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

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

Provider CCN: 315138
Period:
From 01/01/2021
To 12/31/2021
Page 7

				5/ 19/	/2022 1:	Z/ pili
PART I - COST I	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	oort		Date: 5/19/2022	Time:	1: 27 pr
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report en	ter the numbe	r of times the provide	r resubmitted this cos	t report	t
	3.01 [] No Medicare Utilization. Enter '	'Y" for yes o	r Leave blank for no.			
Contractor	4. [1] Cost Report Status	6. Contractor	No	<u> </u>		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN		
	(2) Settled without audit	8.[N] Last Cost Report for this Provider CCN				
	(3) Settled with audit	9. NPR Date:	·			
	(4) Reopened	10. [0] I f I	ine 4. column 1 is "4"	: Enter number of time	s reoper	ned
	(5) Amended	11.Contracto	r Vendor Code	4	•	
	5. Date Received:	12.[F] Medi		er "F" for full, "L" fo	or low,	or "N"

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

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

		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1.00	2.00	3. 00	4. 00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-23, 429	958	0	1. 00
2.00 NURSING FACILITY	0			0	2. 00
3. 00 I CF/I I D				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	-23, 429	958	0	100. 00

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

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

Heal th	Financial Systems	TRO	Y HILLS CEN ⁻	TER		ı	n Lie	u of Form	m CMS-	2540-10
SKI LLE	ED NURSING FACILITY AND SKILLED NURSING FACILIEX INDENTIFICATION DATA					Period: From 01/01/		Workshe Part I		
COMPLE	EX INDENTIFICATION DATA					To 12/31/		Date/Ti 5/19/20		
	1.00		2. 00		3. 00			37 177 20	22 1.2	, pili
1. 00	Skilled Nursing Facility and Skilled Nursing Street: 200 REYNOLDS AVENUE	Facility PO Box:	/ Complex Ad	ldress:						1. 00
2. 00	Ci ty: PARSI PPANY	State: N	IJ	Zi p Code	: 07054					2. 00
3.00	County: MI DDLESEX	CBSA Cod		Urban/Ru	ral: U					3.00
3. 01		CBSA Cod		nent Name	Provi der	Date	Payme	ent Syste	em (P,	3. 01
					CCN	Certi fi ed	, , ,	0, or N		
			1	. 00	2.00	3. 00	4. OC	XVIII 5. 00	6. 00	
	SNF and SNF-Based Component Identification:			OFNITED.	045400	0.4.4.0.4.0.7.0				
4. 00 5. 00	SNF Nursing Facility		TROY HILLS	CENTER	315138	06/12/1972	N	P	Р	4. 00 5. 00
6.00	CF/IID									6. 00
7. 00 8. 00	SNF-Based HHA SNF-Based RHC									7. 00 8. 00
9. 00	SNF-Based FQHC									9. 00
10.00										10. 00 11. 00
11. 00 12. 00										12.00
	SNF-Based CORF									13. 00
						From: 1.00		To: 2. 0		-
	Cost Reporting Period (mm/dd/yyyy)					01/01/2	021	12/31/		14. 00
15. 00	Type of Control (See Instructions)						4	Y/Y	M	15. 00
								1. 0		
14 00	Type of Freestanding Skilled Nursing Facility Is this a distinct part skilled nursing facil		moots the	rogui romo	nts sat forth	in 42 CED		N		16. 00
16.00	section 483.5?	ity that	illeets the	r equi i ellle	iits set rortii	III 42 CFR		IN		16.00
17. 00	Is this a composite distinct part skilled nur 42 CFR section 483.5?	rsing fac	ility that	meets the	requi rements	set forth	in	N		17. 00
18. 00	Are there any costs included in Worksheet A t	that resu	ılted from t	ransacti o	ns with relate	ed		Υ		18. 00
	organizations as defined in CMS Pub. 15-1, ch									-
19. 00	Miscellaneous Cost Reporting Information If this is a low Medicare utilization cost re	eport, in	dicate with	a "Y", f	or yes, or "N	" for no.		N		19. 00
	If line 19 is yes, does this cost report meet	t your co	ntractor's	cri teri a			е	N		19. 01
	utilization cost report, indicate with a "Y", Depreciation - Enter the amount of depreciati	тог yes ion repor	<u>s, or "N" то</u> rted in this	r no. SNF for	the method in	dicated on	Li nes	20 - 22		1
	Straight Line									20.00
	Declining Balance Sum of the Year's Digits								(21.00
23. 00	Sum of line 20 through 22							2	203, 413	23. 00
	If depreciation is funded, enter the balance Were there any disposal of capital assets dur							N	C	24. 00 25. 00
26. 00						porting per	i od?	N		26. 00
27.00	(Y/N)	program	at and of t	ho ported	to which this	c cost ropo	rt	N		27. 00
27.00	Did you cease to participate in the Medicare applies? (Y/N)	pi ogi alli	at end or t	ne perrou	to will cir till :	s cost repo	1 (IN		27.00
28. 00	Was there a substantial decrease in health in	nsurance	proporti on	of allowa	ble cost from	prior cost		N		28. 00
	reports? (Y/N)						Part	A Part B	0ther	
	If this facility contains a public or non multiple	alia ngay	idon that a	ualifiaa	for an avament	ion from th		2.00		
	If this facility contains a public or non-put of the lower of the costs or charges enter "\"									
20.00	exemption.						N.	NJ I		20.00
29. 00 30. 00	,						N	N	N	29. 00 30. 00
31. 00	ICF/IID								N	31.00
32. 00 33. 00	SNF-Based HHA SNF-Based RHC						N	N N		32. 00 33. 00
34. 00	SNF-Based FQHC							N N		34.00
	SNF-Based CMHC SNF-Based OLTC							N		35. 00 36. 00
30.00	JNI -Dased OLIC					Y/N				30.00
27.00	lo the skilled purging Socility Loost 1	0+0+	o+ oo:-+! £'	a +bc	ui don s = - CNI	1.00		2. 0	00	27.00
37.00	Is the skilled nursing facility located in a regardless of the level of care given for Tit				vider as a siv	F Y				37. 00
	Are you legally-required to carry malpractice	e insuran	ice? (Y/N)	, ,	: _	N				38. 00
39. 00	Is the malpractice a "claims-made" or "occurr "claims-made" enter 1. If the policy is "occu			e policy	IS	1				39. 00
					Premiums	Pai d Los	ses :	Self Insu		
41. 00	List malpractice premiums and paid losses:				1.00	2.00		3.00	U	41. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					1	- 1	,		

Health Financial Systems	TROY HILI	S CENTER	In Lie	u of Form CMS-2	2540-10	
SKILLED NURSING FACILITY AND SKIL	_ED NURSING FACILITY HEALTH CARE	Provi der No.: 31		Worksheet S-2		
COMPLEX INDENTIFICATION DATA			From 01/01/2021	Part I		
			To 12/31/2021	Date/Time Pre 5/19/2022 1:2		
				Y/N	/ pili	
				.,		
				1. 00		
42.00 Are malpractice premiums an		N	42.00			
center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and						
amounts.						
43.00 Are there any home office of		Y	43.00			
44.00 If line 43 is yes, enter th	e home office chain number and	enter the name and add	dress of the home	HB0067	44.00	
office on lines 45, 46 and	47.					
1.00	2.	00	3. 00			
If this facility is part of	a chain organization, enter th	e name and address of	the home office on the	lines		
bel ow.	-					
45. 00 Name: GENESIS HEALTHCARE	Contractor's Name: N	OVI TAS Co	ontractor's Number: 1200	1	45. 00	
46.00 Street: 101 EAST STATE STREE	T PO Box:				46. 00	
47.00 City: KENNETT SQUARE	State: F	A Zi	p Code: 1934	8	47. 00	
44.00 If line 43 is yes, enter the office on lines 45, 46 and 1.00 If this facility is part of below. 45.00 Name: GENESIS HEALTHCARE 46.00 Street: 101 EAST STATE STREE	: lines	44. 00 45. 00 46. 00				

	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 01/01/2021 Fo 12/31/2021	Date/Time Pre	epared:
					Y/N	5/19/2022 1:2 Date	2/ pm
				V HAIH (1.00	2.00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column	I, Y FO	r yes or N I	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 trace trons,			Y/N	Date	V/I	
2.00	Has the provider terminated participation in	the Medicare Progra	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 i	n column				
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 office d to the provider or I, or members of the	s, drug its board	Y			3.00
	rerationships: (see Thati 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" f te copy or enter dat	or e	Y	С		4. 00
5.00	available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.			N			5. 00
	T GOONGT TT UET ON.				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 reportin		for Nursing	N N		7. 00 8. 00
						Y/N 1.00	
0.00	Bad Debts	1 1 1 1 2 () (//)					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	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 wai	ved? If "	Y", see instru	uctions.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting peri	od? If "Y			N	12. 00
		Description		Y/N	rt A Date	Part B Y/N	
	DCAD D. I	0		1. 00	2. 00	3. 00	
13. 00	PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			N		N	13. 00
14.00	was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			Y	03/19/2022	Y	14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for			N		N	16. 00
	corrections of other PS&R Report				in the second se		
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 H	II LLS C	ENTER		In Lieu of Form CMS-25				540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			Provi der	No.: 315138		: 1/01/2021 2/31/2021	Worksheet S Part II Date/Time P 5/19/2022 1	rep	ared:
							37 177 2022 1		рш
			1.	00		2.	00		
	Cost Report Preparer Contact Information								
19.00	Enter the first name, last name and the title/position	JE/	۸N		PRI CE				19.00
	held by the cost report preparer in columns 1, 2, and 3 respectively.	1							
20. 00	Enter the employer/company name of the cost report preparer.	GEN	IESIS HEALTH	ICARE					20. 00
21. 00	Enter the telephone number and email address of the cos report preparer in columns 1 and 2, respectively.	t 410	8044481		JEAN.	PRI CE@GENI	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

Provider No.: 315138

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

Date/Time Prepared:

Date/Time Prepared: 5/19/2022 1:27 pm 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 13.00 prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R 03/19/2022 14.00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 15.00 If line 13 or 14 is "Y", were adjustments 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: 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/position REIMBURSEMENT ANALYST 19.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 20.00 20.00 preparer. 21.00 Enter the telephone number and email address of the cost 21.00

report preparer in columns 1 and 2, respectively.

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Provider No.: 315138 Peri od: Worksheet S-3 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021

5/19/2022 1:27 pm Inpatient Days/Visits Title XVIII Component Number of Beds Bed Days Title V Title XIX Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 130 47, 450 2, 538 25, 702 1. 00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 7.00 0 7.00 8.00 Total (Sum of lines 1-7) 130 25, 702 8.00 Inpatient Days/Visits Di scharges Component 0ther Total Title V Title XVIII Title XIX 6.00 8.00 9. 00 10.00 SKILLED NURSING FACILITY 1.00 4,824 33, 064 1.00 62 42 NURSING FACILITY 2.00 2 00 0 0 3.00 ICF/IID 0 3.00 4.00 HOME HEALTH AGENCY COST 0 4.00 Other Long Term Care SNF-Based CMHC 0 5.00 5.00 6.00 6 00 6.10 SNF-Based CORF 6.10 HOSPI CE 7.00 7.00 Total (Sum of lines 1-7) 4,824 8.00 33, 064 42 8.00 62 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 11. 00 13.00 14.00 15.00 12.00 1.00 SKILLED NURSING FACILITY 158 0. 00 40.94 611. 95 1.00 262 2.00 NURSING FACILITY 0.00 0.00 2.00 ICF/IID 0 3.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 0.00 7 00 0 00 0 00 7 00 Total (Sum of lines 1-7) <u>611.</u> 95 8.00 158 262 0.00 40. 94 8.00 Average Length Admi ssi ons of Stay Component Title V Title XVIII 0ther Title XIX Total 19.00 20.00 16.00 17.00 18.00 1.00 SKILLED NURSING FACILITY 126. 20 84 14 176 1.00 2.00 NURSING FACILITY 0.00 0 0 2.00 ICF/IID 3.00 0.00 3.00 0 0 HOME HEALTH AGENCY COST 4 00 4 00 5.00 Other Long Term Care 0.00 5.00 6.00 SNF-Based CMHC 6.00 6.10 SNF-Based CORF 6.10 7.00 HOSPI CE 0.00 Γ Λ 7.00 Total (Sum of lines 1-7) 176 8.00 126.20 84 14 8.00 Admi ssi ons Full Time Equivalent Component Total Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 274 73. 7 0.00 1. 00 NURSING FACILITY 0.00 2.00 2.00 0.00 3.00 LCF/LLD 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 0.00 0.00 5.00 SNF-Based CMHC 0.00 0.00 6.00 6.00 6.10 SNF-Based CORF 0.00 0.00 6. 10 7.00 HOSPI CE 0.00 0.00 7.00 Total (Sum of lines 1-7) 274 73.77 0.00 8.00

8.00

				Ť	0 12/31/2021	Date/Time Prep 5/19/2022 1:2	
		Amount	Reclass, of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6		Salary in col.	col . 4)	
				ĺ	3	Í	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	4, 329, 098	0	4, 329, 098	153, 437. 00	28. 21	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)	4, 329, 098	0	4, 329, 098	153, 437. 00	28. 21	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	4, 329, 098	0	4, 329, 098	153, 437. 00	28. 21	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
	Contract Labor: Patient Related & Mgmt	2, 107, 677	0	2, 107, 677			14.00
	Contract Labor: Physician services-Part A	27, 364	l .	,			
16. 00	Home office salaries & wage related costs	485, 380	0	485, 380	9, 062. 00	53. 56	16. 00
	WAGE-RELATED COSTS						
	Wage-related costs core (See Part IV)	1, 013, 699	0	1, 013, 699			17. 00
	Wage-related costs other (See Part IV)	0	0	0			18. 00
	Wage related costs (excluded units)	0	0	0			19. 00
	Physician Part A - WRC	0	0	0			20.00
	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see	1, 013, 699	0	1, 013, 699			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION TROY HILLS CENTER

				Т	o 12/31/2021	Date/Time Pre 5/19/2022 1: 2	
		Amount	Reclass. of	Adj usted	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 III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1. 00
2.00	Administrative & General	434, 697	0	434, 697	14, 292. 00	30. 42	2. 00
3.00	Plant Operation, Maintenance & Repairs	107, 531	0	107, 531	4, 095. 00	26. 26	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	369, 781	-33, 863	335, 918	6, 285. 00	53. 45	7. 00
8.00	Central Services and Supply	0	4, 959	4, 959	346.00	14. 33	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	28, 904	28, 904	1, 677. 00	17. 24	10.00
11. 00	Soci al Servi ce	124, 085	0	124, 085	4, 117. 00	30. 14	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	128, 069	0	128, 069	6, 525. 00	19. 63	13.00
14.00	Total (sum lines 1 thru 13)	1, 164, 163	0	1, 164, 163	37, 337. 00	31. 18	14.00

SNF WAGE RELATED COSTS Provider No.: 315138 Period: From 01/01/2021 Worksheet S-3 From 01/01/2021 To 12/31/2021 Part IV Date/Time Prepared: 5/19/2022 1: 27 pm	Health Financial Systems	TROY HILLS CENTER	In Lie	u of Form CMS-2540-10
	SNF WAGE RELATED COSTS	Provi der No.: 315138	From 01/01/2021	Part IV

PART I V - WAGE RELATED COSTS 1.00			То	12/31/2021	Date/Time Pre 5/19/2022 1:2	
PART I V - WAGE RELATED COSTS Part A - Core List					•	
PART I V - WAGE RELATED COSTS Part A - Core List						
Part A - Core List RETIREMENT COST A continuation Retirement Cost Retirement Cost Retirement Cost Retirement Cost Retirement Cost Retirement Cost Retirement Retail to Retail Retirement Retail to Retail Retirement Retail to Retail Reported Retail Repail Retail Retail Retail Retail Reported Retail Reported Retail Reported Retail Reported Retail Reported Retail Repail Reported Retail Reported Retail Reported Retail Reported Retail Reported Retail Reported Retail Retail Reported Retail Retail Reported Retail Reported Retail Retail Reported Retail Retail Reported Retail Retail Reported Retail Retail Retail Retail Retail Reported Retail R						
RETIREMENT COST		PART IV - WAGE RELATED COSTS				
A01K Employer Contributions		Part A - Core List				1
Tax Shel tered Annul ty (TSA) Employer Contribution 0 2.00 0.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00		RETI REMENT COST				1
0.00 0ualified and Non-Qualified Pension Plan Cost 0 3. 00 0 0 0 0 0 0 0 0 0	1.00	401K Employer Contributions			47, 477	1.00
0.00 0ualified and Non-Qualified Pension Plan Cost 0 3. 00 0 0 0 0 0 0 0 0 0	2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration Fees	3.00				0	3.00
AUTIK/TSA Plan Administration fees 0 0 0 0 0 0 0 0 0	4.00	Prior Year Pension Service Cost			0	4.00
AUTIK/TSA Plan Administration fees 0 0 0 0 0 0 0 0 0		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
Employee Managed Care Program Administration Fees	5.00				0	5.00
Employee Managed Care Program Administration Fees	6.00	Legal /Accounting/Management Fees-Pension Plan			0	6, 00
HEÂLTH AND INSURANCE COST Heal th Insurance (Purchased or Self Funded)	7. 00				0	7. 00
Health Insurance (Purchased or Self Funded) 460,922 8.00 Prescription Drug Plan 0 9.00 Prescription Drug Plan 0 10.00 Dental, Hearing and Vision Plan 0 11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 Life Insurance (If employee is owner or beneficiary) 0 12.00 Accident Insurance (If employee is owner or beneficiary) 0 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 Ung-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (1		
Prescription Drug Plan	8.00				460, 922	8.00
10.00 Dental, Hearing and Vision Plan	9. 00					1
11. 00 Life Insurance (If employee is owner or beneficiary)	10.00				0	
12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 141,964 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion 320,346 17.00 17.00 FICA-Employers Portion Only 320,346 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 0 19.00 20.00 State or Federal Unemployment Taxes 42,989 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00 Part B - Other than Core Related Cost 1.00 1.00 Part B - Other than Core Related Cost 1.00 1.00 Part B - Other than Core Related Cost 1.00 1.00 14.00 1.00 1.00 1.00 1.00 15.00 1.00 1.00 1.00 16.00 1.00 1.00 1.00 17.00 1.00 1.00 1.00 18.00 1.00 1.00 18.00 1.00 1.00 18.00 1.00 1.00 19.00 1.00 1					0	
13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 13.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.					-	
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 14. 00 14. 00 15. 00 Workers' Compensation Insurance 141,964 15. 00 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16. 00					-	
15. 00 Workers' Compensation Insurance 141, 964 15. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16. 00					-	
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES T. 0.0	15. 00				141 964	
Non cumulative portion TAXES TAXES TAXES TAXES TO FI CA-Employers Portion Only 320, 346 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00	16. 00		dinary accrual required by	FASB 106		
TAXES			arriary assidar required by	17105 1001	ŭ	10.00
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 42,989 20.00 20				1		1
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 42,989 20.00 20	17. 00	FICA-Employers Portion Only			320, 346	17.00
19.00 Unemployment Insurance 19.00 State or Federal Unemployment Taxes 42,989 20.00					•	
20.00 State or Federal Unemployment Taxes 42,989 20.00						
OTHER					42. 989	
21.00 Executive Deferred Compensation 0 21.00				1	.=,	1
22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,013,698 24.00 Amount Reported 1.00 Part B - Other than Core Related Cost	21. 00				0	21.00
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00 Part B - Other than Core Related Cost					-	
24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,013,698 24.00 Amount Reported 1.00					0	
Amount Reported 1.00					1, 013, 698	
Reported 1.00 Part B - Other than Core Related Cost						
Part B - Other than Core Related Cost						
		Part B - Other than Core Related Cost				
	25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00

					o 12/31/2021	Date/Time Prep 5/19/2022 1:2	
	Occupational Category	Amount	Fri nge	Adj usted	Paid Hours	Average Hourly	
		Reported	Benefits	Salaries (col.	Related to	Wage (col. 3 ÷	
				1 + col . 2)	Salary in col.	col . 4)	
					3		
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations	,			1		
1. 00	Registered Nurses (RNs)	1, 401, 871	203, 730				1. 00
2.00	Licensed Practical Nurses (LPNs)	459, 254	106, 595				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 303, 809	530, 378	1, 834, 187	69, 460. 00	26. 41	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 164, 934	840, 703	4, 005, 637			4. 00
5.00	Physical Therapists	0	0	C	0. 00		5. 00
6.00	Physical Therapy Assistants	0	0) c	0.00		6. 00
7. 00	Physi cal Therapy Ai des	0	0) c	0.00		7. 00
8.00	Occupational Therapists	0	0	0	0.00		8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00		9. 00
10. 00	Occupational Therapy Aides	0	0) C	0.00		10.00
11. 00	Speech Therapists	0	0	0	0.00	0. 00	11. 00
12. 00	Respi ratory Therapi sts	0	0	C	0.00	0. 00	12.00
13.00	Other Medical Staff	0	0	C	0.00	0. 00	13.00
	Contract Labor						
	Nursing Occupations						
	Registered Nurses (RNs)	570		570			
15. 00	` '	167, 562		167, 562			15.00
16. 00		96, 968		96, 968	1, 979. 23	48. 99	16. 00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	265, 100		265, 100			
18. 00	Physi cal Therapists	159, 744		159, 744	·		18. 00
19. 00	Physical Therapy Assistants	101, 703		101, 703			19. 00
20. 00	Physi cal Therapy Aides	0		C			20.00
21. 00	Occupational Therapists	205, 128		205, 128			21. 00
22. 00	Occupational Therapy Assistants	5, 158		5, 158			
23. 00		0		0			23. 00
24.00		124, 155		124, 155			
25. 00	Respi ratory Therapi sts	1, 667		1, 667			
26. 00	Other Medical Staff	27, 364		27, 364	322.00	84. 98	26. 00

From 01/01/2021 12/31/2021 Date/Time Prepared: 5/19/2022 1:27 pm Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE2 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC2 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB2 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 SE3 53.00 53.00 54.00 SE2 54.00 55.00 SE1 55.00 SSC 56.00 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 PE1 68.00 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00

75.00

PA₂

75. 00

Health Financial Systems	TROY HILLS CEN	ITER		In Lie	In Lieu of Form CMS-2540-10		
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315138	Peri od:	Worksheet S-	7	
				From 01/01/2021 To 12/31/2021	Date/Time Pr 5/19/2022 1:		
				Group	Days		
				1. 00	2. 00		
76. 00				PA1		76. 00	
99. 00				AAA		99. 00	
100. 00 TOTAL						100.00	
			Expenses	Percentage	Y/N		
			1.00	2. 00	3. 00		
A notice published in the Federal Register Volume 68, No. 149 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 Staffing						101. 00	
102.00 Recrui tment						102. 00	
103.00 Retention of employees						103. 00	
104. 00 Trai ni ng						104. 00	
105.00 OTHER (SPECIFY)						105. 00	
106.00 Total SNF revenue (Worksheet G-2, Part I, Iii	ne 1, column 3)					106. 00	

	Financial Systems	TROY HILLS (CENTER		In Lie	u of Form CMS-	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2021 Fo 12/31/2021	Date/Time Pre	pared:
						5/19/2022 1: 2	7 pm
	Cost Center Description	Sal ari es	Other		Reclassi fi cati	Reclassified	
				+ col . 2)	ons Increase/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col . 4)	
					A-6)	,	
		1.00	2.00	3. 00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		4 000 400	4 000 404		4 000 400	1 4 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		1, 993, 488	1, 993, 488	1	1, 993, 488	1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 018, 037		1	1, 018, 037	3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	434, 697	2, 161, 840			2, 596, 537	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	107, 531	475, 412	582, 943	0	582, 943	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	214, 605			214, 605	6. 00
7.00	00700 HOUSEKEEPI NG	0	260, 001	260, 001		260, 001	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	369, 781	860, 090 69, 379			860, 090 405, 297	1
10. 00	01000 CENTRAL SERVICES & SUPPLY	304, 781	35, 844				1
11. 00	01100 PHARMACY	o	0	(0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	(28, 904	28, 904	12. 00
13.00	01300 SOCIAL SERVICE	124, 085	25, 023	149, 108	0	149, 108	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(0	0	14.00
15. 00	O1500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	128, 069	21, 708	149, 777	7 0	149, 777	15. 00
30. 00	03000 SKILLED NURSING FACILITY	3, 164, 935	441, 988	3, 606, 923	3 0	3, 606, 923	30.00
31. 00	03100 NURSING FACILITY	0, 101, 700	0	0,000,720	ol ol	0,000,720	31.00
32.00	03200 CF/IID	0	0	(o	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	(0	0	33. 00
40.00	ANCILLARY SERVICE COST CENTERS		40.400	10.40		10.400	40.00
40.00	04000 RADI OLOGY 04100 LABORATORY	0	12, 199 68, 634			12, 199 68, 634	1
42. 00	04200 I NTRAVENOUS THERAPY		29, 434			29, 434	1
	04300 OXYGEN (INHALATION) THERAPY	o	20, 856			20, 856	1
44.00	04400 PHYSI CAL THERAPY	0	234, 402	234, 402	0	234, 402	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	212, 426			212, 426	1
46. 00	04600 SPEECH PATHOLOGY	0	150, 522	150, 522	0	150, 522	1
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		179, 213	179, 213	3 0	179, 213	ł
50.00		0	0	. (o	0	ı
51. 00	05100 SUPPORT SURFACES	0	36, 176	36, 176	6 0	36, 176	
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0	0	52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	O	0	· · · · · · · · · · · · · · · · · · ·	ol o	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0			0	
62. 00	06200 FQHC		J	,			62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0		0	٥	70.00
	07100 AMBULANCE	0	0			0	71. 00 72. 00
	07300 CMHC	0	0			0	73.00
	07400 OTHER REIMBURSABLE COST	0	0	(0	0	1
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0	(0	0	80.00
	08100 I NTEREST EXPENSE		0			0	
	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	0			0	
84. 00	I I		0			0	84. 00
89. 00		4, 329, 098	8, 521, 277	12, 850, 375	0	12, 850, 375	
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0		90.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	5, 783	5, 783		5, 783 0	91. 00 92. 00
	09300 NONPALD WORKERS		0			0	1
94.00	09400 PATIENTS LAUNDRY	o o	0		ol ől	0	ı
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	(이	0	95. 00
100.00	TOTAL	4, 329, 098	8, 527, 060	12, 856, 158	3 O	12, 856, 158	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

				To 12/31/2021	Date/Time Prepared: 5/19/2022 1:27 pm
	Cost Center Description	Adjustments to	Net Expenses		37 177 2022 1. 27 pili
			For Allocation		
		Wkst A-8)	(col. 5 +- col. 6)		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	1, 993, 488	•	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	0	•	2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	-42, 251 -920, 480			3.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	1 720, 400	582, 943	•	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	214, 605		6. 00
7.00	00700 HOUSEKEEPI NG	0	260, 001		7. 00
8. 00	00800 DI ETARY	0	860, 090	•	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	405, 297	•	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	40, 803 0		10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY		28, 904	•	12. 00
13. 00	01300 SOCIAL SERVICE	0	149, 108	•	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		14. 00
15. 00	01500 ACTIVITIES	-16, 943	132, 834		15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	655	2 (07 570	I	20.00
30. 00 31. 00	03100 NURSING FACILITY	000		•	30. 00 31. 00
32. 00	03200 CF/IID	0	Ö		32. 00
33.00	03300 OTHER LONG TERM CARE	0	0		33.00
	ANCILLARY SERVICE COST CENTERS				
40.00	04000 RADI OLOGY	0	,		40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	68, 634 29, 434		41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		29, 434		43. 00
44. 00	04400 PHYSI CAL THERAPY	0	234, 402		44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	212, 426		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	150, 522		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	·	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0 179, 213	l .	48. 00 49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	179, 213	I .	50.00
51. 00	05100 SUPPORT SURFACES	0	36, 176		51. 00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		52. 00
	OUTPATIENT SERVICE COST CENTERS	T	T		
60.00	06000 CLINIC	0			60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		63. 00
	OTHER REIMBURSABLE COST CENTERS				
70. 00	07000 HOME HEALTH AGENCY COST	0	_		70. 00
71.00	07100 AMBULANCE	0	0		71.00
72.00	07200 CORF 07300 CMHC	0	0		72. 00 73. 00
	07400 OTHER REIMBURSABLE COST				74.00
7 1. 00	SPECIAL PURPOSE COST CENTERS				7 1. 66
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80. 00
81. 00	08100 I NTEREST EXPENSE	0	0	l .	81.00
82.00	08200 UTI LI ZATI ON REVI EW	0	0		82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0		83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-979, 019	11, 871, 356		89. 00
	NONREI MBURSABLE COST CENTERS	, 3	, 21 1, 300		31.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	_	•	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	5, 783	l .	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0		92. 00 93. 00
	09400 PATIENTS LAUNDRY	0	0		94.00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	Ö		95. 00
100.00	D TOTAL	-979, 019	11, 877, 139		100. 00

Health Financial Systems	TROY HILLS CENTER			In Lieu of Form CMS-2540-10		
RECLASSI FI CATI ONS	P	Provi der No.: 315138		Period: From 01/01/2021	Worksheet A-6	
				To 12/31/2021	Date/Time Pre 5/19/2022 1:2	pared: 7 pm
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2. 00		3. 00	4. 00	5. 00	
(1) A - DEFAULT						
1. 00	CENTRAL SERVICES & SU	UPPLY	10.0	0 4, 959	0	1. 00
2. 00	MEDICAL RECORDS & LIE	BRARY	12. 0	0 28, 904	0	2. 00
TOTALS						
100.00	Total Reclassification	ons (Sum		33, 863	0	100. 00
	of columns 4 and 5 mu	ust				
	equal sum of columns	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	Provi der No.: 315138			Peri od: From 01/01/2021	Worksheet A-6	,
			To 12/31/2021	Date/Time Pre 5/19/2022 1:2	pared: 7 pm	
	Decreases					
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
(1) A - DEFAULT						
1. 00	NURSING ADMINISTRATION		9.0	0 4, 959	0	1.00
2. 00	NURSING ADMINISTRAT	ION	9.0	0 28, 904	0	2. 00
TOTALS						
100. 00				33, 863	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 TROY HILLS CENTER

				To	12/31/2021	Date/Time Prep 5/19/2022 1:27	
	·			Acqui si ti ons			
	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	\$					
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	0	0	0	0	0	3. 00
4.00	Building Improvements	1, 477, 407	22, 433		22, 433	0	4. 00
5.00	Fi xed Equi pment	123, 580	37, 802	0	37, 802	0	5. 00
6.00	Movable Equipment	749, 985	0	0	0	1, 922	6. 00
7.00	Subtotal (sum of lines 1-6)	2, 485, 369	60, 235	0	60, 235	1, 922	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	2, 485, 369	60, 235	0	60, 235	1, 922	9. 00
	Description	Ending Balance	Fully				
			Depreci ated				
			Assets				
	T	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	0	0				3. 00
4.00	Building Improvements	1, 499, 840	0				4. 00
5.00	Fixed Equipment	161, 382	0				5. 00
6.00	Movable Equipment	748, 063	0				6. 00
7.00	Subtotal (sum of lines 1-6)	2, 543, 682	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	2, 543, 682	0			ļ	9. 00

Provi der No.: 315138

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

Description (1) Cap Basis For Admount Cost Center					10 12/31/2021	5/19/2022 1:2	
Description (1) 2 Basis For Adjustment Cost Center Line No.					Expense Classification on		/ piii
Description (1)							
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00					TOTTO WITCH THE AMOUNT 13	to be Aujusteu	
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00							
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00							
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00							
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00		Description (1)	(2) Pacie For	Amount	Cost Contor	Line No	
1.00 Investment Income on restricted funds (Chapter 2) 0 0.00 1.00		Description (1)		AIIIOUITE	Cost center	LITTE NO.	
1.00 Investment income on restricted funds (chapter 2) 0.00 1.00				2.00	2 00	4.00	
Chapter 2)	1 00	Investment income on rectricted funds	1.00				1 00
2.00 Trade, quantity, and time discounts (chapter 8) 0 0.00 2.00 3.00 0.00 3.00 0.00 0.00 3.00 0.	1.00			0	1	0.00	1.00
8)	2 00					0.00	2 00
Refunds and rebates of expenses (chapter 8)	2.00			0	1	0.00	2.00
A. 00 Rental of provider space by suppliers (2 00					0.00	2 00
(chapter s) 1.00 Chapter s) 1.00 Chapter 21) 1.00 Chapter 24) 1.00 Chapter				1			
Telephone services (pay stations excluded)	4.00	1 3 11		0)	0.00	4.00
Chapter 21)				_			
A -16, 943 ACTIVITIES 15, 00 6. 00	5.00			0)	0.00	5.00
7.00							
Remuneration applicable to provider-based physician adjustment P. 00			A	-16, 943	ACTI VI TI ES		
physician adjustment	7. 00			0		0.00	7. 00
9.00 Home office cost (chapter 21) 0 0.00	8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
10.00 Sale of scrap, waste, etc. (chapter 23) 0 0 0 0 0 0 0 0 0		physician adjustment					
11.00 Nonal lowable costs related to certain Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 12.00 13.00 14.00 14.00 15.00 16.00 14.00 15.00 16.00	9.00	Home office cost (chapter 21)		0		0.00	9. 00
Capital expenditures (chapter 24) Adjustment resulting from transactions with related organizations (chapter 10) 12.00 13.00 Laundry and linen service 0 0.00 13.00 15.00	10.00	Sale of scrap, waste, etc. (chapter 23)		0)	0.00	10. 00
12.00	11.00	Nonallowable costs related to certain		0)	0.00	11. 00
related organizations (chapter 10) 13.00 Laundry and linen service 0 0.00 13.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 15.00 16.00 15.00 16.00		Capital expenditures (chapter 24)					
13.00 Laundry and linen service 0 0.00 13.00 14.00 Revenue - Employee meal s 0 0.00 14.00 15.00 0.00 14.00 15.00 0.00 14.00 15.00 0.00 15.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 15.00 0.00 0.00 15.00 0.00	12.00	Adjustment resulting from transactions with	A-8-1	-1, 216			12. 00
14. 00 Revenue - Employee meals 0 0.00 14. 00 15. 00 15. 00 16. 00 15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 17. 00 17. 00 18. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00		related organizations (chapter 10)					
15.00 Cost of meals - Guests 0 0 15.00 16.00 16.00 Sale of medical supplies to other than patients 0 0 16.00 16.00 16.00 16.00 17.00 18.00 Sale of drugs to other than patients 0 0 0.00 17.00 18.00 18.00 Sale of medical records and abstracts 0 0 0.00 18.00 19.00 19.00 19.00 10.00 10.00 19.00 10.0	13.00	Laundry and Linen service		0)	0.00	13. 00
15.00 Cost of meals - Guests 0 0 15.00 16.00 16.00 Sale of medical supplies to other than patients 0 0 16.00 16.00 16.00 16.00 17.00 18.00 Sale of drugs to other than patients 0 0 0.00 17.00 18.00 18.00 Sale of medical records and abstracts 0 0 0.00 18.00 19.00 19.00 19.00 10.00 10.00 19.00 10.0	14.00	Revenue - Employee meals		0	ol .	0.00	14.00
16.00 Sale of medical supplies to other than patients 0 16.00 17.00 18.00 17.00 18.00 19.00	15.00			l o		0.00	15. 00
Datients				0		0.00	16, 00
17. 00 Sale of drugs to other than patients 0 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 10. 00 19. 00 10.				_			
18. 00 Sale of medical records and abstracts 0 19. 00 18. 00 19	17.00			l o		0.00	17. 00
19.00 Vending machines 0 0.00 19.00 20.00 10.00 10.00 20.00				0			
20.00 Income from imposition of interest, finance or penal ty charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 0 UTILIZATION REVIEW 82.00 22.00					1		
or penal ty charges (chapter 21) 21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) 23.00 Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 MISC INCOME 25.00 MISC INCOME 25.01 UNALLOWED A & G 25.01 UNALLOWED A & G 26.02 WORKERS COMPENSATION A -42, 251 EMPLOYEE BENEFITS A 655 SKILLED NURSING FACILITY A 0.00 25.03 100.00 Total (sum of lines 1 through 99) (Transfer) O UTILIZATION REVIEW 82.00 21.00 0 UTILIZATION REVIEW 82.00 22.00 0 CAP REL COSTS - BLDGS & 1.00 23.00 FIXTURES 0 CAP REL COSTS - MOVABLE EQUIPMENT 2 -77, 468 ADMINISTRATIVE & GENERAL 4 -90 25.01 4 -42, 251 EMPLOYEE BENEFITS 3 .00 25.03				· -			
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 0	20.00			٥	<u>'</u>	0.00	20.00
and borrowings to repay Medicare overpayments 22. 00 Utilization reviewphysicians' compensation (chapter 21) 23. 00 Depreciationbuildings and fixtures 24. 00 Depreciationmovable equipment 25. 00 MISC INCOME 25. 01 UNALLOWED A & G 25. 01 UNALLOWED A & G 26. 02 WORKERS COMPENSATION 27. 03 HEP/SALINE A 055 SKILLED NURSING FACILITY A 05. 00 OUTILIZATION REVIEW 82. 00 22. 00 24. 00 24. 00 CAP REL COSTS - BLDGS & 1. 00 23. 00 24. 00 25. 00 EQUIPMENT 26. 00 A -901, 796 ADMINISTRATIVE & GENERAL 27. 00 ADMINISTRATIVE & GENERAL 28. 00 25. 00 29. 00 CAP REL COSTS - MOVABLE 29. 00 A -901, 796 ADMINISTRATIVE & GENERAL 29. 00 CAP REL COSTS - MOVABLE 20. 00 24. 00 25. 00 EQUIPMENT 25. 01 UNALLOWED A & G 25. 02 WORKERS COMPENSATION A -42, 251 EMPLOYEE BENEFITS A 655 SKILLED NURSING FACILITY A 655 SKILLED NURSING FACILITY 30. 00 25. 03 100. 00	21 00			1		0.00	21 00
22.00 Overpayments Utilization reviewphysicians' compensation (chapter 21) Outilization reviewphysicians' compensation (chapter 21) Ocap Rel Costs - BLDGS & 1.00 23.00	21.00			٥	<u>'</u>	0.00	21.00
22. 00 Utilization reviewphysicians' compensation (chapter 21) 23. 00 Depreciationbuildings and fixtures 24. 00 Depreciationmovable equipment 25. 00 MISC INCOME 25. 01 UNALLOWED A & G 26. 02 WORKERS COMPENSATION 27. 02 WORKERS COMPENSATION 28. 00 UTILIZATION REVIEW 88. 00 22. 00 29. 00 CAP REL COSTS - BLDGS & FIXTURES 0 CAP REL COSTS - MOVABLE EQUIPMENT 20. 00 24. 00 24. 00 25. 00 25. 01 UNALLOWED A & G 26. 02 WORKERS COMPENSATION 27. 02 WORKERS COMPENSATION 28. 00 25. 00 29. 00 20. 00 20		. ,					
Chapter 21) Compensation buildings and fixtures Ocap Rel Costs - Blds & 1.00 23.00	22 00			0	 	92.00	22.00
23. 00 Depreciationbuildings and fixtures 24. 00 Depreciationmovable equipment 25. 00 MISC INCOME 25. 01 UNALLOWED A & G 25. 02 WORKERS COMPENSATION 26. 03 HEP/SALINE A 27. 00 CAP REL COSTS - BLDGS & FIXTURES OCAP REL COSTS - MOVABLE EQUIPMENT 29. 00 24. 00 24. 00 25. 00 A 25. 01 A 26. 02 A 27. 048 ADMINISTRATIVE & GENERAL 4. 00 25. 00 A 26. 02 4. 00 25. 00 A 27. 02 4. 00 25. 00 A 28. 02 4. 00 25. 00 A 29. 01, 796 ADMINISTRATIVE & GENERAL 4. 00 25. 01 A 29. 02 40 0 40	22.00			0	OTTETZATION KEVIEW	62.00	22.00
FIXTURES	22 00	1 ,			CAD DEL COSTS DIDOS	1 00	22 00
24. 00 Depreciationmovable equipment 0 CAP REL COSTS - MOVABLE EQUI PMENT 25. 00 MI SC I NCOME 25. 01 UNALLOWED A & G 25. 01 WORKERS COMPENSATION 26. 03 HEP/SALINE 27. 00 CAP REL COSTS - MOVABLE EQUI PMENT 27. 00 PMENT 28. 00 PMENT 29. 0	23.00	beprecrationburidings and fixtures		0		1.00	23.00
EQUI PMENT 25.00 MI SC INCOME B -17, 468 ADMI NI STRATI VE & GENERAL 4.00 25.00	24.00	Dennesiation mayahla agui nmant				2.00	24.00
25. 00 MISC INCOME 25. 01 UNALLOWED A & G 25. 02 WORKERS COMPENSATION 25. 03 HEP/SALINE 100. 00 Total (sum of lines 1 through 99) (Transfer B -17, 468 ADMINISTRATIVE & GENERAL 4. 00 25. 00 A -901, 796 ADMINISTRATIVE & GENERAL 4. 00 25. 01 A -42, 251 EMPLOYEE BENEFITS 3. 00 25. 02 A 655 SKILLED NURSING FACILITY 30. 00 25. 03	24.00	Depreciationmovabre equipment		0		2.00	24.00
25. 01 UNALLOWED A & G 25. 02 WORKERS COMPENSATION 25. 03 HEP/SALINE 100. 00 Total (sum of lines 1 through 99) (Transfer A -901, 796 ADMINISTRATIVE & GENERAL 4. 00 25. 01 A -42, 251 EMPLOYEE BENEFITS 3. 00 25. 02 A 655 SKILLED NURSING FACILITY 30. 00 25. 03	25 00	MLCC INCOME		17 4/0		4 00	25 00
25. 02 WORKERS COMPENSATION A -42, 251 EMPLOYEE BENEFITS 3. 00 25. 02 25. 03 HEP/SALINE A 655 SKILLED NURSING FACILITY 30. 00 25. 03 100. 00 Total (sum of lines 1 through 99) (Transfer -979, 019							
25. 03 HEP/SALINE A 655 SKILLED NURSING FACILITY 30. 00 25. 03 100. 00 Total (sum of lines 1 through 99) (Transfer							
100.00 Total (sum of lines 1 through 99) (Transfer -979,019							
		1	A			30.00	1
to Worksheet A, col. 6, line 100)	100.00	, , ,		-979, 019	<u>'</u>		100. 00
		to Worksheet A, col. 6, line 100)	1	l		l	I

⁽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

UITICE	. 00313			Ť	o 12/31/2021	Date/Time Pr 5/19/2022 1:	
		Li ne No.	Cost	Center	Expense		
		1. 00	2.	00	3. (00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR	
1.00			ADMI NI STRATI VE		HOME OFFICE A&G		1. 00
2.00			ADMI NI STRATI VE		HOME OFFICE CAP	PITAL	2.00
3.00			PHYSICAL THERA		PT		3.00
4.00			OCCUPATI ONAL T		OT		4.00
5.00			SPEECH PATHOLO		ST		5. 00
6.00			SKILLED NURSIN		NURSING PURCHAS	SED SERVICES	6. 00
7.00			OXYGEN (INHALA	,	RT		7. 00
8.00			ADMI NI STRATI VE	& GENERAL	MEDICAL DIRECTO)R	8. 00
9.00		0. 00					9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column						10. 00
	6, line 100 to Worksheet A-8, column 3, line						
	12.						
		Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minus			
		Cost	Wkst. A, col.	col . 5)			
		4.00	5, 00	6, 00	-		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR				D ODCANI ZATIONS	ΛD	
	CLAIMED HOME OFFICE COSTS:	LLD AS A RESULT	UI TRANSACTIO	NS WITH KLLAIL	D ORGANIZATIONS	UK	
1.00	CEATIMED HOME OFFICE COSTS.	631, 379	671, 458	-40, 079			1.00
2.00		38, 863		38, 863			2. 00
3.00		223, 940	l e				3.00
4. 00		212, 227					4. 00
5. 00		150, 522					5. 00
6.00		265, 100					6.00
7. 00		14, 779					7. 00
8.00		27, 364					8. 00
9. 00		2.,001	2.,001	l			9. 00
10.00	TOTALS (sum of lines 1-9). Transfer column	1, 564, 174	1, 565, 390	-1, 216			10.00
. 5. 50	6, line 100 to Worksheet A-8, column 3, line 12.	., 55., 171	., 555, 676	.,210			
	12.		I	I	I		I

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
spe	eci fy:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in rel ated organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Related Organization(s) and/or Home Office						
Name	Percentage of	Type of Business				
11	Ownershi p	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
4.00	5.00	6. 00	1			

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

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

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

1.00		GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2. 00		GRS	100.00	PT OT ST	2.00
3. 00		GSS	100.00	NURSING PURCHASED SERVICES	3.00
4.00		RHS	100.00	RT	4.00
5.00		GPS	100.00	MEDICAL DIRECTOR	5. 00
6. 00			0.00		6.00
7. 00			0.00		7.00
8. 00			0.00		8.00
9. 00			0.00		9.00
10. 00			0.00		10.00
100.00 G. Other (fin	ancial or non-financial)		0.00		100. 00
speci fy:					

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

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			To	12/31/2021	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/19/2022 1: 2	/ pm
Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	Allocation	FIXIURES	EQUIPMENT	DEINEFITS		
	(from Wkst A					
	col. 7)					
CENEDAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	3A	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES	1, 993, 488	1, 993, 488				1. 00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	1, 1, 2, 1, 2, 1, 2, 2	0			2. 00
3.00 00300 EMPLOYEE BENEFITS	975, 786	31, 008	0	1, 006, 794		3. 00
4.00 OO400 ADMINISTRATIVE & GENERAL	1, 676, 057	396, 172	0	101, 095	2, 173, 324	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	582, 943	79, 428	0	25, 008	687, 379	5. 00 6. 00
6.00 00600 LAUNDRY & LI NEN SERVI CE 7.00 00700 HOUSEKEEPI NG	214, 605 260, 001	33, 211 17, 412	0	0	247, 816 277, 413	7. 00
8. 00 00800 DI ETARY	860, 090	230, 814	0	ő	1, 090, 904	8. 00
9.00 00900 NURSING ADMINISTRATION	405, 297	21, 765	0	78, 122	505, 184	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	40, 803	10, 264	0	1, 153	52, 220	10.00
11. 00 01100 PHARMACY	0	0 401	0	(722	0	11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 13. 00 01300 SOCI AL SERVI CE	28, 904 149, 108	8, 491 6, 986	0	6, 722 28, 858	44, 117 184, 952	12. 00 13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0, 700	0	20, 030	0	14. 00
15. 00 01500 ACTIVITIES	132, 834	o	0	29, 784	162, 618	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 O3000 SKILLED NURSING FACILITY 31.00 O3100 NURSING FACILITY	3, 607, 578	1, 078, 778	0	736, 052	5, 422, 408 0	30. 00 31. 00
32.00 03200 CF/IID	0	0	0	0	0	32.00
33. 00 03300 OTHER LONG TERM CARE	Ö	o	0	ő	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	12, 199	0	0	0	12, 199	40.00
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY	68, 634 29, 434	0	0	0	68, 634 29, 434	41. 00 42. 00
43. 00 04300 0XYGEN (INHALATION) THERAPY	20, 856	0	0	0	20, 856	43. 00
44. 00 04400 PHYSI CAL THERAPY	234, 402	26, 440	0	0	260, 842	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	212, 426	36, 490	0	0	248, 916	45. 00
46. 00 04600 SPEECH PATHOLOGY	150, 522	0	0	0	150, 522	46. 00
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 15, 047	0	0	0 15, 047	47. 00 48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	179, 213	1, 182	0	0	180, 395	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	ō	0	50. 00
51. 00 05100 SUPPORT SURFACES	36, 176	o	0	0	36, 176	51.00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
OUTPATIENT SERVICE COST CENTERS 60. 00 06000 CLINIC	O	ol	0	0	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC	0	o	0	0	0	61. 00
62. 00 06200 FQHC						62.00
63.00 O6300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
OTHER REIMBURSABLE COST CENTERS		ما	0	ما		70.00
70. 00 07000 HOME HEALTH AGENCY COST 71. 00 07100 AMBULANCE	0	0	0	0	0	70. 00 71. 00
72. 00 07200 CORF	o	ő	0	o	0	72. 00
73. 00 07300 CMHC	0	ō	0	O	0	73. 00
74. 00 07400 OTHER REIMBURSABLE COST	0	o	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	О	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)	11, 871, 356	1, 993, 488	0	1, 006, 794	11, 871, 356	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	٥	0	O	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	5, 783	o	0	0	5, 783	91. 00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	O	0	0	0	92. 00
93. 00 09300 NONPAI D WORKERS	0	o	0	O	0	93. 00
94. 00 09400 PATI ENTS LAUNDRY	0	0	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	99.00
100. 00 TOTAL	11, 877, 139	1, 993, 488	0	1, 006, 794	11, 877, 139	

			T	o 12/31/2021	Date/Time Pre 5/19/2022 1:2	
Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7 piii
	& GENERAL	OPERATI ON,	LINEN SERVICE			
		MAINT. &				
	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 O0100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00 00300 EMPLOYEE BENEFITS						3. 00
4. 00 00400 ADMI NI STRATI VE & GENERAL	2, 173, 324	0.44 0.00				4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE	153, 950 55, 502	841, 329 18, 792	1			5. 00 6. 00
7. 00 00700 HOUSEKEEPI NG	62, 131	9, 852		349, 396		7. 00
8. 00 00800 DI ETARY	244, 325	130, 602		56, 150	1, 521, 981	8. 00
9. 00 00900 NURSING ADMINISTRATION	113, 144	12, 315		5, 295	0	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	11, 696	5, 808	0	2, 497	0	10. 00
11. 00 01100 PHARMACY	0	0	0	0	0	11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	9, 881	4, 804	1	2, 066	0	12. 00
13. 00 01300 SOCIAL SERVICE	41, 423	3, 953	0	1, 700	0	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 15.00 01500 ACTIVITIES	0 36, 421	0	0	0	0	14. 00 15. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	30, 421		<u> </u>	U _I	0	15.00
30. 00 03000 SKI LLED NURSING FACILITY	1, 214, 434	610, 412	322, 110	262, 430	1, 521, 981	30. 00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00 03200 I CF/I I D	0	0	0	0	0	32. 00
33.00 03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS			1			
40. 00 04000 RADI OLOGY	2, 732	0	0	0	0	40.00
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY	15, 372 6, 592	0	0	0	0	41. 00 42. 00
43. 00 04300 0XYGEN (I NHALATION) THERAPY	4, 671	0	0	0	0	43. 00
44. 00 04400 PHYSI CAL THERAPY	58, 420	14, 961	0	6, 432	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	55, 749	20, 647	1	8, 877	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	33, 712	0	0	0	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 370	8, 514	1	3, 661	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	40, 402	669		288	0	49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 51. 00 05100 SUPPORT SURFACES	0 8, 102	0	0	0	0	50. 00 51. 00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0, 102	0		0	0	52. 00
OUTPATIENT SERVICE COST CENTERS	91			<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 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	ol	0	0	0	0	70. 00
71. 00 07100 AMBULANCE	0	0	0	0	0	71.00
72. 00 07200 CORF	o	0	ő	0	0	72.00
73. 00 07300 CMHC	O	0	0	0	0	73. 00
74.00 07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
SPECIAL PURPOSE COST CENTERS						
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100 INTEREST EXPENSE 82.00 08200 UTI LI ZATI ON REVI EW						81.00
82.00 08200 UTI LI ZATI ON REVI EW 83.00 08300 HOSPI CE		0		0	0	82. 00 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)	2, 172, 029	841, 329	322, 110	349, 396	1, 521, 981	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	1, 295	0	0	0	0	91. 00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93. 00 09300 NONPALD WORKERS 94. 00 09400 PATLENTS LAUNDRY	0	0		0	0	93. 00 94. 00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS		0	0	0	0	95.00
98. 00 Cross Foot Adjustments		0	0	0	0	98. 00
99.00 Negative Cost Centers	o	0	Ō	o	0	99. 00
100. 00 TOTAL	2, 173, 324	841, 329	322, 110	349, 396	1, 521, 981	100. 00

Provi der No.: 315138

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

					10 12/31/2021	5/19/2022 1:2	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	, piii
		9.00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00 5. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS						1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00 10. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	635, 938 0	72, 221				6. 00 7. 00 8. 00 9. 00 10. 00
11. 00	01100 PHARMACY	o	0		o		11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	o	0		0 60, 868		12.00
13.00	01300 SOCIAL SERVICE	o	0		0	232, 028	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0		0	0	14. 00
15.00	01500 ACTI VI TI ES	o	0		0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				<u>_</u>		
30.00	03000 SKILLED NURSING FACILITY	635, 938	72, 221		0 53, 995		30. 00
31. 00	03100 NURSING FACILITY	0	0	i e	0	0	31. 00
32. 00	03200 CF/IID	0	0	i e	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			ı	0 00		40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0		0 88 0 228		40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 106		42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0		0 100	0	43. 00
44. 00	04400 PHYSI CAL THERAPY		0		0 2, 089		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		0		0 2, 109		45. 00
46.00	04600 SPEECH PATHOLOGY	o	0		0 1, 530		46. 00
47. 00	04700 ELECTROCARDI OLOGY	o	0		0 0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 709	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 12		51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	52.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	l ol	0		ol o	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0		0	0	61.00
62. 00	06200 FQHC		· ·				62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	o	0		0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	_	70. 00
71. 00	07100 AMBULANCE	0	0		0	0	71. 00
72. 00	07200 CORF	0	0		0	0	72.00
73. 00 74. 00	07300 CMHC	0	0		0	0	73. 00 74. 00
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	l d	0		0 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 UTILIZATION REVIEW						82. 00
83.00	08300 HOSPI CE	0	0		0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	o	0		0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	635, 938	72, 221		0 60, 868	232, 028	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		0 0	0	92.00
93. 00 94. 00	09400 PATIENTS LAUNDRY		0			0	93. 00 94. 00
94. 00 95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		0			0	95.00
98. 00	Cross Foot Adjustments		0		٦		98.00
99. 00	Negative Cost Centers		0		o	0	99.00
100.00		635, 938	72, 221	1	0 60, 868		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					To 12/31/2021		
			OTHER GENERAL			5/19/2022 1: 2	/ pill
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	SERVI CE ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
	January 2007	14.00	15. 00	16.00	17. 00	18. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	199, 039				1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
30. 00	03000 SKILLED NURSING FACILITY	0	199, 039	10, 546, 990	6 0	10, 546, 996	30. 00
31.00	03100 NURSING FACILITY	0	ł			0	1
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	ł			0	
	ANCILLARY SERVICE COST CENTERS		-			·	
40. 00	04000 RADI OLOGY	0	0	1,		15, 019	1
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	1 0.720	1	84, 234	1
42.00	04200 TNTRAVENOUS THERAPY	0		36, 132 25, 529	1	36, 132 25, 529	1
44. 00	04400 PHYSI CAL THERAPY	0	ĺ	342, 74	1	342, 744	1
45.00	04500 OCCUPATI ONAL THERAPY	0	O	336, 298	1	336, 298	1
46.00	04600 SPEECH PATHOLOGY	0	0	185, 76	4 0	185, 764	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	30, 592	1	30, 592	1
49.00	04900 DRUGS CHARGED TO PATIENTS	0		222, 463	3	222, 463	1
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0		44, 290		0 44, 290	
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0					
02.00	OUTPATIENT SERVICE COST CENTERS			<u> </u>	٥,		02.00
60.00	06000 CLI NI C	0	C) (0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	C) (0	0	61. 00
62. 00	06200 FQHC	_	_			_	62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0) (0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		ol	0	70.00
71. 00	07100 AMBULANCE	0	l			0	1
	1	0		1	o o		
73.00	07300 CMHC	0	o		0	0	73. 00
74.00	07400 OTHER REIMBURSABLE COST	0	0) (0	0	74. 00
	SPECIAL PURPOSE COST CENTERS				1		
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						81. 00 82. 00
83. 00	08300 HOSPI CE	0	l o			0	
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	1		o o	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	199, 039	11, 870, 06	1 0	11, 870, 061	89. 00
	NONREI MBURSABLE COST CENTERS	T	Г	. [_1 _1		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	1	0	0	
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0	7, 078	0	7, 078 0	1
93. 00	09300 NONPAID WORKERS	1 0				0	1
94. 00	09400 PATIENTS LAUNDRY	0			ol ol	0	1
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0) (o o	0	95. 00
98. 00	Cross Foot Adjustments	0	_)	o o	0	
99. 00	Negative Cost Centers	0		(14.077.47	o o	11 077 120	
100.00	D TOTAL	0	199, 039	P 11, 877, 13 ⁹	9 0	11, 877, 139	1100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

							12/31/2021	Date/Time Prep 5/19/2022 1:2	
				CAPI TAL REL	_ATED COSTS			3/14/2022 1.2	/ DIII
		Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	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 EMPLOYEE BENEFITS	0	31, 008		0	31, 008	21 000	2. 00 3. 00
3. 00 4. 00		ADMINISTRATIVE & GENERAL	0	396, 172		0	31, 006 396, 172	31, 008 3, 114	4. 00
5. 00		PLANT OPERATION, MAINT. & REPAIRS	0	79, 428		0	79, 428	770	5. 00
6.00		LAUNDRY & LINEN SERVICE	0	33, 211		0	33, 211	0	6. 00
7.00		HOUSEKEEPI NG	0	17, 412		0	17, 412	0	7. 00
8. 00		DI ETARY	0	230, 814		0	230, 814	0	8. 00
9.00		NURSING ADMINISTRATION	0	21, 765		0	21, 765	2, 406	9.00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	10, 264 0	1	0	10, 264 0	36 0	10. 00 11. 00
12. 00	1	MEDICAL RECORDS & LIBRARY	0	8, 491		0	8, 491	207	12. 00
13.00	01300	SOCIAL SERVICE	0	6, 986		0	6, 986	889	13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14. 00
15. 00		ACTIVITIES	0	0	(0	0	917	15. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	O	1 070 770	Ι ,	0	1 070 770	22 440	30. 00
31. 00		NURSING FACILITY	0	1, 078, 778 0		0	1, 078, 778 0	22, 669 0	30.00
32. 00	1	ICF/IID	o	0		0	o	0	32. 00
33.00	03300	OTHER LONG TERM CARE	0	0	(0	o	0	33. 00
		LARY SERVICE COST CENTERS							
40.00		RADI OLOGY	0	0		0	0	0	40.00
41. 00 42. 00	1	LABORATORY I NTRAVENOUS THERAPY	0	0	•	0	0	0	41. 00 42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY		0		0	0	0	42.00
44. 00		PHYSI CAL THERAPY	o	26, 440		0	26, 440	0	44. 00
45.00		OCCUPATIONAL THERAPY	0	36, 490		0	36, 490	0	45. 00
46. 00		SPEECH PATHOLOGY	0	0		0	0	0	46. 00
47. 00		ELECTROCARDI OLOGY	0	0		0	0	0	47. 00
48. 00 49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	15, 047 1, 182		0	15, 047 1, 182	0	48. 00 49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	1, 102		0	1, 102	0	50.00
51. 00	1	SUPPORT SURFACES	o	0	1	0	o	0	51. 00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	0	52.00
		TIENT SERVICE COST CENTERS	T	_				_	
60.00	1	CLINIC	0	0		0	0	0	60.00
61. 00 62. 00	06200	RURAL HEALTH CLINIC	١	U	'	U	U U	U	61. 00 62. 00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0		0	63. 00
		REIMBURSABLE COST CENTERS			1				
70. 00		HOME HEALTH AGENCY COST	0	0		0	0	0	70. 00
71.00		AMBULANCE	0	0		0	0	0	
72. 00 73. 00	07200		0	0		0	0	0	, 2. 00
74.00		OTHER REIMBURSABLE COST		0		0	ol	0	
, ,, ,,		AL PURPOSE COST CENTERS	<u> </u>	<u> </u>			<u>~1</u>		, ,, ,,
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES							80. 00
81.00		I NTEREST EXPENSE							81. 00
82. 00		UTILIZATION REVIEW		0		_		0	82. 00
83. 00 84. 00		HOSPICE OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	0	83. 00 84. 00
89. 00	08400	SUBTOTALS (sum of lines 1-84)		1, 993, 488		0	1, 993, 488	31, 008	89. 00
	NONRE	IMBURSABLE COST CENTERS	-1	.,		_	.,	0.1, 0.0	
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP	0	0		0	0	0	91. 00
92.00		PHYSICIANS PRIVATE OFFICES	0	0	9	0	0	0	92.00
93. 00 94. 00	1	NONPALD WORKERS PATIENTS LAUNDRY		0		0	0	0	93. 00 94. 00
95.00	1	OTHER NONREIMBURSABLE COST CENTERS		0		0	0	0	94. 00 95. 00
98. 00		Cross Foot Adjustments		J]	-	o		98. 00
99. 00		Negative Cost Centers		0		0	О	0	99. 00
100.00)	TOTAL	0	1, 993, 488		0	1, 993, 488	31, 008	100. 00

			T	o 12/31/2021	Date/Time Pre 5/19/2022 1:2	
Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7 piii
	& GENERAL	OPERATI ON,	LINEN SERVICE			
		MAINT. &				
	4.00	REPAI RS 5. 00	6. 00	7. 00	8. 00	
GENERAL SERVI CE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
1.00 O0100 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 O0400 ADMINISTRATIVE & GENERAL	399, 286	100 400				4. 00 5. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE	28, 284 10, 197	108, 482 2, 423	1			6. 00
7. 00 00700 HOUSEKEEPI NG	11, 415	1, 270		30, 097		7. 00
8. 00 00800 DI ETARY	44, 887	16, 840	1	· ·	297, 378	8. 00
9.00 00900 NURSING ADMINISTRATION	20, 787	1, 588	0	456	0	9. 00
10. 00 01000 CENTRAL SERVI CES & SUPPLY	2, 149	749		215	0	10. 00
11. 00 01100 PHARMACY	0	0	_	0	0	11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 13. 00 01300 SOCI AL SERVI CE	1, 815	619 510		178 146	0	12. 00 13. 00
14.00 O1400 NURSING AND ALLIED HEALTH EDUCATION	7, 610	510		140	0	14.00
15. 00 01500 ACTIVITIES	6, 691	0		0	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	2, 2		_	-1		
30.00 03000 SKILLED NURSING FACILITY	223, 118	78, 708	45, 831	22, 606	297, 378	30. 00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00 03200 I CF/I I D	0	0	_	0	0	32. 00
33. 00 03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY	502	0	0	O	0	40. 00
41. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY	2, 824	0	0	-	0	40.00
42. 00 04200 I NTRAVENOUS THERAPY	1, 211	0	0	0	0	42. 00
43. 00 04300 OXYGEN (INHALATION) THERAPY	858	0	ő	o	0	43. 00
44. 00 04400 PHYSI CAL THERAPY	10, 733	1, 929	0	554	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	10, 242	2, 662	0	765	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	6, 194	0	0	0	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0 (10	1 000	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS	619 7, 423	1, 098 86		315 25	0	48. 00 49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	7,423	0		0	0	50.00
51. 00 05100 SUPPORT SURFACES	1, 489	0	ő	o	0	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
OUTPATIENT SERVICE COST CENTERS						
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 FOHC 63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	62. 00 63. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>		03.00
70. 00 07000 HOME HEALTH AGENCY COST	O	0	0	0	0	70. 00
71. 00 07100 AMBULANCE	o	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 O7400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
SPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00 08100 INTEREST EXPENSE						81. 00
82. 00 08200 UTI LI ZATI ON REVI EW						82. 00
83. 00 08300 HOSPI CE	0	0	О	0	0	83. 00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS	o	0	0	0	0	84. 00
89.00 SUBTOTALS (sum of lines 1-84)	399, 048	108, 482	45, 831	30, 097	297, 378	89. 00
NONREI MBURSABLE COST CENTERS	1 51				_	00.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 91.00 09100 BARBER AND BEAUTY SHOP	238	0	0		0	90. 00 91. 00
92. 00 09200 PHYSI CLANS PRI VATE OFFICES	238	0		0	0	91.00
93. 00 09300 NONPALD WORKERS		0	0	ol	0	93. 00
94. 00 09400 PATIENTS LAUNDRY		0	Ō	o	0	94. 00
95.00 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0	95. 00
98.00 Cross Foot Adjustments			0	0	0	98. 00
99.00 Negative Cost Centers	0	100 400	0	0 007	207 270	99.00
100. 00 TOTAL	399, 286	108, 482	45, 831	30, 097	297, 378	100.00

						10	12/31/2021	5/19/2022 1:2	
		Cost Center Description	NURSI NG ADMI NI STRATI ON		PHARMACY		MEDI CAL RECORDS &	SOCIAL SERVICE	, piii
			0.00	SUPPLY	11 00		LI BRARY	12.00	
	GENER	AL SERVICE COST CENTERS	9. 00	10. 00	11.00		12. 00	13. 00	
1.00		CAP REL COSTS - BLDGS & FIXTURES				т			1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT							2. 00
3.00		EMPLOYEE BENEFITS							3. 00
4.00	00400	ADMINISTRATIVE & GENERAL							4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS							5. 00
6. 00		LAUNDRY & LINEN SERVICE							6. 00
7.00	1	HOUSEKEEPI NG							7.00
8. 00 9. 00	1	DI ETARY NURSI NG ADMINI STRATI ON	47, 002						8. 00 9. 00
10. 00	1	CENTRAL SERVICES & SUPPLY	47,002	13, 413					10.00
11. 00	1	PHARMACY	i o	0		0			11. 00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0		0	11, 310		12. 00
13.00	01300	SOCIAL SERVICE	0	0		0	0	16, 141	13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14. 00
15. 00		ACTIVITIES	0	0		0	0	0	15. 00
30. 00		ENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	47, 002	13, 413	I	0	10, 034	16, 141	30. 00
31. 00	1	NURSING FACILITY	47,002	13, 413	1	0	10, 034	0 10, 141	31.00
32. 00		ICF/IID	o o	0	•	0	0	Ö	ł
33.00	1	OTHER LONG TERM CARE	0	0		0	0	0	ł
		_ARY SERVICE COST CENTERS	,						
40.00		RADI OLOGY	0	0		0	16		40.00
41. 00 42. 00		LABORATORY INTRAVENOUS THERAPY	0	0		0	42 20		41. 00 42. 00
43. 00		OXYGEN (INHALATION) THERAPY	0	0		0	20		42.00
44. 00	1	PHYSI CAL THERAPY	0	0		0	388	1	44. 00
45. 00	1	OCCUPATI ONAL THERAPY	0	0		0	392		45. 00
46.00	04600	SPEECH PATHOLOGY	0	0		0	284	0	46. 00
47. 00	1	ELECTROCARDI OLOGY	0	0		0	0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	_	48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	0	0		0	132		49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0		0	0	0	50. 00 51. 00
52. 00		OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	0	52.00
		TIENT SERVICE COST CENTERS		_					
60.00		CLINIC	0	0		0	0	0	60.00
61. 00		RURAL HEALTH CLINIC	0	0		0	0	0	61.00
62. 00 63. 00	06200	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0	62. 00 63. 00
03.00		REIMBURSABLE COST CENTERS	U	U		U	0	0	03.00
70.00		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		0	0		0	0	0	
73.00	07300		0	0		0	0	0	73.00
74. 00		OTHER REIMBURSABLE COST AL PURPOSE COST CENTERS	0	0		0	0	0	74. 00
80. 00	08000	MALPRACTICE PREMIUMS & PAID LOSSES				Т			80. 00
81. 00		INTEREST EXPENSE							81. 00
82.00	08200	UTILIZATION REVIEW							82. 00
83.00		HOSPI CE	0	0		0	0	0	1
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	0	84. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	47, 002	13, 413		0	11, 310	16, 141	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
91. 00	1	BARBER AND BEAUTY SHOP	0	0		0	0	o o	
92. 00	09200	PHYSICIANS PRIVATE OFFICES	0	0		0	0	0	92. 00
93. 00		NONPALD WORKERS	0	0		0	0	0	93. 00
94. 00	1	PATIENTS LAUNDRY	0	0		0	0	0	
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0		O	0	0	95.00
98.00		Negative Cost Centers		0		0	0	0	98. 00 99. 00
100.00		TOTAL	47, 002	_		0	11, 310	-	
	1		, 552		1	-11	, 3.0		,

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					10 12/31/2021	Date/lime Pre 5/19/2022 1:2	
			OTHER GENERAL				
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
		ALLIED HEALTH EDUCATION			Adjustments		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	1					
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 5. 00	OO4OO ADMINISTRATIVE & GENERAL OO5OO PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00 12. 00	O1100 PHARMACY O1200 MEDI CAL RECORDS & LI BRARY						11. 00 12. 00
13. 00	01300 SOCIAL SERVICE						13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTIVITIES	0	7, 608				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	.,	1			30.00
31.00	03100 NURSING FACILITY	0	0	1			31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0	l .	0 0		32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	0	0	1	<u>J</u>	0	33.00
40. 00	04000 RADI OLOGY	0	0	518	3 0	518	40. 00
41.00	04100 LABORATORY	0	0	1			1
42.00	04200 I NTRAVENOUS THERAPY	0	0	1, 23		1, 231	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	858		858	
44. 00	04400 PHYSI CAL THERAPY	0	0	40, 04		40, 044	1
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0	50, 55° 6, 478		50, 551 6, 478	1
47. 00	04700 ELECTROCARDI OLOGY		0	i .		0,478	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	Ö	17, 07	-	17, 079	1
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	8, 848	0	8, 848	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			_	50. 00
51.00	05100 SUPPORT SURFACES	0	0				51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0		0	0	52. 00
60. 00	06000 CLINIC	1 0	0		0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	Ö	l .			61.00
62. 00	06200 FQHC						62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS	_	_	1			
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	l .	0 0		70.00
	07200 CORF		0	1		_	71. 00 72. 00
	07300 CMHC	0	Ö	1			1
	07400 OTHER REIMBURSABLE COST	0	Ō		0	0	
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82. 00 83. 00	O8200 UTI LI ZATI ON REVI EW O8300 HOSPI CE	0	0		o	0	82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS			1			84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	7, 608				1
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(
91.00	09100 BARBER AND BEAUTY SHOP	0	0	238			
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS					0	1
94.00	09400 PATI ENTS LAUNDRY					0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	Ö	1	o o	0	
98.00	Cross Foot Adjustments	0	0		0	-	98. 00
99. 00	Negative Cost Centers	0	_ 0		0		
100.00	TOTAL	0	7, 608	1, 993, 488	3 0	1, 993, 488	100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

				Т	o 12/31/2021	Date/Time Pre 5/19/2022 1:2	
		CAPI TAL REI	ATED COSTS			371772022 1.2	, biii
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2. 00	3. 00	4A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	37, 095					1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	37,073	37, 095				2. 00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	577	577			0.702.015	3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	7, 372 1, 478				9, 703, 815 687, 379	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	618				247, 816	
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	324 4, 295	324 4, 295		0	277, 413 1, 090, 904	1
9.00	00900 NURSING ADMINISTRATION	405	405	335, 918		505, 184	9. 00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	191	191 0	4, 959 0		52, 220 0	10. 00 11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	158	158	28, 904	0	44, 117	12. 00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	130	130 0	· ·		184, 952 0	13. 00 14. 00
15. 00	01500 ACTI VI TI ES	0	0				•
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	20, 074	20, 074	3, 164, 935	0	5, 422, 408	30. 00
31. 00	03100 NURSING FACILITY	20,074	20,074				31.00
32.00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0				32. 00 33. 00
33. 00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	33.00
40.00	04000 RADI OLOGY	0	0				
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0		68, 634 29, 434	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0		20, 856	1
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	492 679	492 679		_	260, 842 248, 916	1
46. 00	04600 SPEECH PATHOLOGY	0	0	_	_	150, 522	46. 00
47. 00 48. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	280	0 280	0	_	0 15, 047	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	22	22	0	0	180, 395	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		_	0 36, 176	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0					52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	1 0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0		l	61. 00
62. 00 63. 00	06200 FOHC 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	62. 00 63. 00
	OTHER REIMBURSABLE COST CENTERS	_		-			
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0			l e	70. 00 71. 00
72. 00	07200 CORF	0	0	0	0	0	72. 00
73. 00 74. 00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0	0		l .	1
	SPECIAL PURPOSE COST CENTERS	1	-	-	-		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 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)	37, 095	37, 095	4, 329, 098	-2, 173, 324	9, 698, 032	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0		91. 00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		0	0	92. 00 93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	О	0	0	94. 00
95. 00 98. 00	O9500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0	0	0	0	95. 00 98. 00
99. 00	Negative Cost Centers		_				99. 00
102.00	Cost to be allocated (per Wkst. B, Part I)	1, 993, 488	0	1, 006, 794		2, 173, 324	102. 00
103.00	Unit cost multiplier (Wkst. B, Part I)	53. 740073	0. 000000			0. 223966	1
104.00	Cost to be allocated (per Wkst. B, Part II)			31, 008		399, 286	104.00
105.00	Unit cost multiplier (Wkst. B, Part			0. 007163		0. 041147	105. 00
)	I	l	I	I	I	I

Provi der No.: 315138

				1	o 12/31/2021	Date/lime Pre 5/19/2022 1:2	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	, p
		OPERATI ON,	LINEN SERVICE		(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(TOTAL PATIENT			CTOTAL DATIENT	
		REPAIRS (SQUARE FEET)	DAYS)			(TOTAL PATIENT DAYS)	
		5. 00	6.00	7. 00	8. 00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS			•			3.00
4. 00 5. 00	OO4OO ADMINISTRATIVE & GENERAL OO5OO PLANT OPERATION, MAINT. & REPAIRS	27, 668	,}				4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	618	l				6. 00
7. 00	00700 HOUSEKEEPI NG	324	1	26, 726			7. 00
8. 00	00800 DI ETARY	4, 295		4, 295			8. 00
9.00	00900 NURSING ADMINISTRATION	405	1	1		33, 064	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	191	0	191	0	0	10. 00
11. 00	01100 PHARMACY	C		0	_	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	158		158		0	12. 00
13. 00	01300 SOCIAL SERVICE	130	1	130	0	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	C		0	0	0	14. 00
15. 00	01500 ACTIVITIES NPATIENT ROUTINE SERVICE COST CENTERS	C	0	0	0	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	20, 074	33, 064	20, 074	99, 192	33, 064	30. 00
	03100 NURSING FACILITY	20,074	0	1	0	0	31. 00
32. 00	03200 CF/11D	l c	_		Ö		32. 00
33.00	03300 OTHER LONG TERM CARE	C	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	C	0		0	0	40. 00
41. 00	04100 LABORATORY	C	0	0	0	_	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	C	0	0	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	100	0	100	0	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	492 679	1	492 679		0	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	0/9	l .	0/9		0	46. 00
47. 00	04700 ELECTROCARDI OLOGY		1		_	Ö	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	280	1	280	_	Ö	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	22		22		0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	C		0	0	0	51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	C	0	0	0	0	52. 00
(0.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC		0	0			40.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	C			0	0	60. 00 61. 00
62. 00	06200 FQHC						62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	C	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	C	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	C	0	0	0	0	71. 00
	07200 CORF	C	0	0	0	0	72.00
	07300 CMHC 07400 OTHER REIMBURSABLE COST				0	0	, 0. 00
74.00	SPECIAL PURPOSE COST CENTERS		0	<u> </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 UTILIZATION REVIEW						82.00
83.00	08300 H0SPI CE	C	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	27, 668	33, 064	26, 726	99, 192	33, 064	89. 00
	NONREI MBURSABLE COST CENTERS	Ι .		1	1	1	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0		0	0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES				0	0	91. 00 92. 00
93. 00	09300 NONPALD WORKERS				0	0	93.00
94. 00	09400 PATI ENTS LAUNDRY				0	Ö	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	d	o	Ö	0	ō	95. 00
98.00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102.00	Cost to be allocated (per Wkst. B,	841, 329	322, 110	349, 396	1, 521, 981	635, 938	102. 00
	Part I)						
103.00		30. 408016	l t	1			
104.00		108, 482	45, 831	30, 097	297, 378	47, 002	104. 00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	3. 920847	1. 386130	1. 126132	2. 998004	1. 421546	105 00
100.00		3. 720047	1. 300130	1. 120132	2. 970004	1. 421340	100.00
	· · · · ·	•	•	•	•	•	-

	FINANCIAI SYSTEMS	TRUT HILLS				u or Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/19/2022 1:2	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH	, p
		REQUIS.)		CHARGES)	,	TIME)	
	CENEDAL CEDVICE COCT CENTEDO	10.00	11. 00	12.00	13. 00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	50, 239					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
11. 00	01100 PHARMACY	50, 239	0				11.00
	01200 MEDICAL RECORDS & LIBRARY	o	0	17, 477, 173	3		12. 00
13.00	01300 SOCIAL SERVICE	0	0	1	33, 064		13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(0	0	1
15. 00	01500 ACTI VI TI ES	0	0	(0	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	50, 239	0	15, 503, 928	33, 064	0	30.00
31. 00	03100 NURSING FACILITY	0	0	1	0 0	0	
	03200 CF/IID	Ö	0			0	1
33. 00	03300 OTHER LONG TERM CARE	0	0	(0	0	33. 00
40.00	ANCILLARY SERVICE COST CENTERS			05.04			40.00
	04000 RADI OLOGY 04100 LABORATORY	0	0	1		0 0	
42. 00	04200 I NTRAVENOUS THERAPY	0	0	30, 557		0	1
	04300 OXYGEN (INHALATION) THERAPY	o	0	675		0	1
44.00	04400 PHYSI CAL THERAPY	0	0	599, 66°	0	0	
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	605, 543		0	
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY		0	439, 400		0 0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			0	ı
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	203, 504	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	0	
51.00	05100 SUPPORT SURFACES	0	0			0	
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	U U	0	(0	0	52.00
60.00	06000 CLI NI C	0			0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	61. 00
62. 00	06200 FQHC	_	_		_	_	62. 00
63. 00	O6300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	63. 00
70 00	07000 HOME HEALTH AGENCY COST	O	0		0	0	70. 00
	07100 AMBULANCE	O	0		0	0	1
72.00	07200 CORF	0	0		0	0	
73.00	07300 CMHC	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
81.00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW						82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	50, 239	0	17, 477, 173	33, 064		1
07.00	NONREI MBURSABLE COST CENTERS	55/25/		177 1777 178	30,001		07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	-	
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0			0	
94. 00	09400 PATIENTS LAUNDRY		0			Ö	1
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	O	0		0	0	1
98. 00	Cross Foot Adjustments						98. 00
99.00	Negative Cost Centers	70 001	0	,,,,,,,,	222 020		99.00
102. 00	Cost to be allocated (per Wkst. B, Part I)	72, 221	0	60, 868	232, 028		102. 00
103.00	1 ,	1. 437549	0. 000000	0. 003483	7. 017542	0. 000000	103. 00
104.00	Cost to be allocated (per Wkst. B,	13, 413	0	11, 310			104. 00
105.00	Part II)	0.04400:	0.000000	0.000::-	0 40047	0 000000	105 00
105. 00	Unit cost multiplier (Wkst. B, Part	0. 266984	0. 000000	0. 000647	0. 488174	0. 000000	100.00
				'	•	•	

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

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

COST CENTER DESCRIPTION SERVICE				To 12/31/2021	Date/lime Prepared: 5/19/2022 1:27 pm
COLD COUNTER DESCRIPTION					
CIPAL PATIENT DAYS 15.00 1		Cost Contan Decemintion			
DAYS 1.00 DOUGO CAP REL DOSS - BLOSS & FIXTURES 1.00 1.		Cost Center Description			
			7		
0.00 0.000 CAP RILL CUSIS - BLINGS & FIXINES 2.00					
0.0000 CAP REL COSTS - INVARLE BUILDINGST 3.00	1 00				1.00
3.00 00000 INDITION 1 MIN 1 STATU Y & SEREAL 4.00 00000 CLAMT ORGATION, MAINT, REPAIRS 5.00 00000 CLAMT ORGATION, MAINT, REPAIRS 6.00 00000 CLAMT ORGATION, MAINT, REPAIRS 6.00 00000 LIF PARY 7.00 00000 MINSTAR ATMINISTRATION 7.00 MINSTAR MINSTA		1 1			
4.00 0.000 ADMINISTRATIVE & CENERAL 4.00		1 1			
0.000 0.000 JAURDBY & LINEN SERVICE 0.000 0.000 DETARY 0.000 0.000 DETARY 0.000 0.000 DETARY 0.000 0.000 DETARY 0.000 0.00					
2, 00 00700 DUSENEEPH NO 2, 00 0.0 00800 MIRSING ADMINISTRATION 9, 00 10 00 DOBO CHARAL SERVICES & SUPPLY 10, 00 12, 00 00 DOBO CHARAL SERVICES & SUPPLY 11, 00 12, 00 01 DOB CHARAL SERVICES & SUPPLY 12, 00 14, 00 01 DOB CHARAL SERVICES & SUPPLY 12, 00 14, 00 01 DOB CHARAL SERVICE SERVICE SERVICES & 13, 00 14, 00 14, 00 01 HOUNDAIN SERVICE COST CENTERS 30, 00 30, 00 10 SUPPLIANT ROUTH IN SERVICE COST CENTERS 30, 00 30, 00 20 DOB CHEF LINE SERVICE COST CENTERS 31, 00 30, 00 20 DOB CHEF LINE SERVICE COST CENTERS 32, 00 40, 00 32, 00 32, 00 30, 00 2000 CF / 10 32, 00 41, 00 2000 CF / 10 33, 00 41, 00 2000 CF / 10 40, 00 41, 00 2000 CF / 10 40, 00 41, 00 20, 00 32, 00 41, 00 40, 00 41, 00 41, 00 40, 00		1 1			
8.00 00800 NETARY 9.00 10.00 CININAL STRATION 9.00 10.00 CININAL STRATION 9.00 10.00 CININAL STRATION 11.00 10.00 10.00 CININAL STRATION 11.00 11.0		1 1			
9.00 0.0900 NURSHIRS, AND AND INSTRATION 9.00 11.00 0.0000 CORTRAL SERVICES & SUPPLY 11.00 0.000 11.00 0.0000 CORTRAL SERVICES & SUPPLY 11.000 11.00					
11.00 10.00 PIASMACY		1			
12.00 10200 MEDICAL RECORDS & LIBRARY 12.00 13.00 13.00 14.00 15.00		l l			
13.00 1300 SOCIAL SERVICE 13.00 14.00 1400 1500 1500 ACTIVITIES 33.064 15.00 1500 ACTIVITIES 33.064 15.00 1500 ACTIVITIES 33.064 33.00 33.00 30.00 33.00		1			
14.00 1400 NURSING AND ALLIED HEALTH EDUCATION 15.00					
15.00		l l			
30.00 3000 SKILLED NIKSING FACILITY 33,064 31,00 30.00 320.00 330.00	15.00	01500 ACTI VI TI ES	33, 064		15. 00
31.00					
32 00 03200 THEFT LOW TERM CARE			·		
33.00 03300 OTHER LOWN TERM CARE					
0.0 0.0		1			
1.1 00 04100 LABORATORY 0					
42 00 04200 INTRAVENOUS THERAPY 0 43.00 43.00 04300 OVYGEN (INHALATION) THERAPY 0 44.00 44.00 04400 PHYSI CALL THERAPY 0 44.00 45.00 04500 OCCUPATI ONAL THERAPY 0 45.00 46.00 04600 SPEECH PATHOLOGY 0 46.00 47.00 04700 LECTROCARDIOLOGY 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 50.00 05000 DRUGS CHARGED TO PATIENTS 0 49.00 50.00 05000 DRUGS CHARGED TO PATIENTS 0 50.00 50.00 05000 DRUGS CHARGED TO PATIENTS 0 60.00 60.00 05000 DRUGS CHARGED TO PATIENTS 0 60.00 60.00 05000 DRUGS CHARLATH CLINIC 0 60.00 60.00 06000 CLINIC 0 60.00 60.00 06000 DRUGS CHARLATH AGENCY COST 0 60.00 60.00 06000 DRUGS CHARLATH AGENCY COST 0 70.00 70.00 07000 OME CHARLATH AGENCY COST 0 70.00 70.00		+ I	0		
43. 00 04300 OXYGEN (INHALATION) THERAPY 0 44. 00 0450 04500 OXYGEN (INHALATION) THERAPY 0 0 45. 00 04500 OXYGEN THERAPY 0 0 04700 ELECTROCARDIOLOGY 0 0 47. 00 04700 ELECTROCARDIOLOGY 0 47. 00 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48. 00 04900 DRIVES CHARGED TO PATIENTS 0 49. 00 05. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 05000 OTHER ANOLI LARY SERVICE COST CENTERS 0 51. 00 05000 OTHER ANOLI LARY SERVICE COST CENTERS 0 00 00 0000 OTHER ANOLI LARY SERVICE COST CENTERS 0 00 00 0000 OTHER ANOLI LARY SERVICE COST CENTERS 0 00 00 05000 OTHER ANOLI LARY SERVICE COST CENTERS 0 00 05000 OTHER ANOLI LARY SERVICE COST CENTERS 0 00 05000 OTHER ANOLI LARY SERVICE COST CENTERS 0 00 05000 OTHER ANOLI LARY SERVICE COST CENTERS 0 00 05000 OTHER SERVICE COST CENTERS 0 071000 OTHER SERVICE COST CENTERS 0 0710000 OTHER SERVICE COST CENTERS 0 0710000		1 1	0		
45.00 04500 04500 04500 04500 04500 0460		1 1	o		
46.00 04600 04600 04600 04600 047.00 047.00 047.00 047.00 047.00 047.00 047.00 047.00 047.00 048.00 04800 04800 04800 04800 04800 04800 04800 080000 080000 080000 080000 080000 080000 080000 080000 080000 080000 080000		†	0		
47. 00 04700 04700 ELECTROCARD 0LOGY 0 48. 00 48. 00 49. 00 04900		+ I	0		
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 49. 00 04900 005000 005000 00500 005000 005000 005000 005000 005000 005000 005000			0		
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 51.00 051.00 051.00 051.00 051.00 051.00 051.00 050.00 052.0		+ I	Ö		
51.00 05100 SUPPORT SURFACES 0 52.00 05200 OTHER NAIGHLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0		1 1	0		
52.00		1 1	0		
OUTPATLENT SERVICE COST CENTERS 0 06000 CLINIC 0 0 06100 RURAL HEALTH CLINIC 0 0 063.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 07000 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0		1 1	0		
61.00 06100 RURAL HEALTH CLINIC 0 62.00 62.00 606.200 FOHC 62.00 63.00 6	02.00		<u> </u>		02.00
62. 00 06200 OHER OUTPATIENT SERVICE COST CENTERS 0 06300 OTHER OUTPATIENT SERVICE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST 0 70. 00 71.00 70					
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTERS 0 OTHER REIMBURSABLE COST CENTERS 70.00 70.00 OTOOL HOME HEALTH AGENCY COST 0 71.00 07100 AMBULANCE 0 72.00 07200 CORF 72.00 73.00 07300 CMHC 72.00 74.00 07400 OTHER REIMBURSABLE COST 0 74.00 07400 OTHER REIMBURSABLE COST 0 75.00 07400 OTHER REIMBURSABLE COST 0 76.00 07400 OTHER REIMBURSABLE COST 0 77.00 07400 OTHER REIMBURSABLE COST 0 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 81.00 08200 UTILI ZATI ON REVIEW 82.00 82.00 08200 UTILI ZATI ON REVIEW 82.00 83.00 08300 HOSPI CE 0 84.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 89.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 89.00 09000 06 FT. FLOWER, COFFEE SHOPS & CANTEEN 0 99.00 09000 07100			0		
OTHER REIMBURSABLE COST CENTERS O O7000 HOME HEALTH AGENCY COST O O71.00			0		
71.00 07100 AMBULANCE 0 07200 CORF 0 0 07200 CORF 0 0 0 0 07300 CMPC 0 0 07300 CMPC 0 0 07300 CMPC 0 0 07400 OTHER REIMBURSABLE COST 0 0 07400 OTHER REIMBURSABLE COST 0 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 80.00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW 82.00 08300 HOSPI CE 0 083.00 08300 HOSPI CE 0 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 09000 OTHER SPECIAL PURPOSE COST CENTERS 0 09100 OTHER NONREIMBURSABLE COST CENTERS	00.00		<u> </u>		00.00
72. 00 07300 CORF 0 73. 00 07300 CMHC 0 0 73. 00 07400 CMHC 0 0 07400 CMHC			-		
73. 00 07300 CMHC 0 07400 OTHER REI MBURSABLE COST 0 0 0 0 0 0 0 0 0			-		
74. 00 074C0 07HER REI MBURSABLE COST 0 SPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81. 00 82. 00 08200 UTI LI ZATI ON REVI EW 82. 00 83. 00 08300 HOSPI CE 0 0 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 89. 00 00000 00000 0000 00000 00000 00000 00000			0		
80. 00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 80. 00 81. 00 81. 00 82. 00 82. 00 82. 00 82. 00 83. 00 83. 00 83. 00 83. 00 84. 00 85. 00 8			o o		
81.00 08100 INTEREST EXPENSE 82.00 8200 UTILIZATION REVIEW 82.00 83.00 08300 HOSPICE					
82. 00 08200 UTILIZATION REVIEW 83. 00 08300 HOSPICE 0 0 83. 00 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 84. 00 89. 00 SUBTOTALS (sum of lines 1-84) 33, 064 NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 90. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 91. 00 92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 93. 00 93. 00 09300 NONPAID WORKERS 0 992. 00 94. 00 09400 PATIENTS LAUNDRY 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 95. 00 98. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 99. 00 102. 00 Cross Foot Adjustments 99. 00 102. 00 Cost to be allocated (per Wkst. B, 199, 039 Part I) 103. 00 Unit cost multiplier (Wkst. B, Part I) 6. 019810 104. 00 Part II) 105. 00 Unit cost multiplier (Wkst. B, Part I) 0. 230099		1 1			
83.00		1 1			
SUBTOTALS (sum of lines 1-84) 33,064 89.00		1 1	o		
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 91.00 09100 BARBER AND BEAUTY SHOP 0 91.00 092.00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 92.00 93.00 NONPAI D WORKERS 0 93.00 94.00 09400 PATI ENTS LAUNDRY 0 95.00 09500 07HER NONREI MBURSABLE COST CENTERS 0 09500 07HER NONREI MBURSABLE COST CENTERS 0 09500 07HER NONREI MBURSABLE COST CENTERS 0 095.00 07HER NONREI MBURSABLE COST CENTERS 0 075.00		1 1	0		
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 91. 00 91. 00 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 92. 00 93. 00 09300 NONPAID WORKERS 0 93. 00 94. 00 09400 PATIENTS LAUNDRY 0 94. 00 95. 00 00 00 00 00 00 00 00	89. 00		33, 064		89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 0 91. 00 92. 00 93. 00 09200 PHYSICIANS PRIVATE OFFICES 0 92. 00 93. 00 09300 NONPAID WORKERS 0 93. 00 94. 00 94. 00 94. 00 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 94. 00 98. 00 Cross Foot Adjustments 99. 00 Negative Cost Centers 99. 00 Negative Cost Centers 99. 00 102. 00 Part I) 103. 00 Unit cost multiplier (Wkst. B, Part I) 6. 019810 104. 00 Part II) 105. 00 Unit cost multiplier (Wkst. B, Part I) 105. 00 Unit cost multiplier (Wkst. B, Part II) 105. 00	90. 00		O		90.00
93. 00 99300 99300 99300 99300 99400 99400 99400 99500		1 1	o o		
94. 00 94.00 94.00 94.00 95.00 95.00 96.00		1 1	0		
95. 00 995.00 995.00 OTHER NONREIMBURSABLE COST CENTERS 0 995.00		1 1	0		
98.00 Cross Foot Adjustments 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 I) 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part III) 105.00 Unit cost multiplier (Wkst. B, Part IIII) 105.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII					
99.00 102.00 Cost to be allocated (per Wkst. B, 199,039 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, 7,608 Part II) 105.00 Unit cost multiplier (Wkst. B, Part I) 105.00 Negative Cost Centers 99.00 102.00 103.00 104.00 105.00	98.00	1			
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) 105.00 Part I) Cost to be allocated (per Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		Negative Cost Centers			
103.00 Unit cost multiplier (Wkst. B, Part I) 6.019810 104.00 Cost to be allocated (per Wkst. B, Part II) 7,608 105.00 Unit cost multiplier (Wkst. B, Part II) 0.230099	102.00		199, 039		102. 00
104.00 Cost to be allocated (per Wkst. B, Part II) 7,608 105.00 Unit cost multiplier (Wkst. B, Part 0.230099) 105.00	103 00	1 1 '	6 019810		103 00
Part II)		1 1	1		
		Part II)			
1 1117	105.00		0. 230099		105. 00
		1 1117	ı I		I

Health Financial Systems	TROY HILLS CEN	NTER	In	n Lieu of Form CMS-2540-10)
RATIO OF COST TO CHARGES FOR AND	CLILADY AND OUTDATIENT COST CENTEDS	Provider No : 315138	Pari od:	Workshoot C	-

Heal th Finar	ncial Systems	TROY HILLS CEN	ITER		In Lie	u of Form CMS-2	2540-10
RATIO OF CO	ST TO CHARGES FOR ANCILLARY AND OUT	PATIENT COST CENTERS	Provi der	No.: 315138	Peri od:	Worksheet C	
					From 01/01/2021	D 1 /T' D	
					To 12/31/2021	Date/Time Prep 5/19/2022 1:27	
	Cost Center Description			Total (from	Total Charges	Ratio (col. 1	/ pili
	5551 551151 55551 Pt. 511			Wkst. B, Pt I		di vi ded by	
				col . 18)	'	col. 2	
				1.00	2. 00	3. 00	
ANCI L	LARY SERVICE COST CENTERS						
40.00 04000	RADI OLOGY			15, 0°	9 25, 210	0. 595756	40.00
41.00 04100	LABORATORY			84, 23	4 65, 380	1. 288376	41.00
42.00 04200	INTRAVENOUS THERAPY			36, 13	2 30, 557	1. 182446	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY			25, 52	9 675	37. 820741	43.00
44.00 04400	PHYSI CAL THERAPY			342, 74	4 599, 661	0. 571563	44.00
45.00 04500	OCCUPATIONAL THERAPY			336, 29	8 605, 543	0. 555366	45.00
	SPEECH PATHOLOGY			185, 76	439, 400	0. 422767	46. 00
47.00 04700	ELECTROCARDI OLOGY				0	0.000000	47.00
	MEDICAL SUPPLIES CHARGED TO PATIEN	ITS		30, 59	2 0	0.000000	48. 00
49.00 04900	DRUGS CHARGED TO PATIENTS			222, 46	3 203, 504	1. 093163	49. 00
	DENTAL CARE - TITLE XIX ONLY				0	0. 000000	50.00
	SUPPORT SURFACES			44, 29	0 3, 315	13. 360483	
	OTHER ANCILLARY SERVICE COST CENTE	ERS			0 0	0.000000	52.00
	TIENT SERVICE COST CENTERS						
	CLINIC				0	0. 000000	60.00
	RURAL HEALTH CLINIC						61. 00
	FQHC						62. 00
	OTHER OUTPATIENT SERVICE COST CENT	ER			0	0. 000000	63. 00
	AMBULANCE				0	0. 000000	
100. 00	Total			1, 323, 06	5 1, 973, 245		100. 00

PPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS						
		Provider	No.: 315138	Peri od: From 01/01/2021	Worksheet D Part I	
				To 12/31/2021	Date/Time Pre	pared:
					5/19/2022 1: 2	7 pm
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		
		Heal th Care Pr	rogram Charge	s Health Care	Program Cost	
Cook Cooks Decombation	D-+:£ C+	Part A	Part B	Part A (col. 1	D+ D (1	
Cost Center Description	Ratio of Cost to Charges	Part A	Part B	x col. 2)	x col. 3)	
	(Fr. Wkst. C			X COI. 2)	X COI. 3)	
	Column 3)					
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA		2.00	0.00	1. 00	0.00	
ANCILLARY SERVICE COST CENTERS						İ
0. 00 04000 RADI OLOGY	0. 595756	3, 653		0 2, 176	0	40.00
. 00 04100 LABORATORY	1. 288376	1, 457		0 1, 877	0	41.00
2.00 04200 INTRAVENOUS THERAPY	1. 182446	14, 215		0 16, 808	0	42.00
B. OO O4300 OXYGEN (INHALATION) THERAPY	37. 820741	482		0 18, 230	0	43.00
I. 00 04400 PHYSI CAL THERAPY	0. 571563	188, 528		0 107, 756	0	44.00
5. 00 04500 OCCUPATI ONAL THERAPY	0. 555366	211, 540		0 117, 482	0	45. 00
5. 00 04600 SPEECH PATHOLOGY	0. 422767	161, 715		0 68, 368	0	46. 00
7. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47. 00
B. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	48. 00
P. 00 04900 DRUGS CHARGED TO PATIENTS	1. 093163	73, 220		0 80, 041	0	1
0.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
. 00 05100 SUPPORT SURFACES	13. 360483	87		0 1, 162	0	
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	00.00
.00 06100 RURAL HEALTH CLINIC						61.00
2. 00 06200 FQHC						62. 00
3. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0	0	
07100 AMBULANCE (2)	0. 000000	,_,		0	0	1 00
00.00 Total (Sum of lines 40 - 71)		654, 897		0 413, 900	0	100. 00
) For title V and XIX use columns 1, 2, and 4 or	d v					

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

	Financial Systems	TROY HILLS	S CENTER		In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315138	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/19/2022 1:2	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description						
	PART II - APPORTIONMENT OF VACCINE COST					1. 00	
1. 00	Drugs charged to patients - ratio of co	et to charges	(Erom Workshoo	t C column 2	Lino 40)	1. 093163	1.00
2. 00	Program vaccine charges (From your reco			t C, Corumin 3	, TITIE 49)	2, 590	
3. 00	Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet	2, 831	3.00
3.00	E, Part I, line 18)	λνιτι, τιο ριο	videis, transi	ci tiii3 ailloan	t to worksheet	2,001	3.00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	·	(From Wkst. B,	Allied Health	Nursing &	Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,	Allied Healt	h Wkst. D Part	Health Costs	
		18	Part I, Col.			for Pass	
			14)	Costs - Part		Through (Col.	
				(Col . 2 / Col 1)	•	3 x Col. 4)	
		1.00	2.00	3, 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS			3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS	TOK NORSTNO &	ALLIED HEALTH				
40.00	04000 RADI OLOGY	15, 019	(0.00000	00 2, 176	0	40.00
41. 00	04100 LABORATORY	84, 234		0.00000		0	
42.00	04200 I NTRAVENOUS THERAPY	36, 132		0.00000		0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	25, 529	(0. 00000	18, 230	0	43.00
44.00	04400 PHYSI CAL THERAPY	342, 744	C	0.00000	107, 756	0	44. 00
	04500 OCCUPATI ONAL THERAPY	336, 298	C	0.00000		0	45. 00
	04600 SPEECH PATHOLOGY	185, 764	(0.00000		0	46. 00
	04700 ELECTROCARDI OLOGY	0	(0.00000		0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 592		0.00000		0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	222, 463	<u> </u>	0.00000		0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		0.00000		0	50.00
	05100 SUPPORT SURFACES	44, 290	l e	1 0.0000		0	51.00
52. 00 100. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS Total (Sum of lines 40 - 52)	1, 323, 065		1 0.0000	00 0 413, 900	0	52. 00 100. 00
100.00		1, 323, 003	1	Ί	413, 900	0	1100.00

Heal th	Financial Systems TROY HILLS CEN	ITER	In Lie	u of Form CMS-2	2540-10
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315138	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 5/19/2022 1:2	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	INPATIENT DAYS				
1.00	Inpatient days including private room days			33, 064	1. 00
2.00	Private room days			309	
3. 00 4. 00	Inpatient days including private room days applicable to the Pr Medically necessary private room days applicable to the Program			2, 538 0	3. 00 4. 00
5. 00	Total general inpatient routine service cost			10, 546, 996	5.00
0.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			10, 010, 770	0.00
6.00	General inpatient routine service charges			14, 368, 316	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 734045	7. 00 8. 00
8.00					
9. 00					9. 00
10. 00	2) .00 Enter semi-private room charges from your records				10.00
11.00	3. J.				
	semi -pri vate room days)	, i		434.00	
12.00					
13.00					13.00
14. 00 15. 00	Private room cost differential adjustment (Line 2 times line 13 General inpatient routine service cost net of private room cost	,	minus line 14)	13, 608 10, 533, 388	
15.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 5	minus iine 14)	10, 533, 388	15.00
16. 00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		318. 58	16.00
17.00	Program routine service cost (Line 3 times line 16)	,		808, 556	17. 00
18.00	Medically necessary private room cost applicable to program (I			0	18. 00
19. 00	Total program general inpatient routine service cost (Line 17			808, 556	ł
20. 00	Capital related cost allocated to inpatient routine service cos line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ts (From Wkst. B, Par	t II column 18,	1, 863, 286	20. 00
21. 00	Per diem capital related costs (Line 20 divided by line 1)			56. 35	21. 00
22. 00	Program capital related costs (Line 3 times line 21)			143, 016	
23. 00	Inpatient routine service cost (Line 19 minus line 22)			665, 540	•
24.00					24. 00
25. 00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	665, 540	
26.00	Enter the per diem limitation (1)		2() (1)		26. 00
27. 00 28. 00	Inpatient routine service cost limitation (Line 3 times the per Reimbursable inpatient routine service costs (Line 22 plus) the				27. 00 28. 00
20.00	(Transfer to Worksheet E, Part II, line 4) (See instructions)	resser of title 20 of	11116 21)		20.00
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX		'
				1, 00	

	1. 00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00 Total SNF inpatient days	33, 064	1. 00
2.00 Program inpatient days (see instructions)	2, 538	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. 076760	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 FOR TIT	FLE XVIII	Provider No.: 315138	From 01/01/2021	Worksheet E Part I Date/Time Prepared: 5/19/2022 1:27 pm
		Title XVIII	Skilled Nursing	PPS

				5/19/2022 1: 2	/ pm
		Title XVIII	Skilled Nursing Facility	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSE	MENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	INICINI		1, 706, 899	1.00
2. 00	Nursing and Allied Health Education Activities (pass through pay	monts)		1, 700, 077	2.00
3.00	Subtotal (Sum of lines 1 and 2)	ymerits)		1, 706, 899	
4. 00	Primary payor amounts			1, 700, 077	4. 00
5.00	Coi nsurance			251, 353	1
6. 00	Allowable bad debts (From your records)			61, 232	•
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instruc	ctions)		54, 320	•
8. 00	Adjusted reimbursable bad debts. (See instructions)	2013)		39, 801	
9. 00	Recovery of bad debts - for statistical records only			37, 001	•
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			1, 495, 347	
12. 00	Interim payments (See instructions)			1, 518, 243	•
13. 00	Tentati ve adjustment			1, 310, 243	•
14. 00	OTHER adjustment (See instructions)			0	•
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			533	1
14. 75	Sequestration for non-claims based amounts (see instructions)			0	1
14. 79	Sequestration amount (see instructions)			0	
15. 00	Balance due provider/program (see Instructions)			-23, 429	
16. 00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub 15-2	section 115 2)	20, 127	ı
10.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER C				10.00
17. 00	Ancillary services Part B		THE ATTENDED	0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			2, 831	
19. 00	Total reasonable costs (Sum of Lines 17 and 18)			2, 831	
20. 00	Medicare Part B ancillary charges (See instructions)			2, 590	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			2, 590	
22. 00	Primary payor amounts			0	ł
23. 00	Coinsurance and deductibles			0	23. 00
24.00	Allowable bad debts (From your records)			0	•
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instruc	ctions)		0	•
24. 02	Adjusted reimbursable bad debts (see instructions)	,		0	24. 02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			2, 590	25. 00
26. 00	Interim payments (See instructions)			1, 632	
27.00	Tentati ve adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	1
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)			958	29. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	section 115.2	0	30. 00
			•		•

Health Financial Systems	TROY HILLS CEN	In Lie	u of Form CMS-2540-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provi der No.: 315138	From 01/01/2021	Worksheet E Part II Date/Time Prepared: 5/19/2022 1:27 pm
		Title XIX	Skilled Nursing	PPS

1.00			litle XIX	Skilled Nursing Facility	PPS	
1.00				-	1. 00	
2.00		COMPUTATION OF NET COST OF COVERED SERVICES				
2.00	1.00	Inpatient ancillary services (see Instructions)			0	1.00
Inpatient routine services (see Instructions)	2.00		: 5)		0	2. 00
1.00	3.00	Outpati ent servi ces			0	3.00
6.00 Cost of covered services (Sum of lines 1 - 5) 0 6.00 7.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 7.00 9.00 Primary payor amounts 0 9.00 9.00 Total Reasonable Cost (Line 8 minus line 9) 0 10.00 **RASONABLE CHARGES 0 11.00 1.00 Inpatient ancillary service charges 0 12.00 13.00 Inpatient routine service charges 0 12.00 15.00 Ottal reasonable charges 0 13.00 16.00 Total reasonable charges 0 14.00 16.00 Total reasonable charges 0 15.00 17.00 Ottal reasonable charges 0 15.00 18.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 19.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 19.00 Total customary charges (see Instructions) 0 10.00 19.00 Total customary charges (see Instructions) 0 10.00 20.00 COSTOMENT CHARGES 0 10.00 20.00 COSTOMENT CHARGES 0 20.00 20.	4.00	Inpatient routine services (see instructions)			0	4. 00
7.00	5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
8.00 SUBTOTAL (Line 6 minus line 7) 0 8.00 0 0 0 0 0 0 0 0 0	6.00	Cost of covered services (Sum of lines 1 - 5)			0	6. 00
9.00 Primary payor amounts 0 9.00 Total Reasonable Cost (Line 8 minus line 9) 10.00 REASONABLE CHARGES 11.00 Inpatient ancillary service charges 0 11.00 12.00	7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7. 00
10.00 Total Reasonable Cost (Line 8 minus line 9) 10.00 REASONABLE CHARGES	8.00	SUBTOTAL (Line 6 minus line 7)			0	8. 00
REASONABLE CHARGES 11.00 Inpatient anciliary service charges 0 11.00 12.00 Outpatient service charges 0 12.00 13.00 Inpatient routine service charges 0 13.00 14.00 Inferential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14.00 15.00 Total reasonable charges 0 15.00 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 18.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.000000 18.00 19.00 Total customary charges (see instructions) 0 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 22.00 20.00 Subtotal (Line 20 minus line 21) 0 22.00 20.00 Subtotal (Line 22 minus line 23) 0 24.00 20.00 Allowable bad debts (from your records) 0 25.00 20.00 Outoral (Line 22 minus line 23) 0 25.00 20.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 0 27.00 20.00 Cother Adjustments (see instructions) 0 27.00 20.00 Outor Adjustments (see instructions) 0 29.00 20.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (in inus, enter amount in parentheses) 0 31.00 30.00 Interim payments 0 31.00	9.00	Primary payor amounts			0	9. 00
11.00 Inpatient ancillary service charges	10.00	Total Reasonable Cost (Line 8 minus line 9)			0	10.00
12.00 Outpatient service charges 0 12.00 Inpatient routine service charges 0 13.00 Inpatient routine service charges 0 13.00 Inpatient routine service charges 0 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14.00 Total reasonable charges 0 15.00 CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 17.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 17.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 17.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 16 to line 17 (not to exceed 1.000000) 0 18.00 Patients of line 18 (line 20 minus line 21) 0 20.00 Patients of line 18 (line 20 minus line 23) 0 22.00 Patients of line 18 (line 20 minus line 23) Patients of line 18 (line 20 minus line 24) 0 25.00 Patients of line 18 (line 20 minus line 25 (line 20 minus line 27 and 28) Patients of line 18 (line 26 plus or minus lines 29 and 30 minus lines 27 and 28) Patie		REASONABLE CHARGES				
13.00 Inpatient routine service charges 0 13.00 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14.00 15.00 Total reasonable charges 0 15.00 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 17.00 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19.00 19.00 Total customary charges (see instructions) 0 19.00 20.00 Cost of covered services (see instructions) 0 20.00 21.00 Deductibles 0 22.00 22.00 Subtotal (Line 20 minus line 21) 23.00 23.00 Coinsurance 0 24.00 24.00 Subtotal (Line 22 minus line 23) 25.00 25.00 Allowable bad debts (from your records) 0 25.00 26.00 Subtotal (sum of lines 24 and 25) 0 27.00 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 29.00 Other Adjustments (see instructions) Specify 0 29.00 30.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 16.00 17.00 18.00 19.00 17.00 18.00 19.00 19.00 19.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 21.00 22.00 23.00 24.00 25.00 22.00 Subtotal (Line 22 minus line 23) 23.00 23.00 10.00 19.00 25.00 24.00 25.00 25.00 25.00 25.00 26.00 27.00 27.00 26.00 27.00 27.00 28.00 27.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 29	11. 00	Inpatient ancillary service charges			0	
14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 15.00 Total reasonable charges 0 15.00 CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 Total customary charges (see instructions) 0 17.00 Computation of Line 12 to 10.00 Computation of 20.00 Cost of covered services (see Instructions) 0 20.00 Cost of covered services (see Instructions) 0 20.00 Cost of covered services (see Instructions) 0 20.00 Coin surance 0 20.00 C	12.00	Outpatient service charges			0	12. 00
15.00 Total reasonable charges CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis of 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis of 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis of 17.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19.00 Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT COMPUTATION OF REIMBURSEMENT SETTLEMENT 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance 24.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) 26.00 Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program 29.00 Other Adjustments (see instructions) Specify 30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (16.00 if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 32.00 Interim payments 33.00 Bal ance due provider/program (Line 31 minus lines 32) (indicate overpayments in parentheses) (see	13.00	Inpatient routine service charges			0	13. 00
CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.000000 18.00 19.00 Total customary charges (see instructions) 0 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 0 21.00 Deductibles 0 21.00 Deductibles 0 22.00 Subtotal (Line 20 minus line 21) 0 22.00 23.00 Coinsurance 0 24.00 Subtotal (Line 22 minus line 23) 0 24.00 Subtotal (Line 22 minus line 23) 0 24.00 Subtotal (sum of lines 24 and 25) 0 25.00 Allowable bad debts (from your records) 0 25.00 Subtotal (sum of lines 24 and 25) 0 26.00 Subtotal (sum of lines 25 and 25) 0 25.00 Cost limit 0 28.00 Cost limit 0 28.00 Cost limit 0 28.00 Cost limit 0 29.00 Other Adjustments (see instructions) Specify 0 29.00 Other Adjustments (see instructions) Specify 0 29.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 0 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 0 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 0 33.00 Bal ance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	14.00		less than semiprivate	accommodations	0	14. 00
16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.000000 18.00 19.00 CoMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see instructions) 0 20.00 21.00 Deductibles 0 22.00 Subtotal (Line 20 minus line 21) 0 22.00 23.00 Coinsurance 0 24.00 Subtotal (Line 22 minus line 23) 0 24.00 25.00 Allowable bad debts (from your records) 0 25.00 Subtotal (sum of lines 24 and 25) 0 25.00 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 0 27.00 Cost limit	15. 00				0	15. 00
17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19.00 Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles Subtotal (Line 20 minus line 21) Subtotal (Line 22 minus line 23) Subtotal (Line 22 minus line 23) Subtotal (sum of lines 24 and 25) Deductibles Subtotal (sum of lines 24 and 25) Deduction of excess depreciation resulting from provider termination or a decrease in program Unification Deduction of excess depreciation of cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
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Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT Cost of covered services (see Instructions) Deductibles Subtotal (Line 20 minus line 21) Coinsurance Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) Subtotal (sum of lines 24 and 25) Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
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21.00 Deductibles Subtotal (Line 20 minus line 21) Coinsurance 3.00 Coinsurance 4.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 31.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
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25. 00 Allowable bad debts (from your records) 26. 00 Subtotal (sum of lines 24 and 25) 27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29. 00 Other Adjustments (see instructions) Specify 30. 00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31. 00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 32. 00 Interim payments 33. 00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
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29.00 Other Adjustments (see instructions) Specify 30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 32.00 Interim payments 33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	28. 00		ition or a decrease in	program	0	28. 00
30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 0 31.00 Interim payments 0 32.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	29 00				0	29 00
if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 32.00 Interim payments 31.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00			rom disposition of depr	eciable assets (-	
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32.00 Interim payments 0 32.00 33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00	31 00		27 and 28)		Λ	31 00
33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00			2. 33 20)		-	
			overpayments in parent	heses) (see		
	55. 50		par one		Ü	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315138 | Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/19/2022 1: 27 pm

Title XVIII | Skilled Nursing | PPS

		11 (1	e Aviii	Facility	FFS	
		Inpatien	t Part A		t B	
		·				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 491, 875		1, 632	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
5. 00	amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/01/2021	26, 368		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provi der to Program		_1		_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0	3. 53 3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		26, 368			3. 99
3. 77	- 3.98)		20, 300			3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 518, 243		1, 632	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line		.,		.,	
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider TENTATIVE TO PROVIDER					F 01
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0	5. 01 5. 02
5. 02			0			5. 02
5.05	Provider to Program		O _I		0	5. 05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		o	5. 99
	- 5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
_	the cost report. (1)					_
6. 01	PROGRAM TO PROVIDER		0		958	6. 01
6.02	PROVI DER TO PROGRAM		23, 429		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 494, 814	on Nome	2, 590	7. 00
			Contract	.or name	Contractor Number	
			1. (00	2.00	
8. 00	Name of Contractor		1.		2.00	8. 00
3. 00	1				ı I	0.00

⁽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.

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 01/01/2021 To 12/31/2021

| Period: | Worksheet G | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/19/2022 1:27 pm |

oni y)				12/01/2021	5/19/2022 1: 2	7 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	Assets					
	CURRENT ASSETS	1 507	1			4
1. 00 2. 00	Cash on hand and in banks	1, 507		-	0	
3.00	Temporary investments Notes receivable			-		
4. 00	Accounts receivable	1, 625, 655	-		Ö	
5. 00	Other recei vabl es	-28, 946		o o	0	
6.00	Less: allowances for uncollectible notes and accounts	-242, 145	(0	0	6. 00
	recei vabl e					
7.00	Inventory	46, 879		0	0	
8. 00 9. 00	Prepaid expenses	1 520		0	0	
10.00	Other current assets Due from other funds	-1, 528			0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 401, 422		-	1	
	FIXED ASSETS	., ., ., ., .,		-	_	1
12.00	Land	0	C	0	0	12.00
13.00	Land improvements	134, 397	(0	0	13.00
14. 00	Less: Accumulated depreciation	-59, 156		-	0	
15.00	Buildings	0		0	0	
16.00	Less Accumulated depreciation	1 400 040		0	0	
17. 00 18. 00	Leasehold improvements Less: Accumulated Amortization	1, 499, 840 -691, 421		-	0	
19. 00	Fi xed equipment	161, 382		-	0	
20. 00	Less: Accumulated depreciation	-120, 885		-	Ö	
21. 00	Automobiles and trucks	0		o o	0	
22. 00	Less: Accumulated depreciation	0	C	0	0	22. 00
23. 00	Maj or movable equipment	748, 063	C	0	0	23. 00
24. 00	Less: Accumulated depreciation	-544, 986	C	0	0	1
25. 00	Mi nor equi pment - Depreci abl e	0		0	0	
26.00	Mi nor equipment nondepreciable	0	0	-	0	•
27. 00 28. 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	1, 127, 234		-	0	
20.00	OTHER ASSETS	1, 127, 234		<u> </u>		20.00
29. 00	Investments	0	C	0	0	29. 00
30.00	Deposits on Leases	0	C	0	0	30.00
31.00	Due from owners/officers	-6, 263, 961	(0	0	
32. 00	Other assets	3, 370, 718		1	0	
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-2, 893, 243		-	0	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	-364, 587	(0	0	34.00
	CURRENT LIABILITIES					f
35. 00	Accounts payable	538, 796		0	0	35.00
36.00	Sal ari es, wages, and fees payable	0	C	0	0	36.00
37. 00	Payroll taxes payable	0	C	0	0	
38. 00	Notes & Loans payable (Short term)	0	C	0	0	
39. 00	Deferred income	0		0	0	
40.00	Accel erated payments	4 217	,			40.00
41. 00 42. 00	Due to other funds Other current liabilities	4, 217 704, 977		-	0	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 247, 990				
.0.00	LONG TERM LIABILITIES	1,217,770		<u>, </u>		1 .0.00
44. 00	Mortgage payable	10, 083, 482	C	0	0	44.00
45.00	Notes payable	0	C	0	0	45.00
46.00	Unsecured Loans	0	C	0	0	
47. 00	Loans from owners:	0	C	0	0	
48. 00	Other long term liabilities	0	(0	0	
49. 00	APIC DISTRIBUTIONS; R/E EARNINGS	-9, 414, 530		-	0	
50. 00 51. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	668, 952 1, 916, 942			0	
31.00	CAPITAL ACCOUNTS	1, 710, 742		<u> </u>		31.00
52. 00	General fund balance	-2, 281, 529				52.00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
	Donor created - endowment fund balance - unrestricted			0		55. 00
55.00		1	1	0	1	56.00
56.00	Governing body created - endowment fund balance					
56. 00 57. 00	Plant fund balance - invested in plant				0	
56.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
56. 00 57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion	_2 281 520	,		0	58. 00
56. 00 57. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,	-2, 281, 529 -364, 587		0 0		58. 00 59. 00

In Lieu of Form CMS-2540-10 Health Financial Systems TROY HILLS CENTER Provi der No.: 315138

STATEMENT OF CHANGES IN FUND BALANCES

12/31/2021

Peri od: Worksheet G-1 From 01/01/2021

Date/Time Prepared: 5/19/2022 1:27 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -2, 281, 529 2.00 Total (sum of line 1 and line 2) 3.00 -2, 281, 529 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0 0 0 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) -2, 281, 529 11.00 0 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 0000 14.00 0 14.00 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance -2, 281, 529 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 14.00 0 14.00 15.00 15.00 0 16.00 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00 sheet (Line 11 - line 18)

Health Financial Systems	TROY HILLS CENTER	In Lieu of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315138	Peri od: Worksheet G-2

Health Financial S	ystems	TROY HILLS CEN	ΓER		In Li	eu of Form CMS-2	2540-10
STATEMENT OF PATIE	ENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315138	Peri od:	Worksheet G-2	
					From 01/01/2021		
					To 12/31/2021		
						5/19/2022 1: 2	7 pm
Cost (Center Description			I npati ent	Outpati ent	Total	
				1. 00	2. 00	3. 00	
	TIENT REVENUES						
	atient Routine Care Services					_	
	SING FACILITY			15, 503, 92	28	15, 503, 928	1. 00
2.00 NURSING FAC	I LI TY				0	0	2. 00
3.00 ICF/IID					0	0	3. 00
4.00 OTHER LONG	OTHER LONG TERM CARE		0		0	4. 00	
	Total general inpatient care services (Sum of lines 1 - 4)		15, 503, 928		15, 503, 928	5. 00	
All Other Ca	are Servi ces						
6.00 ANCI LLARY S	ERVI CES			1, 986, 19	98 (1, 986, 198	6.00
7.00 CLINIC					(0	7. 00
8.00 HOME HEALTH	AGENCY COST				(0	8. 00
9.00 AMBULANCE						o	9. 00
10.00 RURAL HEALT	H CLINIC					ol ol	10.00
10. 10 FQHC					(0	10. 10
11. 00 CMHC							11. 00
11. 10 CORF						ol ol	11. 10
12. 00 HOSPI CE							12. 00
13. 00 OTHER (SPEC	TEV)						13. 00
	ent Revenues (Sum of Lines 5 - 13) (T	ranefor column 3	to	17, 490, 12	26	1	
Worksheet G		ransier corumn s	10	17, 470, 12		17, 470, 120	14.00
	Center Description						
0031	20111011 203011 pt 1 011				1. 00	2. 00	
PART II - OF	PERATI NG EXPENSES				1.00	2.00	
	Expenses (Per Worksheet A, Col. 3, Li	ne 100)				12, 856, 158	1. 00
2.00 Add (Specif		110 100)				12, 030, 130	2. 00
3. 00 Add (Specif	<i>y)</i>						3. 00
4.00							4. 00
5. 00							5. 00
6.00					9		6. 00
7. 00	. (0 011 0 7)				()	7. 00
	ions (Sum of lines 2 - 7)					0	8. 00
9.00 Deduct (Spe	city))	9. 00
10. 00]	10.00
11. 00)	11. 00
12. 00					()	12.00
13. 00)	13.00
14.00 Total Deduc	tions (Sum of lines 9 - 13)					0	14.00
15.00 Total Opera	iting Expenses (Sum of lines 1 and 8,	minus line 14)				12, 856, 158	15.00
•							

Heal th	Health Financial Systems TROY HILLS CENTER		In Lieu of Form CMS-2540-10		
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315138	Peri od: From 01/01/2021	Worksheet G-3	
			To 12/31/2021	Date/Time Prep 5/19/2022 1: 2	
				1. 00	
1.00	1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			17, 490, 126	1. 00
2.00 Less: contractual allowances and discounts on patients accounts			6, 943, 872	2.00	
3.00 Net patient revenues (Line 1 minus line 2)			10, 546, 254	3.00	
4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15)			12, 856, 158	4.00	
5.00 Net income from service to patients (Line 3 minus 4)			-2, 309, 904	5.00	

		5/19/2022 1: 2	/_pm	
		1. 00		
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	17, 490, 126	1. 00	
2.00	Less: contractual allowances and discounts on patients accounts	6, 943, 872	2.00	
3.00	3.00 Net patient revenues (Line 1 minus line 2)			
4.00				
5.00	5.00 Net income from service to patients (Line 3 minus 4)			
	Other income:			
6.00	Contributions, donations, bequests, etc	0	6. 00	
7.00	Income from investments	0	7. 00	
8.00	Revenues from communications (Telephone and Internet service)	0	8. 00	
9.00	Revenue from television and radio service	0	9. 00	
10.00	Purchase di scounts	0	10.00	
11. 00	Rebates and refunds of expenses	0	11. 00	
12.00	Parking lot receipts	0	12. 00	
13.00	Revenue from laundry and linen service	0	13. 00	
14.00	Revenue from meals sold to employees and guests	0	14. 00	
	.00 Revenue from rental of living quarters		15. 00	
16. 00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00	
17. 00	Revenue from sale of drugs to other than patients		17. 00	
18. 00	00 Revenue from sale of medical records and abstracts		18. 00	
	Tuition (fees, sale of textbooks, uniforms, etc.)		19. 00	
20.00	00 Revenue from gifts, flower, coffee shops, canteen		20. 00	
21. 00	00 Rental of vending machines		21. 00	
22.00	0 Rental of skilled nursing space		22. 00	
23.00	Governmental appropriations	0	23. 00	
24.00	MISC INCOME	28, 375	24. 00	
	COVI D-19 PHE Funding	0	24. 50	
	Total other income (Sum of lines 6 - 24)	28, 375	25. 00	
26.00	Total (Line 5 plus line 25)		26. 00	
27. 00	Other expenses (specify)		27. 00	
28. 00		0	28. 00	
29. 00		0		
	Total other expenses (Sum of lines 27 - 29)	0		
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	-2, 281, 529	31.00	