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).

OMB NO. 0938-0463 Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315138	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared:
		12,01,2020	5/13/2024 9: 40 am

				07 10	,, 2021 ,.	
PART I - COST I	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	ort		Date: 5/13/2024	Ti me:	9: 40 a
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report ent	ter the number	of times the provider	resubmitted this cos	st report	t
	3.01 [] No Medicare Utilization. Enter "	'Y" for yes or	leave blank for no.			
Contractor	4. [1] Cost Report Status	6. Contractor I	No	<u></u>		
use only	(1) As Submitted	7.[N] First	Cost Report for this	Provider CCN		
	(2) Settled without audit	8.[N] Last 0	Cost Report for this P	Provider CCN		
	(3) Settled with audit	9. NPR Date:	·			
	(4) Reopened	10.[0]If lir	ne 4, column 1 is "4":	 Enter number of time	es reoper	ned
	(5) Amended	11.Contractor	Vendor Code	4		
	5. Date Received:	12.[F] Medica	are Utilization. Enter	 r "F" for full, "L" f	or low,	or "N"
		for no	o utilization.			

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 TROY HILLS CENTER (315138) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Dia	ne Morris	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Diane Morris			2
3	Signatory Title	VP OF REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1.00	2.00	3. 00	4. 00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	26, 844	2, 751	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	26, 844	2, 751	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 TROY HILLS CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315138 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/13/2024 9:40 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 200 REYNOLDS AVENUE PO Box: 1.00 2.00 City: PARSIPPANY State: NJ Zi p Code: 07054 2.00 3.00 County: MI DDLESEX CBSA Code: 35154 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF TROY HILLS CENTER 315138 06/12/1972 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) 12/31/2023 01/01/2023 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 230, 089 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 00 230 089 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) 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 34.00 SNF-Based FQHC Ν 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 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

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7. 00
2. 3. 4. 5. 6.

	Financial Systems	TROY HILLS CENT				eu of Form CMS-	
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	IY HEALIH CARE	Provi der	F	Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre	epared:
					Y/N	5/13/2024 9: 4 Date	10 am
			111/11 6	V HAIH (1.00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column i	, "Ү" ТО	r yes or "N" t	or No. For all	the date	
1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter-instructions)				N		1.00
	This tractions,			Y/N	Date	V/I	
2.00	Has the provider terminated participation in	the Medicare Program	n? 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 d to the provider or I, or members of the	its board	Y			3.00
	refutiviships. (see that detrons)			Y/N	Type	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" fo te copy or enter date	or e	Y	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 f	rom	N			5. 00
	T GOSHOT TT UTT OIL				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		for Nursing	N N		7. 00 8. 00
					1	Y/N 1.00	
0.00	Bad Debts	1 1 1 1 0 () (M)					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 o	change du	ring this cost		Y N	9. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance waiv	ved? If "	Y", see instru	uctions.	N N	11. 00
12. 00	Have total beds available changed from prior	cost reporting perio	d? If "Y			N	12. 00
		Description		Y/N	rt A Date	Part B Y/N	
	DCAD Data	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	03/09/2024	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 adjustments made to PS&R data for corrections of other PS&R Report			N		N	16. 00
					A Company of the Comp		1
17. 00	information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			N		N	17. 00

Heal th	Financial Systems TROY HIL	_S CEI	NTER		In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAR X REIMBURSEMENT QUESTIONNAIRE	Ξ	Provi der No.: 315138		d: 01/01/2023 12/31/2023		
						5/13/2024 9: 4	0 am
			1. 00		2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/position	JEAN	I	PRI C	E		19. 00
	held by the cost report preparer in columns 1, 2, and 3, respectively.						
20. 00	Enter the employer/company name of the cost report preparer.	GENE	SIS HEALTHCARE				20. 00
21. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	4108	8044481	JEAN	I. PRI CE@GENE	ESI SHCC. COM	21. 00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE

TROY HILLS CENTER

In Lieu of Form CMS-2540-10

Worksheet S-2

Part II

To 12/31/2023 Date/Time Prepared:

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/2023	Date/Time Prep 5/13/2024 9:40	
		Part B Date 4.00				
	PS&R Data					
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)					13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	03/09/2024				14. 00
15. 00	1 1					15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17. 00
18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18. 00
			3.00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		REIMBURSEMENT ANALYST			19. 00
20. 00	Enter the employer/company name of the cost r preparer.	report				20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective					21. 00

Health Financial Systems TROY HILLS SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE In Lieu of Form CMS-2540-10 TROY HILLS CENTER

COMPLEX STATISTICAL DATA

Provi der No.: 315138 Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/13/2024 9:40 am

						5/13/2024 9: 40	
				I np	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days	Title V	Title XVIII	Title XIX	
			Avai I abl e				
1 00	CVILLED MUDGLING FACILLETY	1.00	2.00	3. 00	4. 00	5. 00	4 00
1.00	SKILLED NURSING FACILITY	130	47, 450	0	,	30, 202	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	I CF/II D	0	0			0	3. 00
4.00	HOME HEALTH AGENCY COST		0	0	0	0	4. 00 5. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	U	U				6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	130	47, 450	0			8. 00
	(55 (55)	Inpatient [Di scharges	221 = 2 =	0.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	SKILLED NURSING FACILITY	4, 720	37, 600	0	73		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 Other Long Term Care	0	0				4. 00
5. 00 6. 00	SNF-Based CMHC	U	U				5. 00 6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	4, 720	37, 600	0	_	56	8. 00
		Di sch		Aver	age Length of		
						-	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	SKILLED NURSING FACILITY	11. 00	12. 00 257	13.00	14.00	15. 00	1 00
1. 00 2. 00	NURSING FACILITY	128	257	0. 00 0. 00		539. 32 0. 00	1. 00 2. 00
3.00	ICF/IID	0	0	0.00		0.00	3. 00
4. 00	HOME HEALTH AGENCY COST		J			0.00	4. 00
5. 00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC		J				6. 00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	128	257	0.00	36. 68	539. 32	8. 00
		Average Length		Admi s	si ons		
		of Stay	- 1 \	- 1 \0		0.11	
	Component	Total	Title V	Title XVIII	Title XIX	Other	
1. 00	SKILLED NURSING FACILITY	16. 00 146. 30	17. 00 0	18. 00 89	19. 00 13	20. 00	1. 00
2. 00	NURSING FACILITY	0. 00	0	07	0	0	2. 00
3. 00	ICF/IID	0.00	J		0	0	3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			J	Ĭ	4. 00
5. 00	Other Long Term Care	0. 00				o	5. 00
6.00	SNF-Based CMHC						6.00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0. 00	0				7. 00
8. 00	Total (Sum of lines 1-7)	146. 30	0		13	142	8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
			Payrol I	Workers			
		21. 00	22. 00	23. 00			
1.00	SKILLED NURSING FACILITY	244	76. 02	0.00			1.00
2.00	NURSING FACILITY	0	0.00	0.00			2.00
3.00	I CF/II D	0	0.00	0.00			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	0. 00 0. 00			5. 00 6. 00
6. 00 6. 10	SNF-Based CMHC 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)	244	76. 02				8. 00
00	1 (0.00	1	'	00

Health Financial Systems
SNF WAGE INDEX INFORMATION TROY HILLS CENTER

				To	0 12/31/2023	Date/Time Prep 5/13/2024 9:40	
		Amount	Reclass. of	Adjusted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		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, 114, 594	0	5, 114, 594		32. 35	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0. 00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
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, 114, 594	0	5, 114, 594	158, 114. 82	32. 35	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, 114, 594	0	5, 114, 594	158, 114. 82	32. 35	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	2, 832, 030	0	2, 832, 030	71, 856. 88	39. 41	14.00
15.00	Contract Labor: Physician services-Part A	39, 125	0	39, 125	460.00	85. 05	15.00
16.00	Home office salaries & wage related costs	349, 394	0	349, 394	7, 110. 00	49. 14	16.00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	910, 235	0	910, 235			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22. 00	Total Adjusted Wage Related cost (see	910, 235	0	910, 235			22.00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION TROY HILLS CENTER

					12/01/2020	5/13/2024 9: 4	
		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 III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1. 00
2.00	Administrative & General	457, 203	0	457, 203	15, 097. 98	30. 28	2. 00
3.00	Plant Operation, Maintenance & Repairs	112, 460	0	112, 460	3, 998. 88	28. 12	3. 00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	0	0.00	0.00	5. 00
6.00	Di etary	0	0	0	0.00	0.00	6. 00
7.00	Nursing Administration	286, 289	-37, 789	248, 500	4, 088. 14	60. 79	7. 00
8.00	Central Services and Supply	0	4, 945	4, 945	323. 13	15. 30	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	32, 844	32, 844	1, 726. 30	19. 03	10.00
11. 00	Soci al Servi ce	129, 937	0	129, 937	3, 608. 00	36. 01	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	125, 927	0	125, 927	6, 057. 41	20. 79	13.00
14. 00	Total (sum lines 1 thru 13)	1, 111, 816	0	1, 111, 816	34, 899. 84	31. 86	14. 00

Health Financial Systems	TROY HILLS CENTER	In Lie	u of Form CMS-2	2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315138	From 01/01/2023	Worksheet S-3 Part IV Date/Time Pre 5/13/2024 9:4	pared:
			Amount Reported 1.00	
PART IV - WAGE RELATED COSTS			1. 00	

		5/13/2024 9: 40	<u>0 am</u>
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	44, 740	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
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)	•	ĺ
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	•	ĺ
8.00	Health Insurance (Purchased or Self Funded)	254, 128	8.00
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		0	14.00
15.00	Workers' Compensation Insurance	157, 686	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	387, 266	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	53, 936	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	12, 479	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	910, 235	24. 00
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems
SNF REPORTING OF DIRECT CARE EXPENDITURES TROY HILLS CENTER

				T	0 12/31/2023	Date/Time Prep	pared:
						5/13/2024 9: 40	o am
	Occupational Category	Amount	Fri nge	Adj usted		Average Hourly	
		Reported	Benefits	Salaries (col.		Wage (col. 3 ÷	
				1 + col . 2)	Salary in col. 3	col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	Di rect Sal ari es	1.00	2.00	3.00	4.00	5.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 636, 519	218, 900	1, 855, 419	32, 272. 10	57. 49	1. 00
2.00	Licensed Practical Nurses (LPNs)	601, 612	121, 745			42. 58	2. 00
3.00	Certified Nursing Assistant/Nursing	1, 764, 647	412, 915			29. 44	3. 00
	Assi stants/Ai des	, , , , , ,		, , , , , ,	,		
4.00	Total Nursing (sum of lines 1 through 3)	4, 002, 778	753, 560	4, 756, 338	123, 214. 98	38. 60	4.00
5.00	Physical Therapists	0	0	0	0.00	0. 00	5.00
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		
10.00	Occupational Therapy Aides	0	0	0	0. 00		
11. 00	Speech Therapists	0	0	0	0. 00		
12. 00	Respi ratory Therapi sts	0	0		0. 00		
13. 00	Other Medical Staff	0	0	0	0. 00	0. 00	13.00
	Contract Labor						
	Nursing Occupations	0, 000				75.00	
14. 00	Registered Nurses (RNs)	86, 923		86, 923		75. 08	
15. 00	Licensed Practical Nurses (LPNs)	287, 332		287, 332		62. 13	
16. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	76, 320		76, 320	2, 058. 29	37. 08	16. 00
17. 00	Total Nursing (sum of lines 14 through 16)	450, 575		450, 575	7, 840. 29	57. 47	17. 00
18. 00	Physical Therapists	352, 016		352, 016	·		18. 00
19. 00	Physical Therapy Assistants	59, 870		59, 870	·		
20. 00	Physical Therapy Assistants	37, 670		37, 670	0.00	0.00	
21. 00	Occupational Therapists	206, 490		206, 490		51. 00	
22. 00	Occupational Therapy Assistants	339		339	8.00	42. 38	
23. 00	Occupational Therapy Aides	0		0.007	0.00	0.00	
24. 00	Speech Therapists	174, 753		174, 753			
25. 00	Respiratory Therapists	0		0	0.00	0.00	
	Other Medical Staff	39, 125		39, 125			26. 00
		·			•		

100			0 12/31/2023	Date/lime Prep 5/13/2024 9:40	
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B. DO	6. 00				6.00
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75. 00 PA2 75. 00	74. 00		PB1		74.00
	75. 00		PA2		75. 00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider No.: 315138 Period: Worksheet S-7	
From 01/01/2023 To 12/31/2023 Date/Time Prep	
Group Days	
1.00 2.00	
76. 00 PA1	76. 00
99. 00 AAA	99. 00
	100. 00
Expenses Percentage Y/N	
1.00 2.00 3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)	
	101.00
	102. 00 103. 00
	103.00
	104. 00
	105. 00

Heal th Fi	nancial Systems	TROY HILLS C	ENTER		In Lie	u of Form CMS-2	2540-10
RECLASSI	FICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	oared:
						5/13/2024 9: 4	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons Increase/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col . 4)	
					A-6)	33.1.1)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	NERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS - BLDGS & FLXTURES		1, 827, 013			1, 827, 013	1.00
	0200 CAP REL COSTS - MOVABLE EQUIPMENT 0300 EMPLOYEE BENEFITS	0	46, 935	46, 93 898, 38		46, 935 898, 382	2. 00 3. 00
	0400 ADMINISTRATIVE & GENERAL	457, 203	898, 382 2, 409, 322	2, 866, 52		2, 866, 525	4. 00
	0500 PLANT OPERATION, MAINT. & REPAIRS	112, 460	486, 534	598, 99		598, 994	5. 00
	0600 LAUNDRY & LINEN SERVICE	0	176, 427	176, 42		176, 427	6. 00
7.00 00	0700 HOUSEKEEPI NG	0	343, 358	343, 35	8 0	343, 358	7. 00
	0800 DI ETARY	0	1, 036, 655	1, 036, 65		1, 036, 655	8. 00
	0900 NURSING ADMINISTRATION	286, 289	191, 436			439, 936	9. 00
	1000 CENTRAL SERVICES & SUPPLY	0	53, 669	53, 66	9 4, 945	58, 614	10.00
	100 PHARMACY 200 MEDICAL RECORDS & LIBRARY		0		32, 844	0 32, 844	11. 00 12. 00
	1300 SOCIAL SERVICE	129, 937	28, 623	158, 56		158, 560	13. 00
	400 NURSING AND ALLIED HEALTH EDUCATION	0	0	.00,00	o o	0	14. 00
	500 ACTIVITIES	125, 927	27, 881	153, 80	8 0	153, 808	15. 00
	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 SKILLED NURSING FACILITY	4, 002, 778	675, 046	4, 677, 82	4 0	4, 677, 824	30. 00
	NOON NURSING FACILITY	0	0		0	0	31.00
	3200 ICF/IID 3300 OTHER LONG TERM CARE	0	0			0	32. 00 33. 00
	ICILLARY SERVICE COST CENTERS	<u> </u>		'	<u> </u>	0	33.00
	1000 RADI OLOGY	0	21, 470	21, 47	0 0	21, 470	40. 00
41. 00 04	1100 LABORATORY	0	23, 565	23, 56	5 0	23, 565	41.00
	1200 I NTRAVENOUS THERAPY	0	13, 561	13, 56	1 0	13, 561	42.00
1	300 OXYGEN (INHALATION) THERAPY	0	0	207.54	0	0	43.00
	1400 PHYSICAL THERAPY 1500 OCCUPATIONAL THERAPY	0	327, 565 246, 934	327, 56 246, 93		327, 565 246, 934	44. 00 45. 00
	1600 SPEECH PATHOLOGY		206, 916	206, 91		206, 916	46. 00
	F700 ELECTROCARDI OLOGY	o	0	200, 71	o o	0	47. 00
	1800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48. 00
	1900 DRUGS CHARGED TO PATIENTS	0	153, 401	153, 40	1 0	153, 401	49. 00
	5000 DENTAL CARE - TITLE XIX ONLY	0	0 (77	05 (7)	0	0 05 (77	50.00
	5100 SUPPORT SURFACES 5200 OTHER ANCILLARY SERVICE COST CENTERS	0	25, 677	25, 67	7 0	25, 677 0	51. 00 52. 00
	ITPATIENT SERVICE COST CENTERS	j U	0	<u> </u>	<u>J</u>	0	32.00
	5000 CLI NI C	0	0		0 0	0	60. 00
61.00 06	5100 RURAL HEALTH CLINIC	0	0		0 0	0	61. 00
	5200 FQHC						62.00
	5300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	63. 00
	THER REIMBURSABLE COST CENTERS TOOO HOME HEALTH AGENCY COST					0	70. 00
	7100 AMBULANCE		0			0	71.00
72.00 07		o	0		o o	0	72. 00
73. 00 07	7300 CMHC	0	0		0 0	0	73. 00
	7400 OTHER REIMBURSABLE COST	0	0		0 0	0	74. 00
	PECIAL PURPOSE COST CENTERS				ما		00.00
	8000 MALPRACTICE PREMIUMS & PAID LOSSES 8100 INTEREST EXPENSE		0			0	80. 00 81. 00
	3200 UTI LI ZATI ON REVI EW	0	0			0	82.00
	3300 HOSPI CE		0			Ö	83. 00
	3400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	5, 114, 594	9, 220, 370	14, 334, 96	4 0	14, 334, 964	89. 00
	NREI MBURSABLE COST CENTERS	T					
	2000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0.44	0	0	90.00
	2100 BARBER AND BEAUTY SHOP 2200 PHYSICIANS PRIVATE OFFICES		8, 466	8, 46		8, 466 0	91. 00 92. 00
	P300 NONPALD WORKERS		0			0	93. 00
	9400 PATIENTS LAUNDRY	l o	0		ol ől	0	94. 00
95. 00 09	0500 OTHER NONREIMBURSABLE COST CENTERS	0	0		o	0	95. 00
100.00	TOTAL	5, 114, 594	9, 228, 836	14, 343, 43	o	14, 343, 430	100. 00

TROY HILLS CENTER In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 TROY

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Cost Conter Description					To 12/31/2023	Date/Time Prepared: 5/13/2024 9:40 am
		Cost Center Description	Adjustments to	Net Expenses		37 137 2024 9. 40 dill
		·				
CENERAL SERVICE COST CENTERS			Wkst A-8)			
EMBRIAL SERVICE COST CENTERS 1.00			6.00			
2.00		GENERAL SERVICE COST CENTERS	0.00	7.00		
0.000 0.000 DIFFLOWER BUNEFITS	1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	1, 827, 013		1.00
4.00 0.0400 AMININ STRATI VE & CEREBRAL -1, 126, 095 598, 994 5.00 0.0500 DAINT OPERATION, MAINT J. & REPAIRS 0.00 176, 427 6.00 0.0			-		•	
5.00 00500 PLANT OPERATION, MAINT: & REPAIRS 0 598, 994 5.00 00 00000 UNINEY ETPING 0 343, 358 7.00 00 00000 DIFFARY 0 439, 358 9.00 00 00000 DIFFARY 0 439, 358 0 00 00000 DIFFARY 0 439, 358 0 00 00000 DIFFARY 0 0 439, 439 00 00000 DIFFARY 0 0 0 01 000000 DIFFARY 0 0 0 01 00000 DIFFARY 0 0 0		1			1	
0.000 0.0000 LAUNDRY & LINEN SERVICE			-1, 126, 095		•	
7. 00 0700 MUSENER SERVICE OST CENTERS 7. 00 343, 358 7. 00 9.00 0.970 MUSEN IN ADMINISTRATION 0 439, 936 9. 00 0.970			0		1	
8.00 9.00 00900 URSN NA ORMINISTRATION 0 1.036, 655 9.00 10.00 10.00 ORSN URSN NA ORMINISTRATION 0 0.439, 936 9.00 11.		1			•	
9.00 0000 NURSI NG ADMINISTRATION 0 439, 936 0 0.00 11.00 01000 CENTRAL SERVICE CES & SUPPLY 0 58, 614 10.00 11.00 11000 CENTRAL SERVICE CES & SUPPLY 0 32, 844 12.20 13.00 01300 SOCIAL SERVICE 0 158, 560 13.00 15.00 01300 SOCIAL SERVICE 0 158, 560 14.00 15.00 01500 ACTIVITIES 1.00 14.00 15.00 01500 ACTIVITIES 1.00 14.00 15.00 10500 ACTIVITIES 1.00 14.00 15.00 IRPATITIES REQUIRE SERVICE COST CENTERS 15.00 18.00 IRPATITIES REQUIRE SERVICE COST CENTERS 15.00 13.00 18		1			1	
11.00 01100 PHARMACY 0 0 0 0 11.00 12.00 13.00 1300 MBD ICAL RECORDS & LIBRARY 0 32.844 12.00 13.00 1300 MBD ICAL RECORDS & LIBRARY 0 32.844 12.00 13.00 13.00 14.00 15.00		1	0		•	
12.00 01200 MEDICAL RECORDS & LIBRARY 0 132, 844 113, 00 130 01300 SOCIAL SERVICE 0 158, 560 133, 00 140 01400 MURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 141, 00 150 01500	10.00		0	58, 614		10.00
13.00 01500 SOCIAL SERVICE 0 15.0, 560 13.0 015.00 14.00 015.00 NURSING AND ALLED HEALTH EDUCATION 0 0 0 015.00 NURSING AND ALLED HEALTH EDUCATION 0 0 015.00 NURSING FACILITY 0 0 0 0 0 0 0 0 0		1	0		1	
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 0		1	0		•	
15. 00 1500 ACTIVITIES					•	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.00 331.00 31.00 331.00 331.00 331.00 331.00 331.00 331.00 332.00 332.00 333.00 INFER LONG TERN CARE 0 0 0 32.00 330.00 333.00 INFER LONG TERN CARE 0 0 0 0 32.00 330.00 330.00 INFER LONG TERN CARE 0 0 0 0 32.00 330.00 INFER LONG TERN CARE 0 0 0 0 0 0 0 0 0 0			_21 130		•	
30.00	13.00		-21, 130	132,070	<u> </u>	13.00
32.00 03200 CIFFI LOWS TERM CARE	30.00		442	4, 678, 266		30.00
33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0	31.00	03100 NURSING FACILITY	0	0		31.00
ANCIL LARY SERVICE COST CENTERS 40.00			0	l .	•	
40, 00 04000 PADI DLOCY	33. 00		0	0		33. 00
1.1 00 0.4100 LABORATORY 0 23, 565 41. 00	40.00			21 470	ı	40.00
42 00 04200 INTRAVENOUS THERAPY 0				,	1	
43. 00 04300 04500 04500 1NEALATION) THERAPY 0 0 226, 936 44. 00 440. 00 440.00 PHYSI CAL THERAPY 0 226, 934 45. 00 45. 00 04600 SPECH PATHOLOGY 0 206, 916 46. 00 04600 SPECH PATHOLOGY 0 0 0 0 04600 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0					1	
44. 00 44.00 04400 PHYSI CAL THERAPY 0 327, 565 44. 00 45. 00 04600 OCCUPATIONAL THERAPY 0 246, 934 45. 00 46. 00 04600 SPEECH PATHOLOGY 0 206, 916 46. 00 47. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 49. 00 04900 DRUDICA CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 52. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 61. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 61. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 61. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 61. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 61. 00 05000 CLINIC 0 0 0 0 61. 00 05000 CLINIC 0 0 0 0 61. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 61. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 61. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 61. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 61. 00 05000 05000 05000 05000 05000 05000 61. 00 05000 05000 05000 05000 05000 05000 05000 62. 00 050					1	
46. 00 04500 04500 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 47. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 48. 00 0490	44.00		0	327, 565		44. 00
47. 00 04700 04700 04700 04800			0	246, 934		45. 00
48. 00 04900 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 04900 DRUGS CHARGED TO PATIENTS 0 153, 401 50. 00 5			0		1	
49.00 04900 DRUGS CHARGED TO PATIENTS			0	1	1	
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			0	_	1	
51.00 05100 SUPPORT SURFACES 0 25,677 52.00 05200 OTHER ARCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0					1	
52. 00				_	1	
60. 00 06000 CLINIC 0 0 0 0 0 0 0 0 0			0		•	
61. 00 06100 RURAL HEALTH CLINIC 0 0 0 06200 FOHC 62. 00 63. 00 0500 FOHC 0 0 06200 FOHC 0 0 0 0 0 0 0 0 0						
62. 00 06200 FOHC 0 0 0 0 0 0 0 0 0		1		ļ	•	
63. 00 06300 OTHER OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0			0	0		
OTHER REI MBURSABLE COST CENTERS			0	0		
70. 00	03.00				<u> </u>	03.00
72. 00	70.00		0	0		70.00
73. 00	71. 00		0	0		71. 00
74. 00 07400 OTHER REIMBURSABLE COST O O O SPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES O O O 81. 00 08100 INTEREST EXPENSE O O O 82. 00 08200 UTI LI ZATI ON REVI EW O O 83. 00 08300 HOSPI CE O O 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS O O 89. 00 SUBTOTALS (sum of lines 1-84) -1, 185, 424 13, 149, 540 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN O O 91. 00 09100 BARBER AND BEAUTY SHOP O 8, 466 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES O O 93. 00 09300 NONPAI D WORKERS O O 94. 00 09400 PATI ENTS LAUNDRY O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 96. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 97. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 97. 00 09500 OTHER NONREI MBURSABLE COST CENTERS O O 98. 00 O O 99. 00 O O 99			0	0		
SPECIAL PURPOSE COST CENTERS SO. 00 O O O O O			0			
80. 00	74.00			0		74.00
81. 00	80 OO			0		80.00
82. 00 08200 UTILIZATION REVIEW 0 0 0 0 82.00 83. 00 08300 HOSPICE 0 0 0 0 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 85. 00 SUBTOTALS (sum of lines 1-84) -1, 185, 424 13, 149, 540 NONREI MBURSABLE COST CENTERS 0 0 0 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 91. 00 09100 BARBER AND BEAUTY SHOP 0 8, 466 92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 93. 00 09300 NONPAID WORKERS 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 96. 00 09500 00500 00500 00500 97. 00 09500 00500 00500 00500 98. 00 00500 00500 00500 98. 00 00500 00500 00500 98. 00 00500 00500 00500 98. 00 00500 00500 00500 98. 00 00500 00500 00500 98. 00 00500 00500 98. 00 00500 00500 98. 00 00500 00500 98. 00 00500 00500 98. 00 00500 00500 98. 00 00500 99. 00 0					•	
84. 00			0			
89. 00 SUBTOTALS (sum of lines 1-84) -1, 185, 424 13, 149, 540 89. 00	83.00		0	0		83.00
NONREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0		1 1	0	0		
90. 00	89. 00		_1, 185, 424	13, 149, 540		89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 0 8, 466 91. 00 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 94. 00 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0	00 00				ı	00.00
92. 00 09200 PHYSI CLANS PRI VATE OFFICES 0 0 0 93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 94. 00 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 95. 00 09500				_	1	
93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 94. 00 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				_	1	
94. 00 09400 PATI ENTS LAUNDRY 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 95. 00 09500		1		Ö		
			0	0		
100. 00 101AL -1, 185, 424 13, 158, 006 100. 00		1	0	0		
	100.00		-1, 185, 424	13, 158, 006	1	100. 00

Health Financial Systems	TROY HILLS CEN	ITER		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Provi der No.: 31			Peri od: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Pre 5/13/2024 9:4	pared: 0 am
			Increases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
(1) A - DEFAULT						
1. 00	CENTRAL SERVICES &	SUPPLY	10. 0	0 4, 945	0	1. 00
2. 00	MEDICAL RECORDS & L	_I BRARY	12. 0	0 32, 844	0	2.00
TOTALS						
100. 00	Total Reclassificat	tions (Sum		37, 789	0	100. 00
	of columns 4 and 5	must				
	equal sum of column	ns 8 and				
	9)					

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

Health Financial Systems	TROY HILLS CEN	TER		In Lie	u of Form CMS-:	2540-10
RECLASSI FI CATI ONS				Peri od:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/13/2024 9:4	pared: O am
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
(1) A - DEFAULT						
1. 00	NURSING ADMINISTRAT	I ON	9. 0	4, 945	0	1. 00
2. 00	NURSING ADMINISTRAT	I ON	9. 0	32, 844	0	2. 00
TOTALS						
100. 00				37, 789	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS In Lieu of Form CMS-2540-10
Worksheet A-7 TROY HILLS CENTER Provi der No.: 315138 Peri od:

ILLOOM	TETATION OF SALTIME ODOTO CENTERO		11001401	110 010100	From 01/01/2023	nor Rancet 71 7	
					To 12/31/2023		pared:
						5/13/2024 9: 4	0 am
				Acqui si ti on	S		
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0		0 0	0	1. 00
2.00	Land Improvements	134, 397	0		0 0	0	2. 00
3.00	Buildings and Fixtures	3, 972, 631	0		0 0	0	3. 00
4.00	Building Improvements	1, 527, 506	0		0 0	0	4. 00
5.00	Fixed Equipment	180, 333	0		0 0	0	5. 00
6.00	Movable Equipment	748, 063	0		0 0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	6, 562, 930	0		0 0	0	7. 00
8.00	Reconciling Items	0	0		0 0	0	8. 00
9.00	Total (line 7 minus line 8)	6, 562, 930	0		0 0	0	9. 00
	Description Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0				1. 00
2.00	Land Improvements	134, 397	0				2. 00
3.00	Buildings and Fixtures	3, 972, 631	0				3. 00
4.00	Building Improvements	1, 527, 506	0				4. 00
5.00	Fixed Equipment	180, 333	0				5. 00
6.00	Movable Equipment	748, 063	0				6. 00
7.00	Subtotal (sum of lines 1-6)	6, 562, 930	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	6, 562, 930	0				9. 00

Provi der No.: 315138

Peri od:

Worksheet A-8

From 01/01/2023 | Worksheet A-8 | To 12/31/2023 | Date/Time Prepared:

				10 12/31/2023	5/13/2024 9:4	
				Expense Classification on		l alli
				To/From Which the Amount is		
				TO/TTOIL WITCH THE AMOUNT TS	to be Aujusteu	
	Doscarintian (1)	(2) Basis For	Amount	Cost Center	Line No.	
	Description (1)	Adjustment	Alliourt	Cost center	Little 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)		C		0.00	1.00
2.00	Trade, quantity, and time discounts (chapter		(0.00	2. 00
2.00			C		0.00	2.00
3.00	8) Refunds and rebates of expenses (chapter 8)		_		0.00	3. 00
4. 00					0.00	
4.00	Rental of provider space by suppliers		C		0.00	4.00
F 00	(chapter 8)				0.00	F 00
5.00	Tel ephone services (pay stations excluded)		C	,	0.00	5. 00
	(chapter 21)		04 400	107114 7150	45.00	
6.00	Television and radio service (chapter 21)	A	-21, 130	ACTI VI TI ES	15.00	
7.00	Parking Lot (chapter 21)		C		0.00	
8.00	Remuneration applicable to provider-based	A-8-2	C)		8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		C)	0.00	
10.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	
11. 00	Nonallowable costs related to certain		C		0.00	11. 00
	Capital expenditures (chapter 24)					
12. 00	Adjustment resulting from transactions with	A-8-1	147, 002	2		12. 00
	related organizations (chapter 10)					
13.00	Laundry and linen service		C	1		13. 00
14.00	Revenue - Employee meals		C	1		14. 00
15. 00	Cost of meals - Guests		C		0.00	
16.00	Sale of medical supplies to other than		C		0.00	16. 00
	patients					
17. 00			C			17. 00
18. 00	Sale of medical records and abstracts		C		0.00	18. 00
19.00	Vending machines		C		0.00	19. 00
20.00	Income from imposition of interest, finance		C		0.00	20. 00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		C		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		C	UTILIZATION REVIEW	82.00	22. 00
	(chapter 21)					
23.00	Depreciationbuildings and fixtures		C	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24.00	Depreciationmovable equipment		C	CAP REL COSTS - MOVABLE	2.00	24. 00
				EQUI PMENT		
25.00	MISC INCOME	В	-4, 180	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	UNALLOWED A & G	A	-1, 268, 917	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	WORKERS COMPENSATION	A	-38, 641	EMPLOYEE BENEFITS	3.00	25. 02
25. 03	HEP/SALI NE	A	442	SKILLED NURSING FACILITY	30.00	25. 03
100.00	Total (sum of lines 1 through 99) (Transfer		-1, 185, 424	l .		100.00
	to Worksheet A, col. 6, line 100)		, .=			
		·		•	•	

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

TROY HILLS CENTER

Health Financial Systems TROY HILLS
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
OFFICE COSTS NTER In Lieu of Form CMS-2540-10
Provider No.: 315138 Period: Worksheet A-8-1
From 01/01/2023 Parts I-II

OFFIC	E COSTS				rom 01/01/2023 o 12/31/2023	Parts I-II Date/Time Pr 5/13/2024 9:	
		Li ne No.	Cost (Center	Expense		40 alli
		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		& GENERAL PY HERAPY GY G FACILITY	HOME OFFICE A&G HOME OFFICE CAF PT OT ST NURSING PURCHAS 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
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR	Amount Allowable In Cost 4.00	Amount Included in Wkst. A, col. 5 5.00	Adjustments (col. 4 minus col. 5) 6.00	D OPGANLZATIONS	S OR	
	CLAIMED HOME OFFICE COSTS:	LED NO 11 NEGGET	01 1101110110110	NO WITH REDATE	D ONOMINI ZATITORO	,	
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	638, 600 33, 182 326, 546 246, 019 206, 916 450, 575 39, 125 0 0 1, 940, 963	0 326, 546 246, 019 206, 916 450, 575 39, 125 0	33, 182 0 0 0 0 0 0 0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00 PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

1.00	В	0.00	1.00
2.00	В	0.00	2. 00
3. 00	В	0.00	3. 00
4. 00	В	0.00	4. 00
5. 00	В	0.00	5. 00
6. 00		0.00	6. 00
7. 00		0.00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100. 00
speci fy:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- 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	ization(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	CSU	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 (financial or non-financial)		0.00	100. 00
speci fy:			

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

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

			To	12/31/2023	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/13/2024 9: 4	J alli
	l					
Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	Allocation	TIATURES	LQUIFWLINI	DENETTIS		
	(from Wkst A					
	col . 7)					
GENERAL SERVI CE COST CENTERS	0	1. 00	2.00	3. 00	3A	
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES	1, 827, 013	1, 827, 013				1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT	46, 935	1,027,010	46, 935			2. 00
3.00 00300 EMPLOYEE BENEFITS	859, 741	28, 419	730	888, 890		3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	1, 740, 430	363, 088	9, 328	79, 460	2, 192, 306	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	598, 994	72, 795	1, 870	19, 545	693, 204	5. 00
6.00 00600 LAUNDRY & LI NEN SERVI CE 7.00 00700 HOUSEKEEPI NG	176, 427 343, 358	30, 438 15, 958	782 410	0	207, 647 359, 726	6. 00 7. 00
8. 00 00800 DI ETARY	1, 036, 655	211, 539	5, 434	ő	1, 253, 628	8. 00
9.00 00900 NURSING ADMINISTRATION	439, 936	19, 947	512	43, 188	503, 583	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	58, 614	9, 407	242	859	69, 122	10. 00
11. 00 01100 PHARMACY	0	0	0	0	0	11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 13. 00 01300 SOCI AL SERVI CE	32, 844 158, 560	7, 782 6, 403	200 164	5, 708 22, 582	46, 534 187, 709	12. 00 13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	138, 300	0, 403	0	22, 362	187, 709	14. 00
15. 00 01500 ACTIVITIES	132, 678	Ö	Ö	21, 885	154, 563	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 SKILLED NURSING FACILITY	4, 678, 266	988, 688	25, 399	695, 663	6, 388, 016	30.00
31. 00 03100 NURSING FACILITY 32. 00 03200 CF/IID	0	0	0	0	0	31. 00 32. 00
33. 00 03300 OTHER LONG TERM CARE		0	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS		- 1	- 1	-,		
40. 00 04000 RADI OLOGY	21, 470	0	0	0	21, 470	40. 00
41. 00 04100 LABORATORY	23, 565	0	0	0	23, 565	41.00
42.00 04200 INTRAVENOUS THERAPY 43.00 04300 OXYGEN (INHALATION) THERAPY	13, 561	0	0	0	13, 561 0	42. 00 43. 00
44. 00 04400 PHYSI CAL THERAPY	327, 565	24, 232	623	0	352, 420	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	246, 934	33, 442	859	0	281, 235	45. 00
46.00 04600 SPEECH PATHOLOGY	206, 916	0	0	0	206, 916	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS	153, 401	13, 791 1, 084	354 28	0	14, 145 154, 513	48. 00 49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	155, 401	1, 064	20	0	154, 513	50.00
51. 00 05100 SUPPORT SURFACES	25, 677	Ö	Ö	Ö	25, 677	51. 00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
OUTPATIENT SERVICE COST CENTERS		٥	0	ام		
60. 00 06000 CLI NI C 61. 00 06100 RURAL HEALTH CLI NI C	0	0	0	0	0	60. 00 61. 00
62. 00 06200 FQHC		J	Ö		O	62. 00
63.00 O6300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
OTHER REIMBURSABLE COST CENTERS			_T	-1		
70.00 07000 HOME HEALTH AGENCY COST 71.00 07100 AMBULANCE	0	0	0	0	0	70.00
71. 00 07100 AMBULANCE 72. 00 07200 CORF	0	0	0	0	0	71. 00 72. 00
73. 00 07300 CMHC	o	Ö	Ö	o	0	73. 00
74. 00 07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
SPECIAL PURPOSE COST CENTERS						00.00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00 08200 UTI LI ZATI ON REVI EW						82. 00
83. 00 08300 HOSPI CE	0	0	0	0	0	83. 00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84. 00
89. 00 SUBTOTALS (sum of lines 1-84)	13, 149, 540	1, 827, 013	46, 935	888, 890	13, 149, 540	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	٥	0	O	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	8, 466	o	Ö	ő	8, 466	91. 00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	O	Ō	O	0	92. 00
93. 00 09300 NONPAI D WORKERS	0	0	0	0	0	93. 00
94. 00 09400 PATIENTS LAUNDRY	0	O	0	0	0	94. 00
95.00 O9500 OTHER NONREIMBURSABLE COST CENTERS 98.00 Cross Foot Adjustments		0	0	0	0	95. 00 98. 00
99.00 Negative Cost Centers		0	0	0	0	98. 00 99. 00
100. 00 TOTAL	13, 158, 006	1, 827, 013	46, 935	888, 890	13, 158, 006	
	•	•	•	•		

					0 12/31/2023	Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	5/13/2024 9: 4 DI ETARY	J am
		& GENERAL	OPERATION,	LINEN SERVICE			
			MAINT. & REPAIRS				
		4.00	5. 00	6. 00	7. 00	8. 00	
1 00	GENERAL SERVICE COST CENTERS	1		1			4 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 192, 306					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	138, 588	831, 792				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	41, 514	18, 579				6. 00
7. 00 8. 00	00800 DI ETARY	71, 918 250, 630	9, 741 129, 122	1	441, 385 70, 933	1, 704, 313	7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	100, 678	12, 176	1	6, 689	1, 704, 313	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	13, 819	5, 742	2 0	3, 154	0	10. 00
11. 00	01100 PHARMACY	0	0	1	0	0	11. 00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	9, 303 37, 528	4, 750 3, 908		2, 609 2, 147	0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	37, 326	3, 9 00		2, 147	0	14. 00
15. 00	01500 ACTIVITIES	30, 901	0	Ö	O	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			,			
30.00	03000 SKILLED NURSING FACILITY	1, 277, 118	603, 491	267, 740	331, 527	1, 704, 313	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0		0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	o o		0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	4, 292	0	0	0	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	4, 711 2, 711	0	0	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	2, /11	0		0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	70, 457	14, 791	Ö	8, 125	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	56, 226	20, 413	0	11, 214	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	41, 367	0	0	0	0	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 2, 828	8, 418		4, 624	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	30, 891	661		363	Ö	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	5, 133	0	0	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0) 0	0	0	52. 00
60. 00	06000 CLINIC	l ol	0	0	O	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	Ö	0	Ö		0	61. 00
62. 00	06200 FQHC						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 ol	0) 0	0	0	70. 00
71. 00	07100 AMBULANCE	Ö	0	Ö	0	0	71. 00
72. 00	07200 CORF	0	0	0	0	0	72. 00
	07300 CMHC	0	0	0	0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0) 0	0	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW						82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	2, 190, 613	831, 792	267, 740	441, 385	1, 704, 313	89. 00
	NONREI MBURSABLE COST CENTERS		331,112		,	., ,	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	-	0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP	1, 693	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0	0	0	0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY		Ö	ol o	O	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
98.00	Cross Foot Adjustments	0	0	0	0	0	98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	2, 192, 306	831, 792	267, 740	441, 385		99. 00 100. 00
. 55. 50	1.0	2, 1, 2, 300	001,772	207,740	111, 505	., , , , , , , , ,	

Provi der No.: 315138 | Peri od: | Worksheet B | From 01/01/2023 | Part I | Date/Time Prepared: | From 21/31/2023 | Date/Time Prepared: | From 21/31/2023 | Part I | Date/Time Prepared: | From 21/31/2023 | Part I | Part

				1	0 12/31/2023	5/13/2024 9: 4	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
		9.00	SUPPLY	11 00	LI BRARY	12.00	
	GENERAL SERVICE COST CENTERS	9.00	10. 00	11.00	12. 00	13. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	623, 126					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	91, 837	1			10. 00
11.00	01100 PHARMACY	0	0	0	(2.10)		11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0	0	0	63, 196	231, 292	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	ĺ	0	231, 2,2	14. 00
15. 00	01500 ACTIVITIES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				T		
30.00	+ I	623, 126	91, 837			231, 292	30.00
31.00	03100 NURSING FACILITY	0	0			0	31.00
32. 00 33. 00	1 1	0	0		_	0	32. 00 33. 00
33. 00	ANCI LLARY SERVI CE COST CENTERS	J					33.00
40.00	04000 RADI OLOGY	0	0	0	59	0	40. 00
41. 00	04100 LABORATORY	0	0	0	171	0	41. 00
42. 00	1	0	0	0	45	0	42. 00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	0	0	2 220	0	43. 00 44. 00
45.00	1 1	0	0		3, 330 2, 601		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	Ö	2, 006	Ö	46. 00
47.00	1	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	637	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0 0	50. 00 51. 00
52. 00	1 1	0	0		0		52.00
02.00	OUTPATIENT SERVICE COST CENTERS	J					02.00
60.00	06000 CLI NI C	0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	1 1		0		0		62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	U	0	0	0	0	63. 00
70. 00		0	0	0	0	0	70. 00
71.00	+ I	0	0		0	0	71. 00
72. 00	07200 CORF	0	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	0	0	0	0	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						81. 00
82.00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	1 1	0	0			0	
84. 00	1 1	(22.12)	01 027			0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	623, 126	91, 837		63, 196	231, 292	89. 00
90. 00		0	0	0	0	0	90. 00
91.00		0	0			0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93.00	1 1	0	0	0	0	0	93. 00
94. 00 95. 00		0	0		0	0	94. 00 95. 00
98.00		0	0	١			98.00
99. 00	1 1	Ö	0	0	0	0	
100.00	D TOTAL	623, 126	91, 837	o	63, 196	231, 292	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					o 12/31/2023		
			OTHER GENERAL			5/13/2024 9: 4	0 am
			SERVI CE				
	Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATION 14.00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	10.00	17.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	OO3OO EMPLOYEE BENEFITS OO4OO 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	00700 HOUSEKEEPI NG						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 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY						11. 00 12. 00
	01300 SOCIAL SERVICE						13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTI VI TI ES	0	185, 464				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0			0	11, 758, 271	30.00
31. 00	03100 NURSING FACILITY	0	0		0	0	
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0			0	0	
33.00	ANCILLARY SERVICE COST CENTERS	0		η	ıl O	0	33.00
40. 00	04000 RADI OLOGY	0	0	25, 821	0	25, 821	40.00
41.00	04100 LABORATORY	0	C		0	28, 447	1
42.00	04200 I NTRAVENOUS THERAPY	0	0	16, 317	0	16, 317	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	
44. 00	04400 PHYSI CAL THERAPY	0	0	1, .=-		449, 123	1
45. 00 46. 00	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	0		371, 689 250, 289		371, 689 250, 289	
	04700 ELECTROCARDI OLOGY	0		1		250, 269	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		Ί "	_	30, 015	1
	04900 DRUGS CHARGED TO PATIENTS	0	O	187, 065		187, 065	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	O	1	_	0	
51. 00	05100 SUPPORT SURFACES	0	-			30, 810	1
52. 00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0) <u> </u>	0	0	52.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	1 0) C	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0				0	
62. 00	06200 FQHC					_	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C) c	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	-			0	
71. 00 72. 00	07100 AMBULANCE 07200 CORF	0	0	1	_	0	
	07300 CMHC		1	1		0	1
	07400 OTHER REIMBURSABLE COST	0			_	0	1
	SPECIAL PURPOSE COST CENTERS						1
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 NTEREST EXPENSE						81.00
	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	
89. 00	SUBTOTALS (sum of lines 1-84)		-	13, 147, 847	0	13, 147, 847	1
07.00	NONREI MBURSABLE COST CENTERS		1007 10 1	10/11//01/	<u> </u>	10/11//01/	7
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	O	_	0	0	90. 00
	09100 BARBER AND BEAUTY SHOP	0	0	10, 159	0	10, 159	1
	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	0	
93.00	09300 NONPALD WORKERS				0	0	
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS					0	
98. 00	Cross Foot Adjustments	0	0		0	0	1
99. 00	Negative Cost Centers	0) c	o o	0	1
100.00		0	185, 464	13, 158, 006	0	13, 158, 006	100.00

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Part II | Part II | Prepared: | Part II | Prepared: | Part II | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315138

					To	12/31/2023	Date/Time Prep 5/13/2024 9: 40	
				CAPI TAL REI	ATED COSTS		37 137 2024 7. 40	J am
		Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
			Assigned New Capital	FIXTURES	EQUI PMENT		BENEFITS	
			Related Costs					
			0	1.00	2.00	2A	3. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT		20 410	720	20 140	20, 140	2.00
3. 00 4. 00		EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL		28, 419 363, 088		29, 149 372, 416	29, 149 2, 606	3. 00 4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS		72, 795		74, 665	641	5. 00
6. 00		LAUNDRY & LINEN SERVICE	0	30, 438		31, 220	0	6. 00
7.00		HOUSEKEEPI NG	0	15, 958	410	16, 368	0	7. 00
8.00		DI ETARY	O	211, 539	5, 434	216, 973	0	8. 00
9.00		NURSING ADMINISTRATION	0	19, 947		20, 459	1, 416	9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	9, 407		9, 649	28	10.00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	0 7, 782		0 7, 982	0 187	11. 00 12. 00
13. 00		SOCIAL SERVICE	0	6, 403		6, 567	741	13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0	0, 100	1	0, 007	0	14. 00
15. 00	1	ACTI VI TI ES	O	0		ō	718	15. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30. 00		SKILLED NURSING FACILITY	0	988, 688		1, 014, 087	22, 812	30. 00
31. 00	1	NURSING FACILITY	0	0		0	0	31. 00
32.00		ICF/IID	0	0		0	0	32.00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	0	0	0	0	33. 00
40. 00		RADI OLOGY	0	0	0	O	0	40. 00
41. 00		LABORATORY	0	0		o	0	41. 00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	o	0	42.00
43.00		OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00		PHYSI CAL THERAPY	0	24, 232		24, 855	0	44. 00
45. 00	1	OCCUPATIONAL THERAPY	0	33, 442		34, 301	0	45. 00
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0		0	0	46. 00 47. 00
48.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13, 791		14, 145	0	48.00
49. 00		DRUGS CHARGED TO PATIENTS	0	1, 084	28	1, 112	0	49. 00
50. 00		DENTAL CARE - TITLE XIX ONLY	O	0		0	0	50. 00
51.00	05100	SUPPORT SURFACES	0	0	0	o	0	51.00
52.00		OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
		TIENT SERVICE COST CENTERS				ما		
60. 00 61. 00	1	CLINIC RURAL HEALTH CLINIC	0	0		0	0	60. 00 61. 00
62.00	06200			U	l 0	٩	U	62.00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	o	0	63. 00
00.00		REI MBURSABLE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		00.00
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
		AMBULANCE	0	0	0	0	0	
72.00			0	0	0	0	0	, 2. 00
	07300	CMHC OTHER REIMBURSABLE COST	0	0		0	0	
74. 00		AL PURPOSE COST CENTERS	J Q	0	0	U	0	74. 00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	1	INTEREST EXPENSE						81. 00
82.00		UTILIZATION REVIEW						82. 00
83. 00	08300	HOSPI CE	0	0	0	o	0	83. 00
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	0	1, 827, 013	46, 935	1, 873, 948	29, 149	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0		ol	0	90. 00
91.00		BARBER AND BEAUTY SHOP	0	0		0	0	91.00
92. 00		PHYSICIANS PRIVATE OFFICES		0		ol	0	92. 00
93. 00		NONPAI D WORKERS		0	o	o	0	93. 00
94. 00		PATIENTS LAUNDRY	0	0	0	o	0	94. 00
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 1, 827, 013	0 46, 935	1 972 040	0 29, 149	
100.00	וי	IUIAL	ı V	1, 827, 013	40, 935	1, 873, 948	29, 149	100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					0 12/31/2023		
	Cost Center Description	ADMINISTRATIVE & GENERAL	PLANT OPERATION,	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	5/13/2024 9: 4 DI ETARY	o am
		& GLINERAL	MAINT. &	LINEN SERVICE			
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
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	375, 022					3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	23, 708	99, 014				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	7, 102	2, 212	1			6. 00
7.00	00700 HOUSEKEEPI NG	12, 303	1, 159	0	29, 830		7. 00
8.00	00800 DI ETARY	42, 874	15, 370	l .	.,	280, 011	8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	17, 223 2, 364	1, 449 684	l .	452 213	0	9. 00 10. 00
11. 00	01100 PHARMACY	2, 304	004	l .	213	0	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	1, 591	565	Ō	176	0	12. 00
13.00	01300 SOCIAL SERVICE	6, 420	465	0	145	0	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	5, 286	0	0	0	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	218, 463	71, 838	40, 534	22, 405	280, 011	30. 00
31.00	03100 NURSING FACILITY	o	0	. 0	0	0	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	734	0	0	0	0	40. 00
41. 00	04100 LABORATORY	806	0	Ö	-	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	464	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	12, 053	1, 761		549	0	44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	9, 618 7, 077	2, 430 0		758 0	0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	7,077	0	Ö	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	484	1, 002	0	313	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	5, 284	79		25	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0 878	0	0	0	0	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0/0	0		0	0	52.00
02.00	OUTPATIENT SERVICE COST CENTERS			1	<u> </u>	<u> </u>	02.00
60.00	06000 CLI NI C	0	0	0	0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 63. 00	06200 FQHC 06300 OTHER OUTPATIENT SERVICE COST CENTER	o	0	0	0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	1 0	j oj	0	03.00
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
72. 00	07200 CORF	0	0	0	0	0	72.00
	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0	0	0	0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>	<u> </u>	74.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I 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 SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	374, 732	99, 014	40, 534	29, 830	280, 011	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	290	0	0	0	0	91. 00 92. 00
92. 00 93. 00	09300 NONPALD WORKERS	0	0	0		0	92.00
94. 00	09400 PATIENTS LAUNDRY		0	Ö	o	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
98.00	Cross Foot Adjustments		_	0	0	0	98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	0 375, 022	99, 014	0 40, 534	0 29, 830	0 280, 011	99.00
100.00) IOTAL	3/3,022	99, 014	1 40, 334	27, 030	200, 011	1100.00

Provi der No.: 315138

				10	12/31/2023	5/13/2024 9: 4	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS &	SOCIAL SERVICE	
		9. 00	10.00	11. 00	<u>LI BRARY</u> 12. 00	13. 00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSING ADMINISTRATION	40, 999					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	12, 938				10.00
11. 00	01100 PHARMACY	0	o	0			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	o	0	10, 501		12. 00
13.00	01300 SOCIAL SERVICE	0	o	0	0	14, 338	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TI ES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	40, 999	12, 938	0	9, 032	14, 338	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/ D	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS		al				
40.00	04000 RADI OLOGY	0	0	0	10	l	40.00
41. 00	04100 LABORATORY	0	0	0	28	l	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	U	0	/	0	42. 00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY		0	0	U EE3	0	43.00
45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY		0	0	553 432	0	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY		0	0	333	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY		0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		0	0	106	1	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	Ö	0	0	o o	50.00
51. 00	05100 SUPPORT SURFACES	0	o	0	0	1	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	o	0	0	Ō	52. 00
	OUTPATIENT SERVICE COST CENTERS	'				<u>'</u>	
60.00	06000 CLI NI C	0	0	0	0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0		70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
72.00	07200 CORF	0	0	0	0	0	72. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	<u> </u>	0	U	0	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 HOSPI CE	0	o	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	o	0	0	Ö	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	40, 999	12, 938	0	10, 501		
	NONREI MBURSABLE COST CENTERS	,	,	-		.,	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	O	0	0	1	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments	0	0	0			98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	TOTAL	40, 999	12, 938	0	10, 501	14, 338	100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				1	To 12/31/2023	Date/Time Pre 5/13/2024 9:4	
			OTHER GENERAL			7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	O alli
			SERVI CE		5 . 0. 5		
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
		EDUCATI ON			Adj d3 tillerits		
	Ta	14.00	15. 00	16. 00	17. 00	18. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			Ι			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 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY						9. 00 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	6, 004				14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		5,001				10.00
30. 00	03000 SKILLED NURSING FACILITY	0	-,				30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0	•	0		31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0		•			33.00
	ANCILLARY SERVICE COST CENTERS	-	-			-	
40.00	04000 RADI OLOGY	0	1			l .	1
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	834 47			41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	Ö	Ö	''(0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	39, 77			1
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0	47, 539		47, 539 7, 410	
47. 00	04700 ELECTROCARDI OLOGY			7, 410		7,410	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	15, 944	1 0	15, 944	1
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	6, 606		6, 606	1
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0		878		0 878	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	Ö	Ö			l .	1
	OUTPATIENT SERVICE COST CENTERS	_	_			_	
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0	l .	60. 00 61. 00
62. 00	06200 FQHC	0		\			62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0		70. 00 71. 00
72.00	07200 CORF	Ö	ő		o o		72. 00
	07300 CMHC	0	0	(0	
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0	(0	0	74. 00
80. 00	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	1
89. 00	SUBTOTALS (sum of lines 1-84)	o o	6, 004		-		
	NONREI MBURSABLE COST CENTERS			I			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	290		0 290	
	09200 PHYSICIANS PRIVATE OFFICES	0	0	290		290	ı
93.00	09300 NONPALD WORKERS	Ö	Ö	Ò	-	Ö	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	(-	0	
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0		0	0	
99. 00	Negative Cost Centers	Ö	Ö		o o		99. 00
100.00	D TOTAL	0	6, 004	1, 873, 948	0	1, 873, 948	100. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Cash Century Repair pitting						Ť	o 12/31/2023	Date/Time Pre 5/13/2024 9:4	pared:
FIXTURES CROUMENT				CAPITAL REL	ATED COSTS			37 137 2024 7. 4	O dili
FIXTURES COLUMN FIRT COL		(Cost Center Description	BLDGS &	MOVABLE	FMPLOYEE	Reconciliation	ADMI NI STRATI VE	
			oost conton boost per on	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
DESIGNAL SERVICE COST CRITICIS 1.00 2.00 3.00 4A 4.00				(SQUARE FEET)	(SQUARE FEET)			(ACCUM. COST)	
1.00 00100 CAP PILL CUSIS - BLIXES & ITTUENES 37,095 1,14 500 1,0				1.00	2. 00		4A	4. 00	
2.00	1 00	GENERA	L SERVICE COST CENTERS	27 OOE			I		1 00
4.00 0.000 AMMINISTRATIVE & GERERAL 7, 372 7, 372 457, 203 -2, 192, 304 10, 065, 700 4, 000				37,095					ł
0.000 CAST OF PART I ON, MAINT & REPAIRS 1,478									ł
0.000 DUDING LINEN SERVICE									
0.00 0.000 DETARY 4,295 4,295 0 0 1,253,628 8,00 10.00 0.000 CENTRAL SERVICES & SUPPLY 191 191 4,945 0 0 503,583 9,00 10.00 0.000 CENTRAL SERVICES & SUPPLY 191 191 4,945 0 0 122 10.00 10.00 10.000 CENTRAL SERVICES & SUPPLY 191 191 4,945 0 0 122 10.00 10.00 10.000 10.000 10.000 187,709 15.00 13.00 10.000 10.000 10.000 187,709 15.00 15.00 10.000 10.000 187,709 15.00 15.00 10.000 10.000 187,709 15.00 15.00 10.000 10.000 187,709 15.00 15.00 10.000 10.000 187,709 15.00 15.00 10.000 10.000 187,709 15.00 15.00 10.000 10.000 187,709 187,709 187,709 15.00 10.000 10.000 187,709 187,709 187,709 15.00 10.000 187,709 187,709 187,709 187,709 15.00 10.000 187,709 187,709 187,709 187,709 15.00 10.000 187,709 187,709 187,709 187,709 187,709 15.00 10.000 187,709 187,709 187,709 187,709 187,709 15.00 10.000 187,709 187,709 187,709 187,709 187,709 187,709 15.00 10.000 187,709 187,709 187,709 187,709 187,709 187,709 187,709 187,709 15.00 10.000 187,709		00600 1	LAUNDRY & LINEN SERVICE						•
9.00 0.0900 NURSING ADMINISTRATION							-		•
11.00 01100 PIASHACY		1 1				1	_		1
12.00 01200 MEDICAL RECORDS & LIBRARY 158 158 32.844 0 46, 534 12.00 13.00 1300 01400 NIRSI NG AND ALLI ED HEALTH EDUCATION 0 0 0 0 0 0 0 0 14.00 14.00									•
13.00 01300 SOCIAL SERVICE 13.00 13.00 129.97 0 17.709 13.00 14.00 14.00 01500 MISSIN KAN BALLIED HEALTH EDUCATION 0 0 125.927 0 154.563 15.00 150.00		1 1		ı	_	1	_		•
15.00 01500 ACTIL VITTES 0 0 125, 927 0 154, 563 15.00	13. 00	01300	SOCIAL SERVICE	130	130	129, 937	0	187, 709	13. 00
INPATT ENT ROUTE NOT THE SERVICE COST CENTERS 20,074 4,002,778 0 6,388,016 30 00				0				_	•
31.00 03100 NURSING FACILITY	13.00			0	0	125, 727	0	154, 503	15.00
32.00 03200 ICFAT I D 0 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS				20, 074	· _				•
33.00 03000 OTHER LONG TERM CARE				0	_				•
0.000 0.00000 0.00000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.00000000		03300	OTHER LONG TERM CARE	0	_				
11.00 04100 LABORATORY 0 0 0 0 0 0 23,565 41.00	40 00			0	0		0	21 470	40 00
43.00 04300 0XYCEN (INHALATION) THERAPY 492 492 0 0 35.4 20 44.0 04400 PHYSICAL THERAPY 479 679 0 0 281.235 45.00 45.00 04500 0XYCENTIONAL THERAPY 679 679 0 0 281.235 45.00 47.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0				ő	_		_		ł
44 00 04400 PHYSICAL THERAPY 492 492 0 0 352, 420 44, 00				0	_		_		ł
45.00 04500 0500				492	_	1			ł
47.00 04700 04700 04500 04500 050 050 050 044, 050 04900 05100 04900				679				281, 235	45. 00
A8 00 04800 MEDIC CAL SUPPLIES CHARGED TO PATIENTS 280 280 0 14, 145 48, 00				0	_	1	_		
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 55.00		04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	280	_	1	_		•
51.00 05100 SUPPORT SURFACES 0 0 0 0 25,677 51.00							0		1
OUTPATIENT SERVICE COST CENTERS O				0	_		_		1
60.00 06000 CLINIC 06000 06000 06100 061.00 062.00 06100 062.00 06200 061.00 062.00 0	52. 00			0	0	c	0	0	52. 00
61.00 06200 FOHC COMPANDED COMPANDED COMPANDED COMPANDED COMPANDED COMPANDED COMPANDED COMPANDED COMPANDED COMPAND COMPA	60. 00			0	0		0	0	60. 00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTERS O O O O O O O O O	61. 00			0	0				61. 00
OTHER REI MBURSABLE COST CENTERS O		1 1		0	0		0	n	•
71.00 07100 AMBULANCE 0 0 0 0 0 0 71.00	00.00	OTHER	REIMBURSABLE COST CENTERS		<u> </u>				00.00
72. 00 07200 CORF 0 0 0 0 0 0 0 72. 00		1 1		0	_				•
73. 00 07300 CMHC 0 0 0 0 0 0 0 0 74. 00 74. 00 07400 07HER REIMBURSABLE COST 0 0 0 0 0 0 0 0 80. 00 08000 MALPRACTICE PREMI UMS & PAID LOSSES 81. 00 81. 00 08200 UTILIZATION REVIEW 82. 00 83. 00 08300 HOSPI CE 0 0 0 0 0 83. 00 84. 00 08400 07HER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 89. 00 SUBTOTALS (sum of lines 1-84) 37, 095 37, 095 5, 114, 594 -2, 192, 306 10, 957, 234 NONREI MBURSABLE COST CENTERS 0 0 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 0 0 0 0 0 0 92. 00 09200 PHYSICI ANS PRI VATE OFFICES 0 0 0 0 0 0 93. 00 09300 NONPAID WORKERS 0 0 0 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 98. 00 Negative Cost Centers 0 0 0 0 0 102. 00 Cost to be allocated (per Wkst. B, Part I) 49. 252271 1. 265265 0. 173795 0. 199924 103. 00 105. 00 Unit cost multiplier (Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Unit cost multipli		1 - 1		0	0		0		
SPECIAL PURPOSE COST CENTERS S0.00				0	0				73. 00
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80. 00 81. 00 81. 00 82. 00 82. 00 82. 00 82. 00 82. 00 82. 00 83. 00 83. 00 83. 00 83. 00 84. 00 83. 00 84.	74.00			0	0		0	0	74.00
82.00 08200 UTILIZATION REVIEW 83.00 08300 HOSPICE 0 0 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 37,095 37,095 5,114,594 -2,192,306 10,957,234 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0,90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 8,466 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 0 0 0 0 92.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 95.00 98.00 Posto Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 49.252271 1.265265 0.173795 0.199924 103.00 104.00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part I) 49.252271 1.265265 0.173795 0.005699 0.034200 105.00		08000	MALPRACTICE PREMIUMS & PAID LOSSES						ł
83.00 08300 HOSPICE 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) 37,095 37,095 5,114,594 -2,192,306 10,957,234 89.00 NONREI MBURSABLE COST CENTERS 90.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 8,466 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 94.00 95.00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 95.00 98.00 99.00 Cross Foot Adjustments 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 49.252271 1.265265 0.173795 0.199924 103.00 104.00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part I) 49.252271 1.265265 0.173795 0.034200 105.00									
SUBTOTALS (sum of lines 1-84) 37,095 37,095 5,114,594 -2,192,306 10,957,234 89.00	83. 00	08300	HOSPI CE	0	0	C	0	0	
NONREI MBURSABLE COST CENTERS O O O O O O O O O				0 27 00E	0 27 00E			-	1
91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 8,466 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 0 92.00 93.00 NONPAID WORKERS 0 0 0 0 0 0 0 0 93.00 93.00 93.00 O9300 NONPAID WORKERS 0 0 0 0 0 0 0 0 0 94.00 94.00 94.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 95.00 98.00 Cross Foot Adjustments 99.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69.00			37,093	37,093	5, 114, 594	-2, 192, 300	10, 937, 234	09.00
92. 00				0	0			-	•
93.00 09300 NONPAID WORKERS 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 98.00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part II) 49.252271 1.265265 0.173795 0.199924 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 0.005699 0.034200 105.00				0	0		0		•
95. 00	93. 00	09300	NONPALD WORKERS	Ö	0	C	0		l
98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIII) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII				0	0	O C	0	-	1
102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 49.252271 1.265265 0.173795 0.199924 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.005699 0.034200 105.00				0			0		1
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 Unit cost multiplier (Wkst. B, Part II) 106.00 Unit cost multiplier (Wkst. B, Part III) 107.00 Unit cost multiplier (Wkst. B, Part III) 108.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			Negative Cost Centers	4 007 040	47,005			0 400 007	•
103.00 Unit cost multiplier (Wkst. B, Part I) 49.252271 1.265265 0.173795 0.199924 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 29,149 375,022 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.005699 0.034200 105.00	102.00			1,827,013	46, 935	888, 890 		2, 192, 306	102.00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.005699 0.034200 105.00		o u	Unit cost multiplier (Wkst. B, Part I)	49. 252271	1. 265265				1
105.00 Unit cost multiplier (Wkst. B, Part 0.005699 0.034200 105.00	104.00					29, 149 		375, 022	104. 00
	105.00	o ı	Unit cost multiplier (Wkst. B, Part			0. 005699		0. 034200	105. 00
			11)			l			l

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315138 Period:

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/13/2024 9:40 am Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (SQUARE FEET) (MEALS SERVED) ADMINISTRATION OPERATI ON, MAINT. & (TOTAL PATIENT (TOTAL PATIENT REPAIRS DAYS) (SQUARE FEET) DAYS) 5.00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 27.668 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 618 37,600 6.00 7.00 00700 HOUSEKEEPI NG 324 26, 726 7.00 8.00 00800 DI ETARY 4, 295 4, 295 112, 800 8.00 37, 600 00900 NURSING ADMINISTRATION 9 00 405 C 405 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 191 191 0 0 10.00 11.00 01100 PHARMACY C 0 0 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 158 158 0 12.00 0 01300 SOCIAL SERVICE 0 13 00 Ω 13 00 130 130 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C 0 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 20,074 37,600 20,074 112, 800 37,600 30.00 03100 NURSING FACILITY 31.00 31.00 0 32.00 03200 | CF/IID 0 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 0 33 00 33.00 Ω 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 0 0 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 43.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 44.00 492 492 44.00 04500 OCCUPATIONAL THERAPY 45.00 679 679 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 280 280 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 22 22 49.00 0 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 C 0 Λ 50.00 05100 SUPPORT SURFACES 0 0 0 51.00 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 n O Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 63.00 0 0 Λ 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST C 70.00 07100 AMBULANCE 71.00 71.00 0 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 72.00 73.00 07300 CMHC 0 0 0 0 73.00 07400 OTHER REIMBURSABLE COST 0 74.00 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 83.00 08300 H0SPLCE Λ 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 27,668 37,600 26, 726 112, 800 37, 600 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 0 0 91.00 91.00 0 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 92.00 0 0 93 00 09300 NONPALD WORKERS 0 93 00 Ω 0 09400 PATIENTS LAUNDRY 94.00 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 95.00 95.00 C 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99 00 102.00 Cost to be allocated (per Wkst. B, 831, 792 267, 740 441, 385 1, 704, 313 623, 126 102. 00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 30.063322 7. 120745 16. 515191 15. 109158 16. 572500 103. 00 104.00 Cost to be allocated (per Wkst. B, 99,014 40, 534 29,830 280, 011 40, 999 104. 00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 3.578647 1.078032 1.116142 2.482367 1. 090399 105. 00

Heal th	Financial Systems	TROY HILLS	CENTER		In Lie	u of Form CMS-2	2540-10
	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Pre 5/13/2024 9:4	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
	CENEDAL CEDALCE COST CENTEDS	10.00	11. 00	12.00	13. 00	14. 00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00 4. 00 5. 00 6. 00	OO300 EMPLOYEE BENEFITS OO400 ADMINISTRATIVE & GENERAL OO500 PLANT OPERATION, MAINT. & REPAIRS OO600 LAUNDRY & LINEN SERVICE						3. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	000000 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION						7. 00 8. 00 9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	43, 878 0	0	40,000,755			10. 00 11. 00
12. 00 13. 00 14. 00	O1200 MEDICAL RECORDS & LIBRARY O1300 SOCIAL SERVICE O1400 NURSING AND ALLIED HEALTH EDUCATION	0	0 0 0	(0	
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	(0	0	15. 00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	43, 878 0	0		37, 600 0	0	30. 00 31. 00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0	•	_	0	32. 00 33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	18, 007	7 0	0	40. 00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	1	0	0	41. 00 42. 00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0	1, 018, 359	0	0	43. 00 44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0	795, 465 613, 551	0	0	45. 00 46. 00
47. 00 48. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	47. 00 48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0	194, 885	0	0	49. 00 50. 00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	93		0	51. 00 52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0				60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0				61.00
62. 00 63. 00	06200 FOHC 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	
	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	0	0	(0		70. 00
72.00	07100 AMBULANCE 07200 CORF	0	0	(0	0	71. 00 72. 00
	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0	(0	0	73. 00 74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00 82. 00	08100 I NTEREST EXPENSE 08200 UTILIZATION REVIEW						81. 00 82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	43, 878	0	, , , , ,			89. 00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0			0	90. 00 91. 00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	(0	0	93. 00
94. 00 95. 00 98. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0	(0 0	0	94. 00 95. 00 98. 00
99. 00 102. 00	Negative Cost Centers	91, 837	0	63, 196	231, 292	0	99. 00 102. 00
103. 00 104. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	2. 093008 12, 938	0. 000000		6. 151383	0. 000000	
104.00	Part II)	0. 294863	0. 000000				
100.00		0. 274003	3. 000000	3. 000340	3. 301330	3. 000000	.00.00

TROY HILLS CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315138

				5/13/2024 9:4	40 am
			OTHER GENERAL SERVI CE		
		Cost Center Description	ACTIVITIES (TOTAL PATIENT		
			DAYS)		
	CENED	AL CERVICE COCT CENTERS	15. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00		EMPLOYEE BENEFITS			3. 00
4. 00 5. 00	1	ADMINISTRATIVE & GENERAL			4.00
6. 00		PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE			5. 00 6. 00
7. 00	1	HOUSEKEEPING			7. 00
8.00		DI ETARY			8. 00
9. 00 10. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY			9. 00 10. 00
11. 00		PHARMACY			11.00
12.00	01200	MEDICAL RECORDS & LIBRARY			12. 00
13.00	1	SOCIAL SERVICE			13.00
14. 00 15. 00	1	NURSING AND ALLIED HEALTH EDUCATION ACTIVITIES	37, 600		14. 00 15. 00
10.00		IENT ROUTINE SERVICE COST CENTERS	07,000		10.00
30.00		SKILLED NURSING FACILITY	37, 600		30.00
31. 00 32. 00		NURSING FACILITY ICF/IID	0		31. 00 32. 00
33. 00		OTHER LONG TERM CARE	0		33. 00
		LARY SERVICE COST CENTERS			
40. 00 41. 00		RADI OLOGY LABORATORY	0		40. 00 41. 00
42. 00	1	INTRAVENOUS THERAPY	o		42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	O		43. 00
44.00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0		44.00
45. 00 46. 00	1	SPEECH PATHOLOGY	0		45. 00 46. 00
47. 00	1	ELECTROCARDI OLOGY	Ö		47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00 50. 00	1	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0		49. 00 50. 00
51. 00	1	SUPPORT SURFACES	o		51.00
52. 00		OTHER ANCILLARY SERVICE COST CENTERS	0		52. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	0		60.00
61. 00	1	RURAL HEALTH CLINIC	o		61. 00
62. 00	06200	l e e e e e e e e e e e e e e e e e e e	_		62. 00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER REIMBURSABLE COST CENTERS	0		63. 00
70. 00		HOME HEALTH AGENCY COST	0		70. 00
71. 00		AMBULANCE	0		71. 00
72. 00 73. 00	07200		0		72. 00 73. 00
	1	OTHER REIMBURSABLE COST	0		74.00
	SPECI.	AL PURPOSE COST CENTERS			
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE			80. 00 81. 00
82. 00	1	UTILIZATION REVIEW			82.00
83. 00	08300	HOSPI CE	O		83. 00
84. 00 89. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0 37, 600		84. 00 89. 00
69.00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	37,600		09.00
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90. 00
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0		91. 00 92. 00
93. 00	1	NONPALD WORKERS	O O		93. 00
94.00	09400	PATIENTS LAUNDRY	O		94. 00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST CENTERS	0		95. 00 98. 00
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers			98.00
102.00		Cost to be allocated (per Wkst. B,	185, 464		102. 00
102.00		Part I)	4 022552		102.00
103.00 104.00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	4. 932553 6, 004		103. 00 104. 00
		Part II)			
105.00)	Unit cost multiplier (Wkst. B, Part	0. 159681		105. 00
	I	11)	l I		1

Health Financial Systems	TROY HILLS CENTER	In Lie	u of Form CMS-2540-10
RATIO OF COST TO CHARGES FO	R ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 31513	8 Peri od:	Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:40 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col . 2 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 25, 821 18, 007 1. 433942 40.00 41.00 04100 LABORATORY 28, 447 52, 338 0.543525 41.00 16, 317 42.00 04200 I NTRAVENOUS THERAPY 13, 666 1. 193985 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 449, 123 1, 018, 359 0.441026 44.00 04500 OCCUPATIONAL THERAPY 45.00 371, 689 795, 465 0.467260 45.00 04600 SPEECH PATHOLOGY 0.407935 46.00 250, 289 613, 551 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 30, 015 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 0. 959874 49.00 49.00 194, 885 187, 065 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 51.00 05100 SUPPORT SURFACES 30, 810 93 331. 290323 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 06300 OTHER OUTPATIENT SERVICE COST CENTER 63.00 0.000000 63.00 0 0

0.000000

1, 389, 576

2, 706, 364

71.00

100.00

71. 00 | 07100 | AMBULANCE

Total

100.00

ealth Financial Systems	TROY HILLS				u of Form CMS-:	2540-10
PPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narodi
				10 12/31/2023	5/13/2024 9: 4	
		Title	XVIII (1)	Skilled Nursing	PPS	-
			, ,	Facility		
		Health Care Pr	rogram Charges	Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Col umn 3) 1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	TENT COST					
0. 00 04000 RADI OLOGY	1, 433942	3, 020		0 4, 331	0	40.00
1. 00 04100 LABORATORY	0. 543525			0 4, 331	0	
2. 00 04200 I NTRAVENOUS THERAPY	1. 193985			0 2, 210	0	
3. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0 0	0	
4. 00 O4400 PHYSI CAL THERAPY	0. 441026	l e		0 112, 769	0	
5. 00 04500 OCCUPATI ONAL THERAPY	0. 467260			0 122, 363	0	
6. 00 04600 SPEECH PATHOLOGY	0. 407935			0 88, 221	0	46. 00
7. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		o o	0	47.00
8.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		o o	0	48. 00
9.00 04900 DRUGS CHARGED TO PATIENTS	0. 959874	64, 492		0 61, 904	0	49.00
O.OO 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
1.00 05100 SUPPORT SURFACES	331. 290323	52		0 17, 227	0	51.00
2.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
0. 00 06000 CLI NI C	0. 000000	0		0 0	0	60.00
1.00 O6100 RURAL HEALTH CLINIC						61.00
2.00 06200 FQHC						62.00
3.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			이	0	
1.00 07100 AMBULANCE (2)	0. 000000	ł		0	0	
00.00 Total (Sum of Lines 40 - 71)		804, 729		0 409, 830	0	100.00
1) For title V and XIX use columns 1, 2, and 4 on			•			

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

	ancial Systems	TROY HILLS				u of Form CMS-2	2540-10
APPORTI ONM	ENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/13/2024 9:4	pared: O am
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description						
DADT	II - APPORTIONMENT OF VACCINE COST					1. 00	
1. 00	Drugs charged to patients - ratio of c	ost to charges	(Erom Workshoo	+ C column 2	lino (O)	0. 959874	1.00
2. 00	Program vaccine charges (From your rec			t C, Corullin 3	, 11110 49)	8, 508	2.00
3. 00	Program costs (Line 1 x line 2) (Title			ar this amoun	t to Workshoot	8, 308 8, 167	3. 00
3.00	E, Part I, line 18)	AVIII, FF3 pio	viders, transi	er tills alliouri	t to worksneet	0, 107	3.00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	oost conton boodinption	(From Wkst. B,			Cost (From	& Allied	
			(From Wkst. B,			Health Costs	
		18	Part I, Col.	Costs to Tota	I I, Col. 4)	for Pass	
			14)	Costs - Part	A	Through (Col.	
				(Col. 2 / Col		3 x Col. 4)	
		1.00	0.00	1)	4.00	F 00	
DADT	III - CALCULATION OF PASS THROUGH COSTS	1.00	2.00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS	FUR NURSTING &	ALLIED HEALIH				1
	00 RADI OLOGY	25, 821		0.00000	00 4, 331	0	40.00
	OO LABORATORY	28, 447	Č	0.00000		0	41. 00
	OO INTRAVENOUS THERAPY	16, 317	Č	0. 00000		0	42.00
	OO OXYGEN (INHALATION) THERAPY	0	Ċ	0.00000		0	43.00
	DO PHYSI CAL THERAPY	449, 123	C	0.00000	112, 769	0	44.00
45. 00 0450	OO OCCUPATIONAL THERAPY	371, 689	C	0.00000	122, 363	0	45.00
46. 00 0460	OO SPEECH PATHOLOGY	250, 289	C	0. 00000	00 88, 221	0	46.00
47. 00 0470	00 ELECTROCARDI OLOGY	0	C	0. 00000	0 0	0	47.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 015	C	0.00000		0	48. 00
	DO DRUGS CHARGED TO PATIENTS	187, 065	C	0.00000		0	49.00
	DO DENTAL CARE - TITLE XIX ONLY	0	(C	0.00000		0	50.00
	OO SUPPORT SURFACES	30, 810	C	0. 00000		0	51.00
	OO OTHER ANCILLARY SERVICE COST CENTERS	0	C	0. 00000		0	
100.00	Total (Sum of lines 40 - 52)	1, 389, 576	[C	1	409, 830	0	100.00

leal th	Financial Systems TROY H	IILLS CENTER	In Lie	u of Form CMS-2	2540-1
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315138	Peri od:	Worksheet D-1	
			From 01/01/2023	Parts I-II	narad.
			To 12/31/2023	Date/Time Prep 5/13/2024 9: 40	
		Title XVIII	Skilled Nursing	PPS	<u>s am</u>
			Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
1.00	Inpatient days including private room days			37, 600	1.00
2. 00	Private room days			235	2.00
3. 00	Inpatient days including private room days applicable t	o the Program		2, 678	
4. 00	Medically necessary private room days applicable to the	Program		0	4.00
5. 00	Total general inpatient routine service cost			11, 758, 271	5.00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			1/ 100 705	
5.00	General inpatient routine service charges	too E alternation (1)		16, 480, 785	
7.00	General inpatient routine service cost/charge ratio (L	ine 5 divided by line 6)		0. 713453	
3. 00 9. 00	Enter private room charges from your records Average private room per diem charge (Private room char	gos lino 9 dividod by privato	room days line	114, 915 489, 00	
9. 00	2)	ges Title & divided by private	Toolii days, TTTIE	469.00	9.00
10.00	Enter semi-private room charges from your records			16, 365, 870	10.00
11. 00	Average semi-private room per diem charge (Semi-privat	e room charges line 10, divide	ed by	438. 00	
	semi -pri vate room days)	3	,		ĺ
12. 00	Average per diem private room charge differential (Line	9 minus line 11)		51.00	12.00
13. 00	Average per diem private room cost differential (Line 7			36. 39	13.00
14. 00	Private room cost differential adjustment (Line 2 times			8, 552	
15. 00		oom cost differential (Line 5	minus line 14)	11, 749, 719	15.00
16. 00	PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line	1E divided by Line 1)		312. 49	16.00
17. 00	Program routine service cost (Line 3 times line 16)	is divided by title ()		836, 848	
18. 00	Medically necessary private room cost applicable to pro	gram (line / times line 13)		030, 646	18.00
19. 00	Total program general inpatient routine service cost (836, 848	
20. 00	Capital related cost allocated to inpatient routine ser		rt II column 18.	1, 753, 461	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID			.,	
21. 00	Per diem capital related costs (Line 20 divided by lin			46. 63	21.00
22. 00	Program capital related cost (Line 3 times line 21)			124, 875	22.00
23. 00	Inpatient routine service cost (Line 19 minus line 22)			711, 973	23.00
24. 00	Aggregate charges to beneficiaries for excess costs (F			0	
25. 00	Total program routine service costs for comparison to t	he cost limitation (Line 23 mi	nus line 24)	711, 973	
26. 00	Enter the per diem limitation (1)				26.00
27. 00	Inpatient routine service cost limitation (Line 3 times				27. 00
28. 00			line 27)		28. 00
(1) !!	(Transfer to Worksheet E, Part II, line 4) (See instruc	•	 -: + 0		l .
, I) LI	nes 26 and 27 are not applicable for title XVIII, but ma	y be used for title v and or t	LI LI E XI X		
				1. 00	

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	37, 600	1.00
2.00	Program inpatient days (see instructions)	2, 678	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. 071223	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	TROY HILLS CEN	ITER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT I	FOR TITLE XVIII	Provi der No.: 315138	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/13/2024 9:40 am
		Title XVIII	Skilled Nursing	PPS

		little XVIII	Facility	PPS	
		L	raciiity		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT	<u>'</u>		
1.00	Inpatient PPS amount (See Instructions)			1, 953, 684	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)			1, 953, 684	3. 00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			287, 200	5.00
6.00	Allowable bad debts (From your records)			133, 650	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		106, 098	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			86, 873	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			1, 753, 357	11. 00
12.00	Interim payments (See instructions)			1, 691, 446	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	
14. 75	Sequestration for non-claims based amounts (see instructions)			1, 737	
14. 99	Sequestration amount (see instructions)			33, 330	
15. 00	Balance due provider/program (see Instructions)			26, 844	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY	0	17.00
17. 00	Ancillary services Part B			0 1/7	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			8, 167	
19. 00 20. 00	Total reasonable costs (Sum of lines 17 and 18) Medicare Part B ancillary charges (See instructions)			8, 167 8, 508	19. 00 20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)		•	8, 167	
21.00	Primary payor amounts			0, 167	22. 00
23. 00	Coinsurance and deductibles			0	
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 00	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 00
24. 01	Adjusted reimbursable bad debts (see instructions)	ctions)		0	24. 01
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			8, 167	25. 00
26. 00	Interim payments (See instructions)			5, 253	
27. 00	Tentati ve adjustment			0, 200	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)			163	
29. 00	Balance due provider/program (see instructions)			2, 751	
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	section 115.2	2, 731	
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			٥١	

Health Financial Systems	TROY HILLS CEN	ITER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provi der No.: 315138	From 01/01/2023	Worksheet E Part II Date/Time Prepared: 5/13/2024 9:40 am
		Title XIX	Skilled Nursing	PPS

		THE XIX	Facility	113	
			Ĺ		
				1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpati ent servi ces			0	
4.00	Inpatient routine services (see instructions)			0	
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			0	
7.00	Differential in charges between semiprivate accommodations and	ess than semiprivate a	accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)			0	8. 00
9.00	Pri mary payor amounts			0	
10. 00	Total Reasonable Cost (Line 8 minus line 9)			0	10. 00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges				11. 00
12. 00	Outpati ent service charges			0	
13. 00	Inpatient routine service charges			0	
14. 00	Differential in charges between semiprivate accommodations and	ess than semiprivate a	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16. 00	Aggregate amount actually collected from patients liable for pa			-	16. 00
17. 00	Amounts that would have been realized from patients liable for	oayment for services or	n 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	
19. 00	Total customary charges (see instructions)			0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20. 00	Cost of covered services (see Instructions)			0	
21. 00	Deducti bl es			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)			0	26. 00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl cost limit	y collected based on co	orrection of	0	27. 00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in p	orogram	0	28. 00
	utilization	·	J I		
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30. 00	Amounts applicable to prior cost reporting periods resulting frif minus, enter amount in parentheses)	om disposition of depre	eciable assets (0	30. 00
31. 00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32.00	Interim payments	27 dia 20)		0	
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overnavments in narenth	1999) (999	0	33. 00
33.00	Instructions)	over payments in parenti	(366	U	33.00
	1		1	· ·	1

NALYSIS OF PAYMENIS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315138 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/13/2024 9: 40 am

Title XVIII | Skilled Nursing | PPS

Inpati ent Part A Part B			liti	e XVIII	Killed Nursing	PPS	
1.00			Innation	+ Dort A	Facility	+ D	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00			<u>'</u>				
Total interim payments paid to provider							
InterIm payments payable on Individual Bills, either substited or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero			1. 00		3. 00		
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero 3.00 Usit 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 0				1, 633, 154			
Services rendered in the cost reporting period. If none, enter zero 1.5 cost 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) 1.5 cost separately each retroactive lump sum adjustment amount (balance due) based on the cost report ing period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 1.5 cost separately each retroactive lump sum adjustment 1.5 cost separately each retroactive lump sum of lines 1.0 cost separately each retroactive lump sum of lines 1.0 cost separately each retroactive lump sum of lines 1.0 cost separately each retroactive lump sum of lines 1.0 cost separately each retroactive lump sum of lines 5.0 cost separately each retroactive lump sum of lines 6.0 cost separate	2.00			0		U U	2. 00
Once Contractor Once O							
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		1 91					
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)	3 00						3 00
For the cost reporting period. Also show date of each payments. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						5. 00
Bayment, If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider ADJUSTMENTS TO PROVIDER 09/11/2023 58,292 0 3. 01 3. 01 3. 02 0 0 0 3. 03 3. 04 0 0 0 0 3. 03 3. 04 0 0 0 0 3. 03 3. 04 0 0 0 0 3. 03 3. 04 0 0 0 0 3. 05 3. 05 0 0 0 0 3. 05 3. 05 0 0 0 0 3. 05 3. 05 0 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 3. 05 0 0 0 3. 05 0 0 0 3. 05 0 0 0 3. 05 0 0 0 0 0 0 0 0 0							
ADJUSTMENTS TO PROVIDER							
3.03	3. 01		09/11/2023	58, 292		0	3. 01
3.04 0	3.02			0		o	3. 02
3.05	3.03			0		o	3. 03
Provider to Program	3.04			0		o	3. 04
ADJUSTMENTS TO PROGRAM	3.05			0		0	3.05
3.51 3.52 3.53 3.54 0 0 0 3.552 3.533 3.54 0 0 0 3.553 3.54 3.59 3		Provider to Program					
3.52 3.53 3.54 3.99 3.53 3.54 3.99 3.54 3.99 3.54 3.99 3.54 3.99 3.59 3.59 3.98 3.59		ADJUSTMENTS TO PROGRAM		_		·	
3.53 3.54 0							
3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 58,292 0 3.54 3.99 1.691.446 58,292 0 3.99 1.691.446 5.253 4.00 1.691.446 5.253				ľ			
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 58,292 0 3.99 -3.98				0		-	
4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,691,446 5,253 4.00				0			
Total interim payments (sum of lines 1, 2, and 3.99)	3. 99			58, 292		0	3. 99
CTransfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR	4 00			1 401 444		E 2E2	4 00
26 for Part B) TO BE COMPLETED BY CONTRACTOR	4.00			1, 091, 440		5, 255	4.00
TO BE COMPLETED BY CONTRACTOR S. 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 S. 01 TENTATIVE TO PROVIDER O O O S. 02 O O O S. 03							
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)	5.00						5. 00
Program to Provider							
TENTATIVE TO PROVIDER		write "NONE" or enter a zero. (1)					
Solidar to Program							
Description		TENTATI VE TO PROVI DER					
Provider to Program							
TENTATI VE TO PROGRAM 0 0 5.50	5. 03			0		0	5. 03
S. 51 S. 52 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 S. 52 S. 99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 S. 99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 S. 99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 S. 99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 S. 99 S.	F F0			0		0	F F0
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		TENTATIVE TO PROGRAM					
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) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) - 26,844 2,751 6.01 0 0 0 0 0 0 0.02 7.00 Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor		Subtatal (Sum of Lines 5.01 5.40 minus sum of Lines 5.50)		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) 26,844 2,751 6.01 7.1718,290 8.004 7.00 Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00	J. 77					ا	J. 77
the cost report. (1) 6. 01 PROGRAM TO PROVIDER 6. 02 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 26, 844 2, 751 6. 01 0 0 6. 02 7. 00 Total Medicare program liability (see instructions) 1, 718, 290 Contractor Name Contractor Number 1. 00 2. 00 8. 00 Name of Contractor	6. 00						6. 00
6. 01 PROGRAM TO PROVIDER (Contractor) 26, 844 PROVIDER TO PROGRAM (Contractor) 8, 004 PROGRAM TO PROVIDER (Contractor) 8, 004 PROGRAM (Contractor) 8, 004 PROGRAM (Contractor) 8, 004 PROGRAM (Contractor) 1, 718, 290 PROGRAM (Contractor) 1, 700 PROGRAM (Contractor) 1, 718, 290 PROGRAM (Contractor) 1, 700 PROGRAM (Contractor) 1, 700 PROGRAM (Contractor) 1, 700 PROGRAM (Contractor) 1, 718, 290 PROGRAM (Contractor) 1		` ,					
6. 02 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1. 00	6. 01			26, 844		2, 751	6. 01
Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00	6.02	PROVI DER TO PROGRAM		0		ol	6. 02
Number 1.00 2.00 8.00 Name of Contractor 8.00	7.00	Total Medicare program liability (see instructions)		1, 718, 290		8, 004	7. 00
8.00 Name of Contractor 8.00 8.00				Contract	tor Name		
8.00 Name of Contractor 8.00							
	0.00			1.	00	2. 00	0.00
		!		1		ا ا	8.00

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

lealth Financial Systems TROY HILLS CENTER In Lieu of Form CMS-2540-10

Health Financial Systems

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

Provider No.: 315138 | Period: From 01/01/202

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/13/2024 9:40 am

11 y)					5/13/2024 9: 4	0 am
		General Fund	Specific E Purpose Fund	Indowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	sets					
	RRENT ASSETS sh on hand and in banks	2, 453	0	0	0	1. (
	mporary investments	2, 455		0	0	
	tes recei vabl e			0	0	
	counts receivable	2, 204, 582	0	0	0	
00 Ot1	her recei vabl es	20, 822	0	0	0	5.
	ss: allowances for uncollectible notes and accounts	-585, 073	0	0	0	6.
1	cei vabl e	40.007				_
	ventory epai d expenses	49, 086	1	0	0 0	
4	her current assets	-1, 528		0	0	
	e from other funds			0	0	
	TAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 690, 342	0	0	0	
FI>	XED ASSETS					
2. 00 Lai		0	0	0	_	
1	nd improvements	134, 397		0		1
1	ss: Accumulated depreciation	-84, 225	l I	0	0	
	ildings ss Accumulated depreciation	3, 972, 631 -1, 564, 976	0	0	0	
	asehold improvements	1, 527, 506		0	0	
	ss: Accumulated Amortization	-959, 845	1	0	0	1
9.00 Fi:	xed equipment	180, 333		0	0	19.
0. 00 Le:	ss: Accumulated depreciation	-141, 276	0	0	0	20.
	tomobiles and trucks	0	0	0	0	
	ss: Accumulated depreciation	0	0	0	0	1
1 -	jor movable equipment	748, 063		0	0	
	ss: Accumulated depreciation nor equipment - Depreciable	-636, 178	0	0	0	
	nor equi pment - bepreci abl e		0	0	0	
	her fixed assets	Ö		0	0	
4	TAL FIXED ASSETS (Sum of lines 12 - 27)	3, 176, 430	-	0	-	
	HER ASSETS					
1	vestments	0	0	0	_	
	posits on leases	0	0	0		
1	e from owners/officers	-8, 065, 890	0	0	0	
	her assets TAL OTHER ASSETS (Sum of lines 29 - 32)	-8, 065, 890		0	0	
- 1	TAL ASSETS (Sum of Lines 11, 28, and 33)	-3, 199, 118		0	-	
	abilities and Fund Balances					
	RRENT LIABILITIES		T			١
	counts payable	1, 953, 660		0	0	
	laries, wages, and fees payable yroll taxes payable		0	0	0	
	tes & Loans payable (Short term)			0	0	
	ferred income			0	0	
4	cel erated payments	0			_	40.
. 00 Du	e to other funds	3, 405	O	0	0	41.
2. 00 Ot1	her current liabilities	1, 357, 496		0		
	TAL CURRENT LIABILITIES (Sum of lines 35 - 42)	3, 314, 561	0	0	0	43.
	NG TERM LIABILITIES	0.400.470			<u> </u>	١
1	rtgage payable	8, 189, 473	0	0	0	
4	tes payable secured Loans		0	0	0	
1	ans from owners:			0	0	
	her long term liabilities	0		0	0	1
4	IC DISTRIBUTIONS; R/E EARNINGS	-12, 801, 113	0	0	0	
. 00 TO	TAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-4, 611, 640	0	0	0	
	TAL LIABILITIES (Sum of lines 43 and 50) PITAL ACCOUNTS	-1, 297, 079	0	0	0	51
. 00 Gei	neral fund balance	-1, 902, 039				52
	ecific purpose fund		0			53
- 1	nor created - endowment fund balance - restricted			0		54
1	nor created - endowment fund balance - unrestricted			0		55
1	verning body created - endowment fund balance ant fund balance - invested in plant			0	0	56 57
1	ant fund balance - rivested in plant ant fund balance - reserve for plant improvement,				0	
	placement, and expansion					"
	TAL FUND BALANCES (Sum of lines 52 thru 58)	-1, 902, 039	o	0	0	59
. 00 TO	TAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-3, 199, 118		0	0	60.
59)					1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2540-10 TROY HILLS CENTER

					10	12/31/2023	5/13/2024 9:4	
		Genera	Fund	Speci al	Purpos	e Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1. 00	Fund balances at beginning of period	1.00	2.00			4.00		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-1, 902, 039				1	2. 00
3.00	Total (sum of line 1 and line 2)		-1, 902, 039			(3. 00
4.00	Additions (credit adjustments)							4. 00
5.00		0			0		0	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	
8.00		0			0		0	8. 00
9.00	Total additions (sum of line 5 - 9)	0	0		U		0	9.00
10. 00 11. 00	Subtotal (line 3 plus line 10)		-1, 902, 039			(10. 00 11. 00
12. 00	Deductions (debit adjustments)		-1, 702, 037			(1	12.00
13. 00	beddetrons (debrt adjustments)	0			0		0	13. 00
14. 00		O			Ö		0	14. 00
15. 00		0			0		0	15. 00
16.00		0			0		0	16. 00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		0			(-1	18. 00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-1, 902, 039			(19. 00
	Sheet (Line II - Iine 18)	Endowment Fund	PI ant	Fund				
		Ziidoimiorre i diid		1 4114				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)	_			_			2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4. 00 5. 00	Additions (credit adjustments)		0					4. 00 5. 00
6.00			0					6.00
7. 00			0					7. 00
8. 00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 5 - 9)	0			0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments)		_					12. 00
13.00			0					13. 00
14. 00 15. 00			0					14. 00 15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 13 - 17)	o	J		0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (Line 11 - line 18)							

Health Financial Systems	TROY HILLS CEN	TER	In Lieu	u of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der No.: 315138	From 01/01/2023	Worksheet G-2 Parts I-II Date/Time Prepared:
				5/13/2024 Q: 40 am

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315138	Period: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/13/2024 9:40	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		16, 617, 39	91	16, 617, 391	1.00
2.00	NURSING FACILITY			0	0	2.00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		16, 617, 39	91	16, 617, 391	5. 00
	All Other Care Services		<u> </u>	<u>'</u>		
6.00	ANCI LLARY SERVI CES		2, 715, 97	75 0	2, 715, 975	6.00
7.00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	8. 00
9.00	AMBULANCE			0	ol	9.00
10.00	RURAL HEALTH CLINIC			0	o	10.00
10. 10	FQHC			0	o	10. 10
11.00	CMHC			0	o	11. 00
	CORF			0	o	11. 10
	HOSPI CE			0 0	0	12. 00
	OTHER (SPECIFY)			o o	Ö	13. 00
14. 00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	to	19, 333, 36			1
	Worksheet G-3, Line 1)				,,	
	Cost Center Description		<u>'</u>			
	'			1. 00	2.00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				14, 343, 430	1.00
2.00	Add (Specify)			0		2.00
3.00				0		3.00
4.00				0		4. 00
5.00				0		5. 00
6.00				0		6.00
7.00				0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)				o	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
	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				14, 343, 430	
	1			ļ	,	

	Financial Systems	TROY HILLS CENTI		•	u of Form CMS-2	
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider No.: 315138	Peri od: From 01/01/2023	Worksheet G-3	
				To 12/31/2023	Date/Time Prep 5/13/2024 9:40	
					1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I				19, 333, 366	
2.00	Less: contractual allowances and discounts on p	patients accounts			6, 919, 515	
3.00	Net patient revenues (Line 1 minus line 2)				12, 413, 851	
4.00	Less: total operating expenses (From Worksheet		e 15)		14, 343, 430	
5.00	Net income from service to patients (Line 3 mir	nus 4)			-1, 929, 579	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	
7. 00	Income from investments				0	
8.00	Revenues from communications (Telephone and Ir	nternet service)			0	
9.00	Revenue from television and radio service				0	
10.00	Purchase di scounts				0	
11. 00	Rebates and refunds of expenses				0	
12. 00					0	
	Revenue from Laundry and Linen service				0	
	Revenue from meals sold to employees and guests	S			0	
15. 00	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical suppl		pati ents		0	
	Revenue from sale of drugs to other than patier				-	17.00
	Revenue from sale of medical records and abstra				0	
	Tuition (fees, sale of textbooks, uniforms, etc				0	
	Revenue from gifts, flower, coffee shops, cante	een			0	
	Rental of vending machines				0	
22. 00	Rental of skilled nursing space				0	
23. 00	Governmental appropriations				0	
24. 00	MI SC I NCOME				27, 540	
24. 50					0	
25. 00	,				27, 540	
26.00	Total (Line 5 plus line 25)				-1, 902, 039	
27. 00	Other expenses (specify)				0	
28. 00					0	
29. 00					0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)				0	30.00

0 30.00

-1, 902, 039 31. 00

30.00 Total other expenses (Sum of lines 27 - 29)
31.00 Net income (or loss) for the period (Line 26 minus line 30)