö	0	0	11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	36, 115	0	36, 115	1, 085	12. 00
13.00	01300 SOCIAL SERVICE	0	46, 791	0		3, 941	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	0 80, 294	0	-	0 3, 328	14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	00, 274		00, 274	3, 320	15.00
30. 00	03000 SKILLED NURSING FACILITY	0	2, 011, 900	0	2, 011, 900	86, 425	30.00
31. 00	03100 NURSING FACILITY	0	0	0	-	0	31. 00
	03200 TUED LONG TERM CARE	0	0	0	-	0	32. 00 33. 00
33.00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	<u> </u>	U		U	0	33.00
40. 00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0	0		0	
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	138, 102		138, 102	)   0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	115, 160	Ö		ő	45. 00
	04600 SPEECH PATHOLOGY	0	26, 462	0	26, 462	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	22, 828 60, 533		22, 828 60, 533	0	48. 00 49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	00, 333		00, 333	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0			0	
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				
	07200 CORF	O	0	Ö			
	07300 CMHC	0	0	0	0	0	
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00							81.00
82. 00							82. 00
83.00	08300 HOSPI CE	0	0	0	0	0	
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0	0 3, 754, 184	0	-	0 119, 249	
07.00	NONREI MBURSABLE COST CENTERS	1 4	3, 734, 104		3, 734, 104	117, 247	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	
	09100 BARBER AND BEAUTY SHOP	0	0	0	_	0	
92. 00 93. 00		0	0	0	0	0	
94. 00			0		0	0	1
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments				0		98. 00
99. 00 100. 00	Negative Cost Centers   TOTAL	0	0 2 754 104	0	2 754 104	0 119, 249	
100.00	)   TOTAL	ı	3, 754, 184	ı	3, 754, 184	117, 249	1100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315243

Period: Worksheet B From 01/01/2021 Part II

0

0

135, 602

0

0

104, 905

0 98.00

0

409, 609 100. 00

99 00

Date/Time Prepared: 12/31/2021 5/19/2022 1:22 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 108, 858 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 6, 923 272, 580 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 2.975 10, 198 135, 602 6.00 00700 HOUSEKEEPI NG 7.00 3.036 7, 833 C 104, 905 7.00 8.00 00800 DI ETARY 10, 417 29, 752 0 12, 261 409, 609 8.00 9.00 00900 NURSING ADMINISTRATION 6, 978 13, 376 0 5, 513 9.00 0 01000 CENTRAL SERVICES & SUPPLY 478 0 10.00 10.00 0 Ω 11.00 01100 PHARMACY 0 C 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 748 3,008 0 1.240 0 12.00 01300 SOCIAL SERVICE 3,898 0 13.00 13.00 2.040 1.606 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 15.00 01500 ACTI VI TI ES 2, 112 6,688 2,756 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 135, 602 30.00 03000 SKILLED NURSING FACILITY 69, 065 409, 609 30.00 57 804 167, 585 31.00 03100 NURSING FACILITY C 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 155 0 0 0 0 40.00 41.00 04100 LABORATORY 353 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY 688 Ω 0 ol 42 00 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 C 0 0 43.00 04400 PHYSI CAL THERAPY 4, 397 11, 503 4,741 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 5, 356 9, 592 0 3, 953 0 45.00 04600 SPEECH PATHOLOGY 46 00 1, 597 2.204 0 908 46 00 0 04700 ELECTROCARDI OLOGY 0 47.00 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 184 1, 901 0 784 48.00 48.00 0 5, 042 49.00 04900 DRUGS CHARGED TO PATIENTS 2.569 0 2,078 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 C 0 0 51.00 05100 SUPPORT SURFACES 37 C 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 60.00 06000 CLI NI C 0 Ω 0 0 0 06100 RURAL HEALTH CLINIC 61.00 0 0 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 0 0 07200 CORF 0 72.00 0 0 72.00 0 73.00 07300 CMHC 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 08300 H0SPLCE 83.00 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 84.00 135, 602 89.00 SUBTOTALS (sum of lines 1-84) 108,847 272, 580 104, 905 409, 609 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90 00 90.00 0 Λ 09100 BARBER AND BEAUTY SHOP 91.00 11 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 0 92.00 0 0 09300 NONPALD WORKERS 0 93.00 93.00 0 0 09400 PATI ENTS LAUNDRY 0 0 0 94.00 C 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 95.00

108,858

272, 580

Cross Foot Adjustments

Negative Cost Centers

**TOTAL** 

98.00

99 00

100.00

					10 12/31/2021	5/19/2022 1: 2	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
			SUPPLY		LI BRARY		
	CENEDAL CEDVICE COCT CENTEDS	9. 00	10.00	11. 00	12.00	13. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						6. 00 7. 00
7. 00 8. 00	00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	198, 500					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	906				10. 00
11. 00		0	0		D		11. 00
12.00		0	0		42, 196		12.00
13. 00 14. 00		0	0			58, 276 0	13. 00 14. 00
15. 00		0	0			0	15. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00		198, 500	906		33, 956		
31. 00		0	0		0	0	31. 00
32. 00 33. 00		0	0			0	32. 00 33. 00
33.00	ANCILLARY SERVICE COST CENTERS	0	0	<u> </u>	<u> </u>		33.00
40.00		0	0		84	0	40. 00
41.00	04100 LABORATORY	0	0		264	0	41. 00
42.00		0	0		168		42. 00
43. 00	, ,	0	0		0	0	43.00
44. 00 45. 00		0	0		2, 709 3, 318		44. 00 45. 00
46. 00		0	0		977		46. 00
47. 00		0	0		0		47. 00
48. 00		0	0		0	0	48. 00
49. 00		0	0		598		49. 00
50.00		0	0		0	0	50.00
51. 00 52. 00		0	0		122		51. 00 52. 00
32.00	OUTPATIENT SERVICE COST CENTERS		U	'	51 0		32.00
60.00		0	0		0	0	60. 00
61. 00		0	0		0	0	61. 00
62. 00	· · · · · · · · · · · · · · · · · · ·						62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0		0	0	63. 00
70.00		0	0		0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0	0	71. 00
72. 00	1	0	0		0	0	72. 00
73.00		0	0		0	0	73.00
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0	1	0	0	74. 00
80. 00							80. 00
81.00							81. 00
82. 00							82. 00
83. 00		0	0		0	0	
84. 00 89. 00		198, 500	0 906		0 0 42, 196	0 58, 276	84. 00 89. 00
67.00	NONREI MBURSABLE COST CENTERS	170, 300	700		5 42, 190	30, 270	09.00
90. 00		0	0		0	0	90. 00
91.00		0	0		0	0	91. 00
92.00		0	0		0	0	92.00
93. 00 94. 00		0	0		0	0	93. 00 94. 00
95.00			0			0	95.00
98. 00		Ö	0	•	ol o		98. 00
99. 00	Negative Cost Centers	0	0		0	0	
100.00	0 TOTAL	198, 500	906	l ·	42, 196	58, 276	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					To 12/31/2021	Date/Time Pro 5/19/2022 1:2	
			OTHER GENERAL			071772022 1.2	Į piii
	Cost Contor Doscription	NURSI NG AND	SERVI CE ACTI VI TI ES	Subtotal	Post Step-Down	Total	
	Cost Center Description	ALLI ED HEALTH		Subtotal	Adjustments	Total	
		EDUCATI ON					
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL			•			3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON			•			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10. 00
11.00	01100 PHARMACY						11.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTI VI TI ES	0	95, 178				15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   SKILLED NURSING FACILITY	1 0	95, 178	3, 324, 80	06 0	3, 324, 806	30.00
31. 00	03100 NURSING FACILITY		95, 176		0 0		1
32. 00	03200   CF/IID	0	0	1	0 0		1
33. 00	03300 OTHER LONG TERM CARE	0	0		0 0	<u>C</u>	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	23	9 0	239	40. 00
41. 00	04100 LABORATORY	0	Ō	1			1
42.00	04200 I NTRAVENOUS THERAPY	0	0	85			1
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	0	161, 45	0 0	1	
45. 00	04500 OCCUPATI ONAL THERAPY	0	Ö	137, 37			1
46. 00	04600 SPEECH PATHOLOGY	0	0	32, 14		,	1
47. 00 48. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	25, 69	0 0	25, 697	
49. 00	04900 DRUGS CHARGED TO PATIENTS		Ö	70, 82			1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	l .	0 0		
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	1	0 0		1
52.00	OUTPATIENT SERVICE COST CENTERS		0	1	0		32.00
60.00	06000 CLI NI C	0	_	1	0 0		
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		0	C	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	c	1
	OTHER REIMBURSABLE COST CENTERS						
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0 0		
71.00	07200 CORF		0		0 0		
73.00	07300 CMHC	0	0		0 0	c	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	0		0 0	<u>C</u>	74. 00
80 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW						82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0				1
89. 00	SUBTOTALS (sum of lines 1-84)		95, 178	3, 754, 17			
	NONREI MBURSABLE COST CENTERS	1	I	1			
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	1	0 0		
91.00	09200 PHYSI CLANS PRI VATE OFFI CES			1	0 0	C	1
93.00	09300 NONPALD WORKERS	0	0		0 0	C	93. 00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	C	
98.00	Cross Foot Adjustments		0		0 0		1
99. 00	Negative Cost Centers	0	0	_	0 0		99. 00
100.00	TOTAL	0	95, 178	3, 754, 18	64 0	3, 754, 184	100. 00

 
 FER
 In Lieu of Form CMS-2540-10

 Provider No.: 315243
 Period: From 01/01/2021 To 12/31/2021
 Worksheet B-1

 To 12/31/2021
 Date/Time Prepared: Date Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					Т	o 12/31/2021	Date/Time Pre 5/19/2022 1: 2	
			CAPITAL REL	ATED COSTS			37 177 2022 1. 2.	Z piii
	Cost Center Description	-	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
			FIXTURES	EQUI PMENT	BENEFITS		& GENERAL	
			(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM. COST)	
			1.00	2. 00	3. 00	4A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FI	VTIIDES	33, 056					1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQ		33, 030	33, 056				2. 00
3.00	00300 EMPLOYEE BENEFITS		1, 050	1, 050			40 540 407	3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. &	REPAIRS	874 2, 318	874 2, 318			13, 513, 637 859, 435	4. 00 5. 00
6.00	00600 LAUNDRY & LINEN SERVICE		1, 078	1, 078	0	0	369, 274	6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY		828 3, 145	828 3, 145		0	376, 889 1, 293, 267	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION		1, 414	1, 414		0	866, 296	9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY		0	0			59, 389 0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		318	318	_	_	92, 896	12.00
13.00	01300 SOCIAL SERVICE		412	412	· ·		253, 274	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH 01500 ACTIVITIES	EDUCATION	0 707	0 707			_	14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST C	CENTERS						
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY		17, 715 0	17, 715 0	_			30. 00 31. 00
32. 00	03200   CF/IID		Ö	0			_	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS		0	0	0	0	0	33. 00
40. 00			0	0	0	0	19, 236	40. 00
41. 00	04100 LABORATORY		0	0	Ĭ		43, 770	
42. 00 43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAP	Y	0	0	0	_	85, 382 0	42. 00 43. 00
44.00	04400 PHYSI CAL THERAPY		1, 216	1, 216	0	0	545, 919	44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY		1, 014 233	1, 014 233			664, 984 198, 265	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY		0	0		_	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED T	O PATIENTS	201	201	0	0	22, 828	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ON	LY	533 0	533 0		0	318, 987 0	49. 00 50. 00
51.00	05100 SUPPORT SURFACES		0	0			4, 552	51. 00
52. 00	05200 OTHER ANCILLARY SERVICE CO OUTPATIENT SERVICE COST CENTERS	SI CENTERS	0	0	0	0	0	52. 00
60.00	06000 CLI NI C		0	0				60. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FQHC		0	0	0	0	0	61. 00 62. 00
63.00	1 1	OST 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
71. 00	07100 AMBULANCE		0	0				70.00
			0	0	0	0	0	72.00
73. 00 74. 00			0	0	0			73. 00 74. 00
	SPECIAL PURPOSE COST CENTERS	5 1 00050				I		
80.00	08000 MALPRACTICE PREMIUMS & PAI 08100 INTEREST EXPENSE	D LOSSES						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW							82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST	CENTERS	0	0	0	0	0 0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-		33, 056	33, 056			_	89. 00
90. 00	NONREI MBURSABLE COST CENTERS	O CANTEEN	٥	0			0	90. 00
90.00		& CANTEEN	0	0	0			
92. 00	09200 PHYSICIANS PRIVATE OFFICES	1	0	0	0	0	0	92.00
93. 00 94. 00	09300 NONPALD WORKERS 09400 PATLENTS LAUNDRY		0	0	0	0	0	93. 00 94. 00
95.00	09500 OTHER NONREIMBURSABLE COST	CENTERS	Ö	Ö	Ö	Ö	Ö	95. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers							98. 00 99. 00
102.00		Wkst. B,	3, 754, 184	0	1, 138, 156		2, 139, 046	
103. 00	Part I) Unit cost multiplier (Wkst	R Dart I)	113. 570426	0. 000000	0. 222960		0. 158288	103 00
103.00			113. 370420	0.000000	119, 249		108, 858	
105 00	Part II)	D Dowt					0.000055	105 00
105. 00	Unit cost multiplier (Wkst	. b, Part			0. 023360		0. 008055	105.00
		,	,	'				

Provi der No.: 315243

Period: Worksheet B-1 From 01/01/2021 Date/Time Prepared: 5/19/2022 1:22 pm

				''	0 12/31/2021	5/19/2022 1: 2	
	Cost Center Description	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN SERVICE (TOTAL PATIENT		DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON	
		REPAI RS	DAYS)			(TOTAL PATIENT	
		(SQUARE FEET) 5.00	6. 00	7.00	8. 00	DAYS) 9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	28, 814	1				5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 078					6. 00
7.00	00700 HOUSEKEEPI NG	828	0	26, 908			7. 00
8.00	00800 DI ETARY	3, 145	1	-,	127, 716	1	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	1, 414		1, 414	0	42, 572	9. 00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY		1	0	0	0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	318		318	0		12. 00
13. 00	01300 SOCI AL SERVI CE	412	l .	412	0	Ö	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	0	0	0	0	14. 00
15. 00	01500 ACTI VI TI ES	707	7 0	707	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	47.745	10 570	47.745	407.74/	40.570	00.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	17, 715	42, 572	17, 715	127, 716	42, 572	30. 00 31. 00
32. 00	03200   CF/11D			0	0	1	32.00
33. 00	03300 OTHER LONG TERM CARE				0	1	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	C	-	_	0	-	40. 00
41. 00	04100 LABORATORY	C		0	0	-	41. 00
42. 00 43. 00	04200   NTRAVENOUS THERAPY 04300   OXYGEN (INHALATION) THERAPY			0	0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	1, 216		1, 216	0		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	1, 014	l .	1, 014	0	Ö	45. 00
46.00	04600 SPEECH PATHOLOGY	233	0	233	0	0	46. 00
47. 00		C	-	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	201	1		0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	533	1	533 0	0	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES			0	0		51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	d	1	Ö	0	Ö	52. 00
	OUTPATIENT SERVICE COST CENTERS	_	_			,	
60.00	06000 CLINIC	C			0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	C	٥	U U	0	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER			0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	C	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	C	0	0	0	0	71.00
	07200 CORF 07300 CMHC			0	0	0	72. 00 73. 00
	07400 OTHER REIMBURSABLE COST			0	Ü	1	
71.00	SPECIAL PURPOSE COST CENTERS		,,		0	,	71.00
80.00	l l						80. 00
81. 00	08100   NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW				0		82.00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS			0	0	0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	28, 814	42, 572	26, 908	127, 716	42, 572	
	NONREI MBURSABLE COST CENTERS				.=.,	.=/	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	C		_	0	_	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		1	_	0	0	92.00
93. 00 94. 00	09400 PATI ENTS LAUNDRY			0	0	0	93. 00 94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		ol o	ő	0	ő	95. 00
98.00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102.00	**	995, 473	464, 969	465, 152	1, 660, 997	1, 076, 714	102. 00
103. 00	Part I)   Unit cost multiplier (Wkst. B, Part I)	34. 548240	10. 921944	17. 286755	13. 005395	25. 291600	103 00
103.00		272, 580	l .	1	409, 609	1	
. 5 1. 50	Part II)	2,2,300	.30,002	.51, 755	.57,007		55
105.00		9. 459985	3. 185239	3. 898655	3. 207186	4. 662689	105. 00
	1 )		I	I		I	

			051755			6.5. 040	
	Financial Systems NLLOCATION - STATISTICAL BASIS	MI LLVI LLE			Peri od:	worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/19/2022 1:2	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. ) 10, 00	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 12.00	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	43, 755 0 0 0 0 0	0 0 0 0 0		8 0 42, 572 0 0	0	
30. 00		43, 755	0	18, 212, 46	9 42, 572	0	30.00
31. 00 32. 00	03100   NURSING FACILITY   03200   CF/IID	0	0		0 0	0	
33. 00	03300 OTHER LONG TERM CARE	ő	ő		0 0	0	1
40. 00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY	0	ol	45, 22	1 0	0	40.00
41. 00 42. 00	1 1	0 0	0 0	141, 48 89, 94	5 0 8 0 0 0	0 0	41. 00 42. 00 43. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0	1, 779, 14 523, 61		0	
47. 00	04700 ELECTROCARDI OLOGY	o o	Ö		ó	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	320, 71	0	0	48. 00 49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	1
51. 00 52. 00	05100   SUPPORT SURFACES   05200   OTHER ANCILLARY SERVICE COST CENTERS	0	0	65, 18	4 O	0	
52.00	OUTPATIENT SERVICE COST CENTERS	l ol	O <sub>I</sub>		0 0	0	52.00
60.00	O6000   CLINIC   O6100   RURAL HEALTH CLINIC	0	0		0 0	0	
	06200 FQHC					0	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	
	07200   CORF   07300   CMHC	0	0		0 0	0	
	07400 OTHER REIMBURSABLE COST	0	0		0 0	0	1
80 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES		1				80.00
81. 00	08100 I NTEREST EXPENSE						81. 00
	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	0		0	0	82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS		o		o o	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	43, 755	0	22, 630, 51	8 42, 572	0	89. 00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	o		0 0	0	
	09300 NONPALD WORKERS	0	0		0 0	0	1

68, 790

906

0. 000000

0.000000

1. 572163

0. 020706

124, 083

0.005483

0.001865

42, 196

314, 720

7. 392652

1. 368881

58, 276

94.00

95.00

98. 00 99. 00

0 102.00

0. 000000 103. 00 0 104. 00

0. 000000 105. 00

94.00 09400 PATIENTS LAUNDRY

Part I)

Part II)

11)

95.00

98.00 99. 00 102.00

103.00

104.00

105.00

09500 OTHER NONREIMBURSABLE COST CENTERS

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Cross Foot Adjustments Negative Cost Centers

MILLVILLE CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | To 12/31/2021 | Date/Time Prepared: Provi der No.: 315243

DEST CENTER   DESCRIPTION   SERVICE   SERVIC				To 12/31/2021	Date/lime Prepared:   5/19/2022 1:22 pm
Control Process   Control Pr				 <u> </u>	
CIPAL PATILENT   DAYS   19.00		Coot Conton Decemintion			
DATE		Cost Center Description			
REPERLY SERVICE ONLY CENTERS   15.00					
0.00   0.00   CAP REL COSTS - BLIDGS & FLYURES   2.00					
2.00   00000 CAP RELOSTS - MOVABLE SUIJ PRENT   3.00   00000 AUMINISTRATIVE & CENERAL   4.00   4.00   00000 AUMINISTRATIVE & CENERAL   4.00   4.00   00000 AUMINISTRATIVE & CENERAL   4.00   6.	1 00				1.00
0.000   0.000   DEPLOYER INFELTION   4.00   0.000   DEPLOYER INFELTION   4.00   0.000   DEPLOYER OF SERVICE   4.00   DEPLOYER OF SERVICE   4.00   DEPLOYER OF SERVICE   0.000   DEPLOYER OF SERVICE   4.00   DEPLOYER OF SERVICE   0.000   DEPLOYER OF SERVICE					
4.00					
6.00 0 0000 JAUNDRY & LINEN SERVICE         6.00 0           7.00 00700 JUNISHEEPING         7.00 0           8.00 0000 DI ETARY         9.00 0           10.00 0000 JUNISHEEPING         9.00 0           11.00 0000 JUNISHEEPING         9.00 0           11.00 0000 JUNISHEEPING         9.00 0           11.00 00 0000 JUNISHEEPING         19.00 0           11.00 00 1000 JUNISHEEPING         11.00 0           11.00 01 1000 JUNISHEEPING         12.00 0           13.00 01 1000 JUNISHEEPING         13.00 0           15.00 01 1000 JUNISHEEPING EXCENT CENTERS         15.00 0           31.00 01 1000 JUNISHEEPING EXCENT CENTERS         13.00 0           41.00 01 1000 JUNISHEEPING EXCENT CENTERS         14.00 0           41.00 01 1000 JUNISHEEPING EXCENT CENTERS         14.00 0           41.00 01 1000 JUNISHEEPIN					
7.00   0.0700   0.005EREEPING   7.00   9		1			
8.00   0.0000   DETARY     8.00   0.000   DETARY     9.00   0.000   DETARY     9.00   0.000   DETARY     9.00   0.000   DETARY   9.00   0.000   DETARY   9.00   0.000   DETARY   9.00   1.000   DETARY   9.00   9.000   DETARY   9.000   9.000   DETARY   9.000   9.000   PETARY   9.000   9.000   PETARY   9.000   9.000   9.000   PETARY   9.000   9.000   9.000   PETARY   9.000   9.000   9.000   9.000   PETARY   9.000   9.000   9.000   PETARY   9.000   9.000   9.000   9.000   PETARY   9.000   9.					
9.00   0.0900   MURSING AMAIN INSTRATION   9.00   11.00   11.00   0.01000   CENTRAL SERVICE SES SUPPLY   11.00					
11.00   1100   PHASMACY					
12.00   1200   MEDICAL RECORDS & LIBRARY     12.00   13.00   13.00   14.00					l l
13.00   1300   SOCIAL SERVICE   13.00   14.00   1400   1500   1500   ACTIVITIES   42.572   15.00   1500   ACTIVITIES   42.572   30.00   30.00   SMILLED MASS NO FACILITY   42.572   30.00   30.00   30.00   SMILLED MINSS NO FACILITY   0   32.00   30.00   33.00					
14.00   01400   NURSI NO AND ALLIED HEALTH EDUCATION					l
15.00   1000   ACTIN ITIES   14.2   572   15.00   1000					l
	15. 00		42, 572		15. 00
31.00     33.00     33.00     33.00     33.00     33.00       33.00     33.00       33.00			10.570		
32.00   03200   CHEFT LID			1		I
33.00   ANOLLARY SERVICE COST CENTERS			1		
0.00   04000   ABDIOLOGY			1		l l
1.1 00   04100   LABORATORY   0   0   42.00   04200   INTRAVENUS THERAPY   0   0   43.00   04300   OXYGEN (INHALATION) THERAPY   0   0   43.00   04500   OXYGEN (INHALATION) THERAPY   0   0   45.00   04500   OXYGEN (INHALATION) THERAPY   0   0   0   04500   OXYGEN (INHALATION) THERAPY   0   0   0   0   0   0   0   0   0					
42 00   04200   NTRAVENOUS THERAPY   0   43.00     43.00   04400   OHYSE CAL THERAPY   0   44.00     44.00   04400   OHYSE CAL THERAPY   0   45.00     45.00   04500   OCCUPATI ONAL THERAPY   0   45.00     46.00   04500   OCCUPATI ONAL THERAPY   0   46.00     47.00   04700   CELCTROCARDI OLOGY   0   47.00     48.00   04500   SPECEH PATHOLOGY   0   47.00     49.00   04500   ORLES CHARGED TO PATIENTS   0   48.00     49.00   04500   ORLES CHARGED TO PATIENTS   0   49.00     50.00   05000   ORLES CHARGED TO PATIENTS   0   49.00     50.00   05000   ORLES CHARGED TO PATIENTS   0   50.00     50.00   05000   ORLES CHARGED TO PATIENTS   0   60.00     60.00   05000   ORLES CHARGED TO PATIENTS   0   60.00     60.			0		l l
43. 00   04300   OXYGEN (I INHALATION) THERAPY   0   44. 00   045. 00   04500   OXYGEN (I INHALATION) THERAPY   0   0   45. 00   04500   OXYGEN THERAPY   0   0   04700   ELECTROCARDIOLOGY   0   04700   ELECTROCARDIOLOGY   0   47. 00   48. 00   04800   DRICAL SUPPLIES CHARGED TO PATIENTS   0   48. 00   04900   DRICAL SUPPLIES CHARGED TO PATIENTS   0   49. 00   05. 00   0500   DRITAL CARE - TITLE XIX SULY   0   0   05. 00   0500   DRITAL CARE - TITLE XIX SULY   0   0   05. 00   0500   DRITAL CARE - TITLE XIX SULY   0   0   05. 00   0500   DRITAL CARE - TITLE XIX SULY   0   0   05. 00   0500   OTHER ANGLI LARY SERVICE COST CENTERS   0   05. 00			0		
45.00   04500   04500   04500   04500   04500   0460		1 1	0		
46.00   04600   SPEECH PATHOLOGY   0   47.00   470   047			0		
47. 00   04700   04700   04500   049			0		l l
AB .00   04800   MEDIC ALL SUPPLIES CHARGED TO PATIENTS   0   49. 00   05000   DRUGS CHARGED TO PATIENTS   0   50. 00   50. 00   05000   DRUGS CHARGED TO PATIENTS   0   50. 00   50. 00   05000   DRUGS CHARGED TO PATIENTS   0   51. 00   51. 00   05000   DRUGS CHARGED TO PATIENTS   0   51. 00   51. 00   05000   DRUGS CHARGED TO PATIENTS   0   51. 00   05200   DRUGS CHARGED TO PATIENT SERVICE COST CENTERS   0   00000   CLI NIC   0   00000   CLI NIC   0   06. 00   06.			0		
50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   51.00   51.00   51.00   51.00   51.00   51.00   52.00   05200   OTHER ANCILLARY SERVICE COST CENTERS   0   52.00   00000   00000   CLINIC   0   60.00   6			o o		
51.00   05100   SUPPORT SURFACES   0   52.00			0		
52.00			0		
OUTPATLENT SERVICE COST CENTERS   0   06000 CLINIC   0   06100 RIRAL HEALTH CLINIC   0   0   06100 RIRAL HEALTH CLINIC   0   0   06100 RIRAL HEALTH CLINIC   0   0   062.00   06200 FOHC   062.00   063.00   06300 OTHER OUTPATIENT SERVICE COST CENTER   0   0   07000 OTHER REIMBURSABLE COST CENTERS   70.00   770.00   07000 HOME HEALTH AGENCY COST   0   771.00   07100 AMBULANCE   0   771.00   07100 AMBULANCE   0   772.00   07300 CMPC   773.00   07300 CMPC   073000 CMPC   073000 CMPC   073000 CMPC   073000 CMPC			0		
61.00   06200   FOHC   CORP	02.00		<u> </u>		02.00
62. 00   06200   OFOHC   O6300   OTHER OUTPATIENT SERVICE COST CENTERS   O   OTHER REI MBURSABLE COST CENTERS   O   OTHER REI MBURSABLE COST CENTERS   O   OTHER REI MBURSABLE COST   O   O   O   O   O   O   O   O   O			1		
63.00   06300   OTHER OUTPATIENT SERVICE COST CENTERS   0   0   OTHER REIMBURSABLE COST CENTERS   0   70.00   OTHOR HEALTH AGENCY COST   0   71.00   OT100   OT100   AMBULANCE   0   0   0   OT200   CORF   0   0   OT200   CORF   0   OT300   CMHC   OT400   OTHER REIMBURSABLE COST   O   OT400   OT400			0		
OTHER REIMBURSABLE COST CENTERS   O   O70.00   HOME HEALTH AGENCY COST   O   O70.00   O71.00   O71.00   AMBULANCE   O   O71.00			0		
71.00   07100   AMBULANCE   0   07200   CORF   0   0   07200   CORF   0   0   0   0   07300   CMPC   0   0   0   0   0   0   0   0   0	00.00	-	<u> </u>		00.00
72. 00 07200 CORF 073.00 07300 CMHC 73.00 07300 CMHC 074.00 07400 OTHER REIMBURSABLE COST 0 0 73.00 07400 OTHER REIMBURSABLE COST 0 0 74.00 OTHER REIMBURSABLE COST 0 0 74.00 OTHER REIMBURSABLE COST 0 0 08000 MALPRACTICE PREMI UMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW 82.00 083.00 08300 HOSPICE 0 0 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 091.00 09000 Physicians Private Offices 0 0 09300 NoNPal D WORKERS 0 0 09300 NoNPal D WORKERS 0 0 09300 NONPal D WORKERS 0 0 09400 PATIENTS LAUNDRY 0 0 9400 PATIENTS LAUNDRY 0 0 9400 PATIENTS LAUNDRY 0 0 9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 09400 PATIENTS LAUNDRY 0 0 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 09400 PATIENTS LAUNDRY 0 0 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0000 OTHER NONREIMBURSABLE COST CENTERS 0 0 0000 OTHER NONREI			1 -1		
73. 00 74. 00 74. 00 7400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS  80. 00 81. 00 81. 00 81. 00 81. 00 81. 00 82. 00 82. 00 83. 00 83. 00 84. 00 84. 00 85. 00 86. 00 86. 00 87. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 99. 00 102. 00 00 00 00 00 00 00 00 00 00 00 00 00			1 -1		
74. 00   07400  07HER REIMBURSABLE COST   SPECIAL PURPOSE COST CENTERS   S0. 00   08000  MALPRACTI CE PREMI UMS & PAI D LOSSES   S1. 00   08000  MALPRACTI CE PREMI UMS & PAI D LOSSES   S1. 00   08200  UTI LI ZATI ON REVI EW   S2. 00   08200  UTI LI ZATI ON REVI EW   S2. 00   08400  OTHER SPECIAL PURPOSE COST CENTERS   0   08400  OTHER SPECIAL PURPOSE COST CENTERS   0   08400  OTHER SPECIAL PURPOSE COST CENTERS   0   09000  ONNER MBURSABLE COST CENTERS   0   09000  ONNER MBURSABLE COST CENTERS   0   09100  BARBER AND BEAUTY SHOP   0   09100  BARBER AND BEAUTY SHOP   0   09100  BARBER AND BEAUTY SHOP   0   09200  PHYSI CI ANS PRI VATE OFFI CES   0   09300  NONPAI D WORKERS   0   09300  NONPAI D WORKERS   0   09400  PATI ENTS LAUNDRY   0   09500  OTHER NONREI MBURSABLE COST CENTERS   0   09500  OTHER NONREI MBURSABLE			0		
80. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   80. 00   81. 00   81. 00   82. 00   82. 00   82. 00   82. 00   83. 00   83. 00   83. 00   83. 00   84. 00   85. 00   8			o o		
81.00 08100   INTEREST EXPENSE 82.00 8200   UTILIZATION REVIEW 82.00 8300   MOSPICE 84.00 08400   OTHER SPECIAL PURPOSE COST CENTERS 0 84.00					
82. 00 08200 UTILIZATION REVIEW 83. 00 08300 HOSPICE 0 0 83. 00 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 84. 00 89. 00 SUBTOTALS (sum of lines 1-84) 42,572 89. 00  NONREI MBURSABLE COST CENTERS  90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 91. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 91. 00 92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 92. 00 93. 00 09300 NONPAID WORKERS 0 92. 00 94. 00 09400 PATIENTS LAUNDRY 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 95. 00 98. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 95. 00 102. 00 Cross Foot Adjustments 99. 00 102. 00 Cost to be allocated (per Wkst. B, 340, 358 Part I) 7. 994879 103. 00 Unit cost multiplier (Wkst. B, Part I) 7. 994879 105. 00 Unit cost multiplier (Wkst. B, Part I) 7. 994879 105. 00 Unit cost multiplier (Wkst. B, Part I) 105. 00					•
83.00 84.00 88.00 89.00    08400   OTHER SPECIAL PURPOSE COST CENTERS   0   84.00     SUBTOTALS (sum of lines 1-84)   42,572   89.00       NONREI MBURSABLE COST CENTERS   0   90.00     91.00   09100   BARBER AND BEAUTY SHOP   0   91.00     92.00   09200   O9300   NONPAI D WORKERS   0   92.00     93.00   09400   PATIENTS LAUNDRY   0   94.00     95.00   09500   OTHER NONREI MBURSABLE COST CENTERS   0     99.00   Cross Foot Adjustments   99.00     99.00   Negative Cost Centers   99.00     99.00   Cost to be allocated (per Wkst. B, Part I)   7.994879     103.00   Unit cost multiplier (Wkst. B, Part II)     105.00   Unit cost multiplier (Wkst. B, Part III)     105.00   Unit cost multiplier (Wkst. B, Part IIII)     105.00   Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		1 1			
89.00   SUBTOTALS (sum of lines 1-84)   42,572   89.00		1 1	0		
NONRE   MBURSABLE   COST   CENTERS		1 1	0		•
90. 00	89. 00		42, 572		89. 00
91.00   09100   BARBER AND BEAUTY SHOP   0   91.00   92.00   92.00   93.00   93.00   93.00   93.00   93.00   93.00   93.00   93.00   93.00   94.00   9	90. 00		O		90.00
93.00   93.00   93.00   93.00   94.00   94.00   95.00   95.00   95.00   95.00   95.00   97.00			o o		•
94. 00			0		•
95. 00			0		
98.00   Cross Foot Adjustments   98.00   99.00   Negative Cost Centers   99.00   Cost to be allocated (per Wkst. B, Part I)   103.00   Unit cost multiplier (Wkst. B, Part I)   104.00   Cost to be allocated (per Wkst. B, Part II)   105.00   Unit cost multiplier (Wkst. B, Part III)   105.00   Unit cost multiplier (Wkst. B, Part III)   105.00   Unit cost multiplier (Wkst. B, Part IIII)   105.00   Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			0		
99.00  Negative Cost Centers  102.00  Cost to be allocated (per Wkst. B, Part I)  103.00  Unit cost multiplier (Wkst. B, Part I)  104.00  Cost to be allocated (per Wkst. B, Part II)  105.00  Negative Cost Centers  99.00  102.00  103.00  103.00  103.00  104.00  Part II)  105.00  Unit cost multiplier (Wkst. B, Part III)  105.00	98. 00				
Part I)  103.00 Unit cost multiplier (Wkst. B, Part I)  104.00 Cost to be allocated (per Wkst. B, Part II)  105.00 Unit cost multiplier (Wkst. B, Part II)  105.00  Part II)  105.00  Part II)  105.00  103.00 104.00 105.00		Negative Cost Centers			•
103.00       Unit cost multiplier (Wkst. B, Part I)       7.994879         104.00       Cost to be allocated (per Wkst. B, Part II)       95,178         105.00       Unit cost multiplier (Wkst. B, Part II)       2.235695	102.00		340, 358		102. 00
104.00       Cost to be allocated (per Wkst. B, Part II)       95,178         105.00       Unit cost multiplier (Wkst. B, Part 2.235695)       105.00	103 00		7 994879		103 00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 2.235695 105.00		1 1	1		
		Part II)			
	105.00		2. 235695		105. 00
		1 1117	ı		I

Health Financial Systems	MILLVILLE CENTER	In Lieu of Form CMS-2540-10
DATIO OF COCT TO CHARCES FOR	NCLLIARY AND OUTDATIENT COST CENTERS   Droy i don No . 215242	Dominal Mankahaat C

Peri od: From 01/01/2021 To 12/31/2021 RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Worksheet C Provi der No.: 315243 Date/Time Prepared: 5/19/2022 1:22 pm Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col. 2 1.00 2. 00 3. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 22, 529 45, 221 0. 498198 40.00 04100 LABORATORY 51, 474 141, 485 0.363812 41.00 41.00 42.00 04200 I NTRAVENOUS THERAPY 99, 390 89, 948 1. 104972 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 703, 328 1, 452, 737 0. 484140 44.00 04500 OCCUPATIONAL THERAPY 45.00 832, 559 1, 779, 143 0.467955 45.00 04600 SPEECH PATHOLOGY 0.467130 46.00 244, 597 523, 617 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 36, 860 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 398, 865 49.00 49.00 320, 714 1. 243678 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 Λ 50.00 51.00 05100 SUPPORT SURFACES 5,630 65, 184 0.086371 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 52.00 OUTPATIENT SERVICE COST CENTERS 0.000000 60.00 06000 CLI NI C 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 61.00 62.00 06200 FQHC 62.00 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 63.00 0 0 71. 00 | 07100 | AMBULANCE 0.000000 71.00 100.00 Total 2, 395, 232 4, 418, 049 100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315243	Peri od:	Worksheet D	
ALLOCATION WENT OF ANOTEENIN AND OUTFAILENT COSTS		Trovidei		From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre	pared:
					5/19/2022 1: 2	2 pm
		Title	XVIII (1)	Skilled Nursing	PPS	
	T			Facility		
		Heal th Care Pr	rogram Charges	s Health Care	Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col. 1	Dort P (col 1	
cost center bescription	to Charges	Part A	Part B	x col. 2)	x col. 3)	
	(Fr. Wkst. C			X COI. 2)	X COI. 3)	
	Column 3)					
	1.00	2. 00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPATI		2.00	0.00	1. 00	0.00	
ANCI LLARY SERVI CE COST CENTERS	2 555.					1
40. 00 04000 RADI OLOGY	0. 498198	16, 801		0 8, 370	0	40.00
41. 00  04100   LABORATORY	0. 363812	4, 778		0 1, 738	0	41.00
42. 00 04200 INTRAVENOUS THERAPY	1. 104972	52, 092		0 57, 560	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0. 484140	573, 453		0 277, 632	0	44.00
45. 00 04500 OCCUPATIONAL THERAPY	0. 467955	622, 995		0 291, 534	0	45.00
46. 00 04600 SPEECH PATHOLOGY	0. 467130	225, 448		0 105, 314	0	46.00
47. 00   04700   ELECTROCARDI OLOGY	0. 000000	0		0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 243678	121, 429		0 151, 019	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00   05100   SUPPORT SURFACES	0. 086371	41		0 4	0	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60. 00  06000  CLI NI C	0. 000000	0		0	0	
61.00  06100 RURAL HEALTH CLINIC						61.00
62. 00  06200 FQHC						62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0	0	
71.00   07100   AMBULANCE (2)	0. 000000			0	0	
100.00   Total (Sum of Lines 40 - 71)		1, 617, 037		0 893, 171	Λ.	100.00

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

Heal th	Financial Systems	MI LLVI LLE	CENTER		In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315243	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/19/2022 1:2	
	Title XVIII Skilled Nursing Facility					PPS	
	Cost Center Description	_			•		
						1. 00	
	PART II - APPORTIONMENT OF VACCINE COST						
1.00	Drugs charged to patients - ratio of co			t C, column 3	, line 49)	1. 243678	
2.00	Program vaccine charges (From your reco					5, 439	
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	6, 764	3. 00
	E, Part I, line 18) Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Dont A Nuncina	
	cost center bescriptron	(From Wkst. B.			Cost (From	& Allied	
			(From Wkst. B,			Health Costs	
		18	Part I, Col.	Costs to Total		for Pass	
		10	14)	Costs - Part		Through (Col.	
			,	(Col. 2 / Co		3 x Col . 4)	
				1)		,	
	1.00 2.00 3.00 4.00 5.0						
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	22, 529		0.0000		0	
	04100 LABORATORY	51, 474		0.0000		0	41. 00
	04200 I NTRAVENOUS THERAPY	99, 390	(	0.0000		0	
	04300 OXYGEN (INHALATION) THERAPY	0	(	0.0000		0	
	04400 PHYSI CAL THERAPY	703, 328	<b>.</b>	0.0000		0	
	04500 OCCUPATI ONAL THERAPY	832, 559		0.0000		0	
	04600 SPEECH PATHOLOGY	244, 597	(	0.0000		0	
	04700 ELECTROCARDI OLOGY	0	(	0.0000		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	36, 860	<b>.</b>	0.0000		0	
	04900 DRUGS CHARGED TO PATIENTS	398, 865	(	0.0000		0	
	05000 DENTAL CARE - TITLE XIX ONLY	D F (20	(	0.0000		0	00.00
	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	5, 630	(	0.0000		0	0 00
52. 00 100. 00		2 205 222		0.0000		0	100.00
100.00		2, 395, 232	1	4	893, 171	ı	1100.00

From 01/01/2021 To 12/31/2021					pared
		Title XVIII	Skilled Nursing Facility	5/19/2022 1: 2 PPS	<u> </u>
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	INPATIENT DAYS				
00	Inpatient days including private room days			42, 572	
00	Private room days			328	
0	Inpatient days including private room days applicable to the	9		5, 863	
0	Medically necessary private room days applicable to the Prog	gram		0	1 .
0	Total general inpatient routine service cost			13, 255, 824	5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			17 500 700	6
0	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5	divided by Line 6)		17, 520, 708 0. 756580	
0	Enter private room charges from your records	divided by Title 0)		158, 424	
0	Average private room per diem charge (Private room charges I	ine 8 divided by private	room days line	483.00	
	2)	The b divided by private	Toom days, Title	403.00	′
00	Enter semi-private room charges from your records			17, 362, 284	10
00	Average semi-private room per diem charge (Semi-private room	om charges line 10, divide	ed by	411.00	11
	semi-private room days)				
00	Average per diem private room charge differential (Line 9 mi			72. 00	
	Average per diem private room cost differential (Line 7 time			54. 47	
	Private room cost differential adjustment (Line 2 times line			17, 866	
	General inpatient routine service cost net of private room op PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus line 14)	13, 237, 958	15
	Adjusted general inpatient service cost per diem (Line 15 c	livided by line 1)		310. 95	16
00	Program routine service cost (Line 3 times line 16)			1, 823, 100	17
00	Medically necessary private room cost applicable to program			0	18
00	Total program general inpatient routine service cost (Line			1, 823, 100	
00	Capital related cost allocated to inpatient routine service	costs (From Wkst. B, Par	t II column 18,	3, 324, 806	20
00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			70.40	
00	Per diem capital related costs (Line 20 divided by line 1)			78. 10 457, 900	
00	Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22)			1, 365, 200	
	Aggregate charges to beneficiaries for excess costs (From p	provider records)		1, 303, 200	
00	Total program routine service costs for comparison to the co	,	nus line 24)	1, 365, 200	
	Enter the per diem limitation (1)	(2 20		., 555, 200	26
00	Inpatient routine service cost limitation (Line 3 times the	per diem limitation line	26) (1)		27
	Reimbursable inpatient routine service costs (Line 22 plus				28
	(Transfer to Worksheet E, Part II, line 4) (See instructions	5)	,		
Lin	nes 26 and 27 are not applicable for title XVIII, but may be	used for title V and or t	title XIX		

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	42, 572	1.00
2.00	Program inpatient days (see instructions)	5, 863	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 137720	4. 00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	MILLVILLE CEN	TER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE	XVIII	Provider No.: 315243	From 01/01/2021	Worksheet E Part I Date/Time Prepared: 5/19/2022 1:22 pm
		T1 11 10 11	01 1 1 1 1 1 1	000

		Title XVIII	Skilled Nursing	PPS	Ζ μιιι
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSE	MENT			
1.00	Inpatient PPS amount (See Instructions)			3, 669, 988	•
2.00	Nursing and Allied Health Education Activities (pass through pay	ments)		0	
3.00	Subtotal (Sum of lines 1 and 2)			3, 669, 988	
4.00	Pri mary payor amounts			0	4.00
5.00	Coinsurance			525, 674	1
6.00	Allowable bad debts (From your records)			272, 255	•
7.00	Allowable Bad debts for dual eligible beneficiaries (See instruc	ctions)		253, 188	
8.00	Adjusted reimbursable bad debts. (See instructions)			176, 966	
9.00	Recovery of bad debts - for statistical records only			0	
10.00	Utilization review			0	
11.00	Subtotal (See instructions)			3, 321, 280	
12.00	Interim payments (See instructions)			3, 403, 422	1
13.00	Tentati ve adjustment			0	
14.00	OTHER adjustment (See instructions)			0	
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			20, 843	1
14. 75	Sequestration for non-claims based amounts (see instructions)			0	
14. 99	Sequestration amount (see instructions)			-	
15. 00 16. 00	Balance due provider/program (see Instructions) Protested amounts (Nonallowable cost report items in accordance	with CMS Dub 1E 2	continu 11E 2)	-102, 985 0	1
16.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER C			U	16.00
17. 00	Ancillary services Part B	OF COST OR CHARGES -	TITLE AVITE ONLY	0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			6, 764	ı
19. 00	Total reasonable costs (Sum of Lines 17 and 18)			6, 764	1
20. 00	Medicare Part B ancillary charges (See instructions)			5, 439	1
21. 00	Cost of covered services (Lesser of line 19 or line 20)			5, 439	1
22. 00	Primary payor amounts			0, 107	•
23. 00	Coinsurance and deductibles			0	ł
24. 00	Allowable bad debts (From your records)			0	
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instruc	ctions)		0	
24. 02	Adjusted reimbursable bad debts (see instructions)	,		0	24. 02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			5, 439	25. 00
26.00	Interim payments (See instructions)			2, 925	26. 00
27.00	Tentati ve adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)			2, 514	29. 00
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	section 115.2	0	30. 00

Health Financial Systems	MILLVILLE CEN	TER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provi der No.: 315243	From 01/01/2021	Worksheet E Part II Date/Time Prepared: 5/19/2022 1:22 pm
		Title XIX	Skilled Nursing	PPS

1.00			litle XIX	Facility	PPS		
COMPUTATION OF NET COST OF COVERED SERVICES				Facility			
COMPUTATION OF NET COST OF COVERED SERVICES					1 00		
Inpatient ancillary services (see Instructions)		COMPUTATION OF NET COST OF COVERED SERVICES			1.00		
2.00	1.00				0	1.00	
3.00	2.00		5)		0	2.00	
Utilization reviewphysicians' compensation (from provider records)	3.00				0	3. 00	
1.00   1.00	4.00	Inpatient routine services (see instructions)			0	4.00	
7.00   Differential in charges between semiprivate accommodations and less than semiprivate accommodations   0   7.00	5.00		ords)		0	5. 00	
SUBTOTAL (Line 6 minus line 7)   0   8.00	6.00	Cost of covered services (Sum of lines 1 - 5)	ŕ		0	6. 00	
SUBTOTAL (Line 6 minus line 7)   0   8.00	7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7. 00	
10.00   Total Reasonable Cost (Line 8 minus line 9)   10.00   REASONABLE CHARGES	8.00		·		0	8. 00	
REASONABLE CHARGES  Inpatient ancillary service charges  11.00  12.00  13.00  Inpatient routine service charges  13.00  Inpatient routine service charges  14.00  Differential in charges between semiprivate accommodations and less than semiprivate accommodations  15.00  Total reasonable charges  CUSTOMARY CHARGES  16.00  Aggregate amount actually collected from patients liable for payment for services on a charge basis on the advance of the services on a charge basis on the such payment been made in accordance with 42 CFR 413. 13(e)  18.00  Ratio of line 16 to line 17 (not to exceed 1.000000)  Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00  Cost of covered services (see Instructions)  Deductibles  Subtotal (Line 20 minus line 21)  Subtotal (Line 20 minus line 23)  Allowable bad debts (from your records)  Allowable bad debts (from your records)  Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost I limit  Recovery of excess depreciation resulting from provider termination or a decrease in program  Utilization  11.00  12.00  13.00  14.00  15.00  16.00  17.00  18.00  0.0000000  18.00  0.0000000  18.00  0.0000000  18.00  0.0000000  18.00  0.0000000  18.00	9.00	Primary payor amounts			0	9. 00	
11. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1.	10.00	Total Reasonable Cost (Line 8 minus line 9)			0	10.00	
12. 00 Outpatient service charges 0 13. 00 Inpatient routine service charges 0 13. 00 Inpatient routine service charges 0 13. 00 Inpatient routine service charges 0 13. 00 Inferential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14. 00 Inferential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14. 00 Inferential in charges between semiprivate accommodations and less than semiprivate accommodations 0 15. 00 Interest of Interest		REASONABLE CHARGES					
13. 00 Inpatient routine service charges 14. 00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15. 00 Total reasonable charges CUSTOMARY CHARGES 16. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis On 17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis On 17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis On 17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis On 17. 00 Description of the payment been made in accordance with 42 CFR 413. 13(e) On 17. 00 Description of Description of One of Computation of the payment for services on a charge basis On 17. 00 Description of	11.00	Inpatient ancillary service charges			0	11. 00	
14. 00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14. 00 15. 00 CUSTOMARY CHARGES  16. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16. 00 17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17. 00 had such payment been made in accordance with 42 CFR 413. 13(e) 18. 00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 19. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 19. 00 Color of covered services (see Instructions) 0 21. 00 Deductibles 0 22. 00 Subtotal (Line 20 minus line 21) 0 22. 00 Coinsurance 0 23. 00 Coinsurance 0 24. 00 Subtotal (Line 22 minus line 23) 0 24. 00 Subtotal (Line 22 minus line 24) 0 25. 00 Subtotal (sum of lines 24 and 25) 0 27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 1 28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program 0 29. 00 Other Adjustments (see instructions) Specify	12.00	Outpati ent servi ce charges			0	12.00	
15. 00 Total reasonable charges CUSTOMARY CHARGES  16. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis on the payment that would have been realized from patients liable for payment for services on a charge basis on the payment been made in accordance with 42 CFR 413.13(e)  18. 00 Ratio of line 16 to line 17 (not to exceed 1.000000)  19. 00 Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20. 00 Deductibles  20. 00 Deductibles  20. 00 Subtotal (Line 20 minus line 21)  20. 00 Subtotal (Line 22 minus line 23)  20. 00 Allowable bad debts (from your records)  20. 00 Subtotal (sum of lines 24 and 25)  10. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program  29. 00 Other Adjustments (see instructions) Specify	13.00	Inpatient routine service charges			0	13. 00	
CUSTOMARY CHARGES  16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 had such payment been made in accordance with 42 CFR 413.13(e)  18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.000000 18.00 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Cost of covered services (see Instructions) 0 20.00 Deductibles 0 0 21.00 22.00 Subtotal (Line 20 minus line 21) 0 22.00 Coinsurance 0 23.00 Subtotal (Line 22 minus line 23) 0 24.00 Subtotal (Line 22 minus line 23) 0 25.00 Allowable bad debts (from your records) 0 25.00 Subtotal (sum of lines 24 and 25) 0 26.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of 0 27.00 cost limit Recovery of excess depreciation resulting from provider termination or a decrease in program 0 28.00 29.00 Other Adjustments (see instructions) Specify 0 29.00	14.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	14. 00	
16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 20.00 Deductibles 20.00 Subtotal (Line 20 minus line 21) 21.00 Coinsurance 22.00 Subtotal (Line 22 minus line 23) 24.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) 26.00 Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program 29.00 Other Adjustments (see instructions) Specify	15. 00				0	15. 00	
17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)  18. 00 Ratio of line 16 to line 17 (not to exceed 1.000000)  Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20. 00 Cost of covered services (see Instructions)  Deductibles  Subtotal (Line 20 minus line 21)  Coinsurance  4. 00 Subtotal (Line 22 minus line 23)  Allowable bad debts (from your records)  Subtotal (sum of lines 24 and 25)  Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28. 00 Other Adjustments (see instructions) Specify  17. 00  18. 00  0. 000000  18. 00  0. 000000  19. 00  20. 00  20. 00  20. 00  21. 00  22. 00  23. 00  24. 00  25. 00  26. 00  27. 00  28. 00  28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00							
had such payment been made in accordance with 42 CFR 413.13(e)							
18.00 Ratio of line 16 to line 17 (not to exceed 1.000000)  Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Deductibles  Subtotal (Line 20 minus line 21)  23.00 Coi nsurance  Subtotal (Line 22 minus line 23)  Allowable bad debts (from your records)  Subtotal (sum of lines 24 and 25)  77.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  Ratio of line 16 to line 17 (not to exceed 1.000000)  18.00  19.00  20.00  20.00  20.00  21.00  22.00  23.00  24.00  25.00  26.00  27.00  28.00  29.00  29.00  29.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  21.00  22.00  23.00  24.00  25.00  26.00  27.00  28.00  29.00  29.00  29.00	17. 00						
19.00 Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Cost of covered services (see Instructions) Deductibles Subtotal (Line 20 minus line 21) Coinsurance 23.00 Coinsurance 24.00 Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) Cost of covered services (see Instructions) Deductibles Coinsurance Cost of covered services (see Instructions) Coinsurance Cost of covered services (see Instructions) Coinsurance Cost line 22 minus line 21) Coinsurance Cost line 22 minus line 23) Coinsurance Cost line 22 minus line 21) Coinsurance Cost line 22 minus line 23) Coinsurance Cost line 22 minus line 21) Coinsurance Cost line 22 minus line 21) Coinsurance Cost line 22 minus line 21) Coinsurance	40.00						
COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Cost of covered services (see Instructions)  21.00 Deductibles  22.00 Subtotal (Line 20 minus line 21)  23.00 Coi nsurance  24.00 Subtotal (Line 22 minus line 23)  25.00 Allowable bad debts (from your records)  26.00 Subtotal (sum of lines 24 and 25)  27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program  29.00 Other Adjustments (see instructions) Specify  0 20.00  21.00  22.00  22.00  23.00  24.00  25.00  26.00  27.00  28.00  29.00 Other Adjustments (see instructions) Specify							
20.00 Cost of covered services (see Instructions)  10 20.00 Deductibles  20 00 Subtotal (Line 20 minus line 21)  20 00 Coinsurance  24 00 Subtotal (Line 22 minus line 23)  25 00 Allowable bad debts (from your records)  26 00 Subtotal (sum of lines 24 and 25)  27 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization  29 00 Other Adjustments (see instructions) Specify	19.00				0	19.00	
21. 00 Deductibles  Subtotal (Line 20 minus line 21)  Coinsurance  Subtotal (Line 22 minus line 23)  Allowable bad debts (from your records)  Subtotal (sum of lines 24 and 25)  Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  Recovery of excess depreciation resulting from provider termination or a decrease in program  utilization  29. 00 Other Adjustments (see instructions) Specify	20.00					20.00	
22.00 Subtotal (Line 20 minus line 21) Coinsurance Subtotal (Line 22 minus line 23) 24.00 Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) Subtotal (sum of lines 24 and 25) Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit Recovery of excess depreciation resulting from provider termination or a decrease in program Utilization  29.00 Other Adjustments (see instructions) Specify  0 22.00 23.00 24.00 25.00 26.00 27.00 28.00 28.00 29.00		,			-		
23. 00   Coinsurance   0   23. 00   24. 00   Subtotal (Line 22 minus line 23)   0   24. 00   25. 00   Allowable bad debts (from your records)   0   25. 00   26. 00   Subtotal (sum of lines 24 and 25)   0   26. 00   27. 00   Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit   28. 00   Recovery of excess depreciation resulting from provider termination or a decrease in program   0   28. 00   29. 00   Other Adjustments (see instructions)   Specify   0   29. 00					-		
24. 00 Subtotal (Line 22 minus line 23)  25. 00 Allowable bad debts (from your records)  26. 00 Subtotal (sum of lines 24 and 25)  27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization  29. 00 Other Adjustments (see instructions) Specify  0 24. 00  25. 00  26. 00  27. 00  27. 00  28. 00  29. 00		· · · · · · · · · · · · · · · · · · ·					
25. 00 Allowable bad debts (from your records)  26. 00 Subtotal (sum of lines 24 and 25)  27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization  29. 00 Other Adjustments (see instructions) Specify  0 25. 00 26. 00 27. 00 27. 00 27. 00 27. 00 27. 00 28. 00							
26.00 Subtotal (sum of lines 24 and 25)  27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization  29.00 Other Adjustments (see instructions) Specify					-		
27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization  29.00 Other Adjustments (see instructions) Specify  0 27.00 27.00 28.00 29.00						•	
cost limit Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 0 29.00		· · · · · · · · · · · · · · · · · · ·	y call acted based on c	orroction of	-		
28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 0 29.00	27.00		y corrected based on c	or rectron or	Ü	27.00	
utilization 29.00 Other Adjustments (see instructions) Specify 0 29.00	28 00		tion or a decrease in	program	0	28 00	
29.00 Other Adjustments (see instructions) Specify	20.00			program	Ü	20.00	
	29. 00				0	29. 00	
30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets ( 0 30.00	30. 00		om disposition of depr	eciable assets (	0	30.00	
if minus, enter amount in parentheses)				`			
31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 0 31.00	31.00		27 and 28)		0	31.00	
32.00   Interim payments   0   32.00	32.00	Interim payments	-		0	32. 00	
33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00	33.00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see	0	33. 00	
Instructions)		Instructions)					

Provi der No.: 315243 Peri od: Worksheet E-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/19/2022 1:22 pm Title XVIII Skilled Nursing PPS

Impatient Part A			11 (1)	e AVIII	Facility	PP3	
1.00			Inpatien	t Part A		rt B	
1.00			/ -  -  /	A	/ -l -l /	A	
1.00							
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 00	Total interim nayments haid to provider	1.00		3.00		1 00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero				3, 341, <del>3</del> 67			
Services rendered in the cost reporting period. If none, enter zero   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   O5/28/2021   61,435   O 3.01   O 0 0 3.03   O 0 0 0 3.04   O 0 0 0 3.04   O 0 0 0 3.05   O 0 0 0 3.05   O 0 0 0 3.05   O 0 0 0 0 3.05   O 0 0 0 0 3.05   O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00			Š			2.00
List separately each retroactive lunp 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							
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)  2.01		1					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Program to Provider   DJUSTIMENTS TO PROVIDER   DS/28/2021   61,435   D							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 0 3.03 3.51 3.52 0 0 0 0 3.51 3.53 3.54 0 0 0 0 3.51 3.52 0 0 0 0 3.53 3.54 0 0 0 0 3.55 3.54 0 0 0 0 3.55 3.54 0 0 0 3.55 3.54 0 0 0 0 3.55 0 0 0 0 3.56 0 0 3.57 0 0 0 3.59 0 0 0 3.59 0 0 0 3.50 0 0 0 3.50 0 0 0 3.51 0 0 0 0 3.50 0 0 0 3.51 0 0 0 0 3.50 0 0 0 3.50 0 0 0 3.50 0 0 0 3.50 0 0 0 3.50 0 0 0 3.50 0 0 0 0 3.50 0 0 0 0 3.50 0 0 0 0 3.50 0 0 0 0 3.50 0 0 0 0 0 3.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3 01		05/28/2021	61 435		0	3 01
3.03 3.04 3.05 Provider to Program  3.50 3.51 3.52 3.53 3.54 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) PB E COMPLETED BY CONTRACTOR List sparately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  TENTATIVE TO PROGRAM  TO THE TENTATIVE TO PROGRAM		ABSOSTMENTS TO TROVIDER	007 207 202 1	01, 100			
3.05				0		1	
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3.50				0		0	3.04
ADJUSTMENTS TO PROGRAM	3.05			0		0	3. 05
3.51							
3.52   3.53   3.54   3.59   3.54   3.59   3.54   3.59   3.54   3.59   3.54   3.59		ADJUSTMENTS TO PROGRAM		_			
3.53   3.54   3.59   Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   61,435   0   3.53   3.54   3.99   Subtotal (Sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total Medicare program liability (see instructions)   S. 50   Contractor Name   Contractor Number   Contractor				-			
3.54   0   0   0   3.54   0   3.99   3.403, 422   2.925   4.00   0   0   3.54   0   0   0   3.54   0   0   0   3.54   0   0   0   3.54   0   0   0   3.54   0   0   0   0   0   0   0   0   0				0			
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50				0			
- 3.98) 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) TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  5.01 TENTATIVE TO PROVIDER  5.02 0 0 0 5.03  0 0 0 5.03  Provider to Program  TENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  TO DO		Subtotal (Sum of Lines 2.01 2.40 minus sum of Lines 2.50)		61 425			
A.00	3. 77			01, 433		١	3. 77
CTransfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)   TO BE COMPLETED BY CONTRACTOR	4.00			3, 403, 422		2, 925	4.00
TO BE COMPLETED BY CONTRACTOR   Solution						, , ,	
5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Write "NONE" or enter a zero. (1)   Program to Provider   S. 01   TENTATI VE TO PROVIDER   O	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVIDER							
5.02	5 01			0		0	5 01
5.03   Provider to Program   5.50   TENTATIVE TO PROGRAM   0   0   5.50     5.51   0   0   0   5.50     5.52   0   0   0   5.51     5.52   0   0   0   5.52     5.99   Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0   0   5.59     - 5.98   0   0   5.99     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   0   0   2,514     6.01   PROGRAM TO PROVIDER   0   2,514   6.01     6.02   PROVIDER TO PROGRAM   102,985   0   6.02     7.00   Total Medicare program liability (see instructions)   3,300,437   5,439   7.00     Contractor Name   Contractor Number		TENTITY E TO TROVIDEN					
TENTATI VE TO PROGRAM   0   0   5.50				-			
5.51		Provider to Program					
5.52   0 0 5.52   5.99   Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0 0 5.99   -5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		TENTATI VE TO PROGRAM		0		0	
5. 99       Subtotal (Sum of lines 5. 01 - 5. 49 minus sum of lines 5. 50 - 5. 98)       0       0       5. 99 - 5. 98         6. 00       Determined net settlement amount (balance due) based on the cost report. (1)       6. 00 - 6. 00       6. 00         6. 01       PROGRAM TO PROVIDER       0       2, 514 - 6. 01         6. 02       PROVIDER TO PROGRAM       102, 985 - 0 - 6. 02         7. 00       Total Medicare program liability (see instructions)       3, 300, 437 - 5, 439 - 7. 00         Contractor Name         Contractor Number				-			
- 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name  Contractor Number				0			
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name  Contractor Number	5. 99			0		0	5. 99
the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name Contractor Number	4 00						4 00
6. 01 PROGRAM TO PROVIDER 0 2, 514 6. 01 6. 02 PROVIDER TO PROGRAM 102, 985 0 6. 02 7. 00 Total Medicare program liability (see instructions) 3, 300, 437 5, 439 7. 00 Contractor Name Contractor Number	6.00						6.00
6.02       PROVI DER TO PROGRAM       102, 985       0 6.02         7.00       Total Medicare program liability (see instructions)       3, 300, 437       5, 439       7.00         Contractor Name       Contractor Number	6 01			n		2 514	6 01
7.00 Total Medicare program liability (see instructions) 3,300,437 5,439 7.00 Contractor Name Contractor Number				102, 985		2,314	
Contractor Name Contractor Number	7. 00	· · · · · · · · · · · · · · · · · · ·		•		5, 439	
					or Name	· · · · · · · · · · · · · · · · · · ·	
1.00 2.00							
		In the second second		1.	00	2. 00	
8.00   Name of Contractor     8.00		·				1	8. 00

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

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

Provi der No.: 315243 | Peri od: From 01/01/2021 To 12/31/2021

| Period: | Worksheet G | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/19/2022 1:22 pm |

only)					5/19/2022 1:2	2 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	Assets CURRENT ASSETS					-
. 00	Cash on hand and in banks	6, 484	(	0	0	1.0
2. 00	Temporary investments	0	(	o	0	
3. 00	Notes recei vabl e	0	(	0	0	
. 00	Accounts receivable	1, 782, 289			0	
5. 00 5. 00	Other receivables Less: allowances for uncollectible notes and accounts	-113, 169 -241, 189			0	
5. 00	recei vabl e	-241, 109		1	U	0.0
7. 00	Inventory	93, 488	(	o	0	7.0
3. 00	Prepai d expenses	0	(	o	0	8.0
9. 00	Other current assets	0	(	이	0	
0.00	Due from other funds	0	(	0	0	
1. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10) FIXED ASSETS	1, 527, 903		0	0	11. 0
2. 00	Land	Ι ο		ol ol	0	12. 0
3. 00	Land improvements	1, 134		-	0	
4. 00	Less: Accumulated depreciation	-38	d	o	0	
5.00	Bui I di ngs	0	(	o	0	15. 0
6.00	Less Accumulated depreciation	0	(	0	0	
7. 00	Leasehold improvements	446, 600		0	0	
8.00	Less: Accumulated Amortization	-35, 598			0	
9. 00	Fixed equipment Less: Accumulated depreciation	17, 048 -5, 022		-	0	
21. 00	Automobiles and trucks	-5, 022		-	0	
22. 00	Less: Accumulated depreciation				0	
23. 00	Major movable equipment	111, 466		ol ol	0	
24. 00	Less: Accumulated depreciation	-29, 071		o	0	1
25. 00	Mi nor equi pment - Depreci abl e	0	(	o	0	25. C
26. 00	Mi nor equi pment nondepreci abl e	0	(	-	0	1
27. 00	Other fixed assets	0		-	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)  OTHER ASSETS	506, 519	(	0	0	28. 0
29. 00	Investments	1 0		ol ol	0	29. 0
30.00	Deposits on Leases	0		-	0	
31. 00	Due from owners/officers	1, 923, 663	d	o	0	
32. 00	Other assets	30, 666	(	o	0	32.0
3. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	1, 954, 329		1 1	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	3, 988, 751		0	0	34.0
	Liabilities and Fund Balances CURRENT LIABILITIES					-
35. 00	Accounts payable	679, 040		ol ol	0	35.0
36. 00	Salaries, wages, and fees payable	0		-	0	
37. 00	Payrol I taxes payable	0		o	0	1
88. 00	Notes & Loans payable (Short term)	0	(	o	0	38. 0
39. 00	Deferred income	0	(	0	0	
10.00	Accel erated payments	0			_	40.0
1.00	Due to other funds	1, 136, 130			0	1
12. 00 13. 00	Other current liabilities TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 308, 578 4, 123, 748			0	
13.00	LONG TERM LIABILITIES	4, 123, 740		<u> </u>		43.0
4. 00	Mortgage payable	30, 859	(	o	0	44.0
5. 00	Notes payable	0	į (		0	
6. 00	Unsecured Loans	0	(	o	0	1
7. 00	Loans from owners:	0	(	이	0	
8.00	Other long term liabilities	0	(		0	
19.00	APIC DISTRIBUTIONS; R/E EARNINGS	1, 923, 610			0	1
50. 00 51. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	1, 954, 469 6, 078, 217		-	0	
71.00	CAPITAL ACCOUNTS	0,070,217		91 91		] 31. 0
2. 00	General fund balance	-2, 089, 466				52.0
3. 00	Specific purpose fund		(			53. C
4. 00	Donor created - endowment fund balance - restricted			0		54.0
5. 00	Donor created - endowment fund balance - unrestricted			0		55.0
6. 00	Governing body created - endowment fund balance			0	=	56.0
7.00	Plant fund balance - invested in plant				0	
8. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.0
9. 00	TOTAL FUND BALANCES (Sum of Lines 52 thru 58)	-2, 089, 466	(	ار ا	0	59. C
		3, 988, 751			0	
0.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	3, 700, /31	,			

In Lieu of Form CMS-2540-10 Health Financial Systems MILLVILLE CENTER

STATEMENT OF CHANGES IN FUND BALANCES

sheet (Line 11 - line 18)

Provider No.: 315243 Peri od: From 01/01/2021

Worksheet G-1

12/31/2021

Date/Time Prepared: 5/19/2022 1:22 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -2, 089, 466 2.00 Total (sum of line 1 and line 2) 3.00 -2, 089, 466 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0 0 0 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) -2, 089, 466 11.00 0 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 0000 14.00 0 14.00 0 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance -2, 089, 466 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 14.00 0 14.00 15.00 15.00 0 16.00 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00

Health Financial Systems	MILLVILLE CENTER		In Lieu of Form CMS-2540-1		
CTATEMENT OF DATIENT DEVENUES AND OPERATING EVENUES		' I N 045040	D	W I I I O O	

Health Financial Systems MILLVILLE CENTER		LE CENTER	In Lieu of Form CMS-2540-10			2540-10
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/19/2022 1:2	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
1 00	General Inpatient Routine Care Services		10 010 4/	ol	10 212 4/0	1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY		18, 212, 46	9	18, 212, 469 0	1. 00 2. 00
3.00	ICE/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	)	18, 212, 46	9	18, 212, 469	5. 00
0.00	All Other Care Services	/	10,212,10		10, 212, 107	0.00
6.00	ANCI LLARY SERVI CES		4, 430, 25	5 0	4, 430, 255	6. 00
7.00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	8. 00
9.00	AMBULANCE			0	0	9. 00
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
11. 10	CORF			0	0	11. 10
12. 00	HOSPI CE			0	0	12. 00
13.00	OTHER (SPECIFY)		00 / 10 70	0	0	13.00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer co Worksheet G-3, Line 1)	lumn 3 to	22, 642, 72	4 0	22, 642, 724	14. 00
	Cost Center Description					
	I			1. 00	2. 00	
4 00	PART II - OPERATING EXPENSES				4/ 45/ 0/0	4 00
1. 00 2. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				16, 456, 268	1.00
3. 00	Add (Specify)			0		2. 00 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	14. 00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus lin	e 14)			16, 456, 268	15. 00

Health Financial Systems		MILLVILLE CENTER	In	In Lieu of Form CMS-2540-10		
	STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 3152	243 Peri od:	Worksheet G-3		

Heal th	Health Financial Systems MILLVILLE CENTER In Lie		eu of Form CMS-2	2540-10	
	STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315243 Period:			Worksheet G-3	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/19/2022 1: 2	
				5/ 19/ 2022   1; 2;	2 piii
				1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1	4)		22, 642, 724	1. 00
2.00	Less: contractual allowances and discounts on patients accounts			8, 333, 214	2.00
3.00	Net patient revenues (Line 1 minus line 2)			14, 309, 510	3. 00
4. 00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		16, 456, 268	4. 00
5. 00	Net income from service to patients (Line 3 minus 4)			-2, 146, 758	5. 00
0.00	Other income:			2/110/700	0.00
6.00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8.00	Revenues from communications (Telephone and Internet 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
	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 supplies to other tha	n patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of skilled nursing space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MISC INCOME			57, 292	24. 00
24. 50	COVI D-19 PHE Funding			0	24. 50
25.00	Total other income (Sum of lines 6 - 24)			57, 292	25. 00
26.00	Total (Line 5 plus line 25)			-2, 089, 466	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 minus line 30)			-2, 089, 466	31. 00