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).

FORM APPROVED
OMB NO. 0938-0463
EXPIRES: 12/31/2021

TROY HILLS CENTER	Period:	Run Date Time:	5/13/2025 12:00 pm
	From: 01/01/2024	MCRIF32	**2540-10**
Provider CCN: 315138	To: 12/31/2024	Version:	10.23.179.0

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

Worksheet S
Parts I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: — Time:
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report.
3.01. [ ] No Medicare Utilization. Enter "Y" for yes or leave blank for no.

Contractor use only:

4. [1] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended
5. Date Received: _____
6. Contractor No.: _____
7. [ ] First Cost Report for this Provider CCN
8. [ ] Last Cost Report for this Provider CCN
9. NPR Date: _____
10. If line 4, column 1 is "4": Enter number of times reopened 0
11. Contractor Vendor Code: 4
12. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED 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 {Provider Name(s) and CCN(s)}for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 and that 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 FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	*Diane 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	Signature Date	(Dated when report is electronically signed.)			4

PART III - SETTLEMENT SUMMARY

			Title XVIII			
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
1.00	SKILLED NURSING FACILITY	0	9,248	1,371	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
7.10	SNF - BASED CORF I	0		0		7.10
100.00	TOTAL	**0**	**9,248**	**1,371**	**0**	100.00

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

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	From: 01/01/2024	MCRIF32 **2540-10**
Provider CCN: 315138	To: 12/31/2024	Version: 10.23.179.0

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

Worksheet S-2
Part I
PPS

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1.00	Street:	200 REYNOLDS AVENUE	P.O. Box:					1.00
2.00	City:	PARSIPPANY	State:	NJ	ZIP Code:	07054		2.00
3.00	County:	MIDDLESEX	CBSA Code:	35154	Urban / Rural:	U		3.00
3.01	CBSA on/after October 1 of the Cost Reporting Period (if applicable)							3.01

SNF and SNF-Based Component Identification:

	Component	Component Name	Provider CCN	Date Certified	Payment System (P, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	
4.00	SNF	TROY HILLS CENTER	315138	06/12/1972	N	P	P	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00

		From:	To:	
		1.00	2.00	
14.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2024	12/31/2024	14.00
15.00	Type of Control (See Instructions)	4 - Proprietary, Corporation		15.00

		Y/N	
		1.00	
Type of Freestanding Skilled Nursing Facility			
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.	Y	18.00
Miscellaneous Cost Reporting Information			
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.	N	19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.	N	19.01
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.			
20.00	Straight Line	222,701	20.00
21.00	Declining Balance	0	21.00
22.00	Sum of the Year's Digits	0	22.00
23.00	Sum of line 20 through 22	222,701	23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.	0	24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)	N	25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	N	26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)	N	27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)	N	28.00

		Part A	Part B	Other	
		1.00	2.00	3.00	
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.					
29.00	Skilled Nursing Facility	N	N		29.00
30.00	Nursing Facility			N	30.00
31.00	ICF/IID			N	31.00
32.00	SNF-Based HHA	N	N		32.00
33.00	SNF-Based RHC				33.00
34.00	SNF-Based FQHC		N		34.00
35.00	SNF-Based CMHC		N		35.00
36.00	SNF-Based OLTC				36.00

		Y/N		
		1.00	2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)	Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)	N		38.00

TROY HILLS CENTER	Period:	Run Date Time:	5/13/2025 12:00 pm
	From: 01/01/2024	MCRIF32	**2540-10**
Provider CCN: 315138	To: 12/31/2024	Version:	10.23.179.0

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

Worksheet S-2
Part I
PPS

			Y/N		
			1.00	2.00	
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.		1		39.00
		Premiums	Paid Losses	Self Insurance	
		1.00	2.00	3.00	
41.00	List malpractice premiums and paid losses:	1	0	0	41.00
				Y/N	
				1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.			N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?			Y	43.00
				Provider CCN	
				1.00	
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.			HB0067	44.00

If this facility is part of a chain organization, enter the name and address of the home office on the lines below.

45.00	Name:	GENESIS HEALTHCARE	Contractor Name:	NOVITAS	Contractor Number:	12001	45.00
46.00	Street:	101 EAST STATE STREET	P.O. Box:				46.00
47.00	City:	KENNETT SQUARE	State:	PA	ZIP Code:	19348	47.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

Worksheet S-2
Part II
PPS

General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)

Completed by All Skilled Nursing Facilites

Provider Organization and Operation

			Y/N	Date	
			1.00	2.00	
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	

Financial Data and Reports

4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	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
			Y/N	Legal Oper.	
			1.00	2.00	

Approved Educational Activities

6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N		8.00
			Y/N	
			1.00	

Bad Debts

9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.	Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.	N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.	N	11.00

Bed Complement

12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.	N	12.00

			Part A		Part B		
		Description	Y/N	Date	Y/N	Date	
		0	1.00	2.00	3.00	4.00	
PS&R Data							
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4.(see Instructions.)		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	03/04/2025	Y	03/04/2025	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		N		N		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		N		N		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		N		N		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		N		N		18.00

		1.00	2.00	3.00	
Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JEAN	PRICE	REIMBURSEMENT ANALYST	19.00
20.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTHCARE			20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	4108044481	JEAN.PRICE@GENESISHCC.COM		21.00

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

Worksheet S-3
Part I
PPS

				Inpatient Days/Visits					Discharges					
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	11.00	12.00	
1.00	SKILLED NURSING FACILITY	130	47,580	0	2,869	27,217	5,755	**35,841**	0	59	62	125	**246**	1.00
2.00	NURSING FACILITY	0	0	0		0	0	**0**	0		0	0	**0**	2.00
3.00	ICF/IID	0	0			0	0	**0**			0	0	**0**	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	0	**0**						4.00
5.00	Other Long Term Care	0	0				0	**0**				0	**0**	5.00
6.00	SNF-Based CMHC													6.00
6.10	SNF-Based CORF													6.10
7.00	HOSPICE	0	0	0	0	0	0	**0**	0	0	0	0	**0**	7.00
8.00	Total (Sum of lines 1-7)	**130**	**47,580**	**0**	**2,869**	**27,217**	**5,755**	**35,841**	**0**	**59**	**62**	**125**	**246**	8.00

		Average Length of Stay				Admissions					Full Time Equivalent			
	Component	Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers		
		13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00		
1.00	SKILLED NURSING FACILITY	0.00	48.63	438.98	**145.70**	0	73	26	142	**241**	73.32	0.00		1.00
2.00	NURSING FACILITY	0.00		0.00	**0.00**	0		0	0	**0**	0.00	0.00		2.00
3.00	ICF/IID			0.00	**0.00**			0	0	**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	**0**	0.00	0.00		5.00
6.00	SNF-Based CMHC										0.00	0.00		6.00
6.10	SNF-Based CORF										0.00	0.00		6.10
7.00	HOSPICE	0.00	0.00	0.00	**0.00**	0	0	0	0	**0**	0.00	0.00		7.00
8.00	Total (Sum of lines 1-7)	**0.00**	**48.63**	**438.98**	**145.70**	**0**	**73**	**26**	**142**	**241**	**73.32**	**0.00**		8.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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SNF WAGE INDEX INFORMATION

Worksheet S-3
Part II
PPS

PART II - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
SALARIES							
1.00	Total salaries (See Instructions)	5,125,313	0	**5,125,313**	152,496.47	33.61	1.00
2.00	Physician salaries-Part A	0	0	**0**	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	**0**	0.00	0.00	3.00
4.00	Home office personnel	0	0	**0**	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	**0**	**0**	**0**	**0.00**	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	5,125,313	0	**5,125,313**	152,496.47	33.61	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	HOSPICE	0	0	**0**	0.00	0.00	10.00
11.00	Other excluded areas	0	0	**0**	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	**0**	**0**	**0**	**0.00**	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	**5,125,313**	**0**	**5,125,313**	**152,496.47**	33.61	13.00
OTHER WAGES & RELATED COSTS							
14.00	Contract Labor: Patient Related & Mgmt	2,786,839	0	**2,786,839**	70,275.19	39.66	14.00
15.00	Contract Labor: Physician services-Part A	39,098	0	**39,098**	460.00	85.00	15.00
16.00	Home office salaries & wage related costs	328,401	0	**328,401**	6,011.00	54.63	16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs core (See Part IV)	1,006,786	0	**1,006,786**			17.00
18.00	Wage-related costs other (See Part IV)	0	0	**0**			18.00
19.00	Wage related costs (excluded units)	0	0	**0**			19.00
20.00	Physician Part A - WRC	0	0	**0**			20.00
21.00	Physician Part B - WRC	0	0	**0**			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	**1,006,786**	**0**	**1,006,786**			22.00

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SNF WAGE INDEX INFORMATION

Worksheet S-3
Part III
PPS

PART III - OVERHEAD COST - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Employee Benefits	0	0	**0**	0.00	0.00	1.00
2.00	Administrative & General	438,088	0	**438,088**	12,617.68	34.72	2.00
3.00	Plant Operation, Maintenance & Repairs	132,120	0	**132,120**	4,844.14	27.27	3.00
4.00	Laundry & Linen Service	0	0	**0**	0.00	0.00	4.00
5.00	Housekeeping	0	0	**0**	0.00	0.00	5.00
6.00	Dietary	0	0	**0**	0.00	0.00	6.00
7.00	Nursing Administration	307,689	-59,445	**248,244**	3,103.21	80.00	7.00
8.00	Central Services and Supply	0	0	**0**	0.00	0.00	8.00
9.00	Pharmacy	0	0	**0**	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	59,445	**59,445**	2,189.37	27.15	10.00
11.00	Social Service	199,514	0	**199,514**	4,627.67	43.11	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	132,326	0	**132,326**	6,117.59	21.63	13.00
14.00	Total (sum lines 1 thru 13)	**1,209,737**	**0**	**1,209,737**	**33,499.66**	36.11	14.00

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SNF WAGE RELATED COSTS

Worksheet S-3
Part IV
PPS

PART IV - WAGE RELATED COSTS			
		Amount Reported	
		1.00	
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	40,214	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	398,359	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	154,774	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	347,533	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	56,052	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	9,854	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	**1,006,786**	24.00
		Amount Reported	
		1.00	
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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SNF REPORTING OF DIRECT CARE EXPENDITURES

Worksheet S-3
Part V
PPS

	OCCUPATIONAL CATEGORY	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	1,555,974	205,641	**1,761,615**	30,173.43	58.38	1.00
2.00	Licensed Practical Nurses (LPNs)	561,345	98,265	**659,610**	15,256.50	43.23	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,798,258	457,617	**2,255,875**	73,566.88	30.66	3.00
4.00	Total Nursing (sum of lines 1 through 3)	**3,915,577**	**761,523**	**4,677,100**	**118,996.81**	39.30	4.00
5.00	Physical Therapists	0	0	**0**	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	**0**	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	**0**	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	**0**	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	**0**	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	**0**	0.00	0.00	10.00
11.00	Speech Therapists	0	0	**0**	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	**0**	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	**0**	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	32,240		**32,240**	509.19	63.32	14.00
15.00	Licensed Practical Nurses (LPNs)	245,866		**245,866**	3,929.30	62.57	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	42,160		**42,160**	1,161.90	36.29	16.00
17.00	Total Nursing (sum of lines 14 through 16)	**320,266**		**320,266**	**5,600.39**	57.19	17.00
18.00	Physical Therapists	315,868		**315,868**	4,181.92	75.53	18.00
19.00	Physical Therapy Assistants	101,686		**101,686**	2,073.25	49.05	19.00
20.00	Physical Therapy Aides	0		**0**	0.00	0.00	20.00
21.00	Occupational Therapists	223,943		**223,943**	3,984.69	56.20	21.00
22.00	Occupational Therapy Assistants	3,748		**3,748**	87.27	42.95	22.00
23.00	Occupational Therapy Aides	0		**0**	0.00	0.00	23.00
24.00	Speech Therapists	177,216		**177,216**	3,077.13	57.59	24.00
25.00	Respiratory Therapists	10,365		**10,365**	216.00	47.99	25.00
26.00	Other Medical Staff	39,098		**39,098**	460.00	85.00	26.00

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **Worksheet S-7**

PPS

	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
16.00	RHC		16.00
17.00	RHB		17.00
18.00	RHA		18.00
19.00	RMC		19.00
20.00	RMB		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	HD1		30.00
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	CE1		44.00
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	CA1		52.00
53.00	SE3		53.00
54.00	SE2		54.00
55.00	SE1		55.00
56.00	SSC		56.00
57.00	SSB		57.00

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Provider CCN: 315138	To: 12/31/2024	Version:	10.23.179.0

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **Worksheet S-7**

PPS

	Group	Days	
	1.00	2.00	
58.00	SSA		58.00
59.00	IB2		59.00
60.00	IB1		60.00
61.00	IA2		61.00
62.00	IA1		62.00
63.00	BB2		63.00
64.00	BB1		64.00
65.00	BA2		65.00
66.00	BA1		66.00
67.00	PE2		67.00
68.00	PE1		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
76.00	PA1		76.00
99.00	AAA		99.00
100.00			100.00

		Expenses	Percentage	Y/N	
		1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)					
101.00	Staffing				101.00
102.00	Recruitment				102.00
103.00	Retention of employees				103.00
104.00	Training				104.00
105.00	OTHER (SPECIFY)				105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)				106.00

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **Worksheet A**

PPS

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1,801,836	**1,801,836**	0	1,801,836	0	**1,801,836**	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		42,214	**42,214**	0	42,214	0	**42,214**	2.00
3.00	00300	EMPLOYEE BENEFITS	0	997,694	**997,694**	0	997,694	0	**997,694**	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	438,088	2,082,284	**2,520,372**	0	2,520,372	-620,583	**1,899,789**	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	132,120	503,186	**635,306**	0	635,306	0	**635,306**	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	154,520	**154,520**	0	154,520	0	**154,520**	6.00
7.00	00700	HOUSEKEEPING	0	453,174	**453,174**	0	453,174	0	**453,174**	7.00
8.00	00800	DIETARY	0	1,089,803	**1,089,803**	0	1,089,803	0	**1,089,803**	8.00
9.00	00900	NURSING ADMINISTRATION	307,689	133,083	**440,772**	-59,445	381,327	0	**381,327**	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	38,266	**38,266**	0	38,266	0	**38,266**	10.00
11.00	01100	PHARMACY	0	0	**0**	0	0	0	**0**	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	**0**	59,445	59,445	0	**59,445**	12.00
13.00	01300	SOCIAL SERVICE	199,514	9,138	**208,652**	0	208,652	0	**208,652**	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	**0**	0	0	0	**0**	14.00
15.00	01500	ACTIVITIES	132,326	24,640	**156,966**	0	156,966	-18,994	**137,972**	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	SKILLED NURSING FACILITY	3,915,576	489,295	**4,404,871**	0	4,404,871	1,115	**4,405,986**	30.00
31.00	03100	NURSING FACILITY	0	0	**0**	0	0	0	**0**	31.00
32.00	03200	ICF/IID	0	0	**0**	0	0	0	**0**	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	**0**	0	0	0	**0**	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	04000	RADIOLOGY	0	16,608	**16,608**	0	16,608	0	**16,608**	40.00
41.00	04100	LABORATORY	0	24,166	**24,166**	0	24,166	0	**24,166**	41.00
42.00	04200	INTRAVENOUS THERAPY	0	18,401	**18,401**	0	18,401	0	**18,401**	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	37,236	**37,236**	0	37,236	0	**37,236**	43.00
44.00	04400	PHYSICAL THERAPY	0	321,777	**321,777**	0	321,777	0	**321,777**	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	279,855	**279,855**	0	279,855	0	**279,855**	45.00
46.00	04600	SPEECH PATHOLOGY	0	213,962	**213,962**	0	213,962	0	**213,962**	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	**0**	0	0	0	**0**	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	**0**	0	0	0	**0**	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	149,777	**149,777**	0	149,777	0	**149,777**	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	**0**	0	0	0	**0**	50.00
51.00	05100	SUPPORT SURFACES	0	5,241	**5,241**	0	5,241	0	**5,241**	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	**0**	0	0	0	**0**	52.00
OUTPATIENT SERVICE COST CENTERS										
60.00	06000	CLINIC	0	0	**0**	0	0	0	**0**	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	**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	0	**0**	63.00
OTHER REIMBURSABLE COST CENTERS										
70.00	07000	HOME HEALTH AGENCY COST	0	0	**0**	0	0	0	**0**	70.00
71.00	07100	AMBULANCE	0	0	**0**	0	0	0	**0**	71.00
72.00	07200	CORF	0	0	**0**	0	0	0	**0**	72.00
73.00	07300	CMHC	0	0	**0**	0	0	0	**0**	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	**0**	0	0	0	**0**	74.00
SPECIAL PURPOSE COST CENTERS										
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		0	**0**	0	0	0	**0**	80.00
81.00	08100	INTEREST EXPENSE		0	**0**	0	0	0	**0**	81.00
82.00	08200	UTILIZATION REVIEW	0	0	**0**	0	0	0	**0**	82.00
83.00	08300	HOSPICE	0	0	**0**	0	0	0	**0**	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	**0**	0	0	0	**0**	84.00
89.00		SUBTOTALS (sum of lines 1-84)	5,125,313	8,886,156	**14,011,469**	0	14,011,469	-638,462	**13,373,007**	89.00
NONREIMBURSABLE COST CENTERS										
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	**0**	0	0	0	**0**	90.00

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **Worksheet A**

PPS

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
91.00	09100	BARBER AND BEAUTY SHOP	0	11,182	**11,182**	0	11,182	0	**11,182**	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	**0**	0	0	0	**0**	92.00
93.00	09300	NONPAID WORKERS	0	0	**0**	0	0	0	**0**	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	**0**	0	0	0	**0**	94.00
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	**0**	0	0	0	**0**	95.00
100.00		TOTAL	**5,125,313**	**8,897,338**	**14,022,651**	**0**	**14,022,651**	**-638,462**	**13,384,189**	100.00

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RECLASSIFICATIONS

Worksheet A-6

PPS

	Increases				Decreases				
	Cost Center	Line #	Salary	Non Salary	Cost Center	Line #	Salary	Non Salary	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - DEFAULT									
1.00	MEDICAL RECORDS & LIBRARY	12.00	59,445	0	NURSING ADMINISTRATION	9.00	59,445	0	1.00
100.00	**TOTAL RECLASSIFICATIONS (Sum of columns 4 and 5 must equal sum of columns 8 and 9 (2)**		**59,445**	**0**			**59,445**	**0**	100.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COSTS CENTERS **Worksheet A-7**

PPS

			Acquisitions						
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES									
1.00	Land	0	0	0	**0**	0	0	0	1.00
2.00	Land Improvements	134,397	0	0	**0**	0	134,397	0	2.00
3.00	Buildings and Fixtures	3,972,631	0	0	**0**	0	3,972,631	0	3.00
4.00	Building Improvements	1,527,506	0	0	**0**	0	1,527,506	0	4.00
5.00	Fixed Equipment	180,333	3,141	0	**3,141**	0	183,474	0	5.00
6.00	Movable Equipment	748,063	0	0	**0**	0	748,063	0	6.00
7.00	Subtotal (sum of lines 1-6)	**6,562,930**	**3,141**	**0**	**3,141**	**0**	**6,566,071**	**0**	7.00
8.00	Reconciling Items	0	0	0	**0**	0	0	0	8.00
9.00	Total (line 7 minus line 8)	**6,562,930**	**3,141**	**0**	**3,141**	**0**	**6,566,071**	**0**	9.00

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ADJUSTMENTS TO EXPENSES **Worksheet A-8**

PPS

	Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
				Cost Center	Line No.	
		1.00	2.00	3.00	4.00	
1.00	Investment income on restricted funds (chapter 2)		0		0.00	1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3.00
4.00	Rental of provider space by suppliers (chapter 8)		0		0.00	4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	5.00
6.00	Television and radio service (chapter 21)	A	-18,994	ACTIVITIES	15.00	6.00
7.00	Parking lot (chapter 21)		0		0.00	7.00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0			8.00
9.00	Home office cost (chapter 21)		0		0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00	11.00
12.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	134,410			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals		0		0.00	14.00
15.00	Cost of meals - Guests		0		0.00	15.00
16.00	Sale of medical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Vending machines		0		0.00	19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	21.00
22.00	Utilization review--physicians' compensation (chapter 21)		0	UTILIZATION REVIEW	82.00	22.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00	Depreciation--movable equipment		0	CAP REL COSTS - MOVABLE EQUIPMENT	2.00	24.00
25.00	MISC INCOME	B	-6,213	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01	UNALLOWED A & G	A	-748,780	ADMINISTRATIVE & GENERAL	4.00	25.01
25.02	HEP/SALINE	A	1,115	SKILLED NURSING FACILITY	30.00	25.02
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		**-638,462**			100.00

(1) Description - All chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Worksheet A-8-1
Parts I & II
PPS

PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	4.00	ADMINISTRATIVE & GENERAL	HOME OFFICE A&G	604,118	497,626	**106,492**	1.00
2.00	4.00	ADMINISTRATIVE & GENERAL	HOME OFFICE CAPITAL	27,918	0	**27,918**	2.00
3.00	44.00	PHYSICAL THERAPY	PT	321,316	321,316	**0**	3.00
4.00	45.00	OCCUPATIONAL THERAPY	OT	279,238	279,238	**0**	4.00
5.00	46.00	SPEECH PATHOLOGY	ST	213,855	213,855	**0**	5.00
6.00	30.00	SKILLED NURSING FACILITY	NURSING PURCHASED SERVICES	320,266	320,266	**0**	6.00
7.00	43.00	OXYGEN (INHALATION) THERAPY	RT	10,365	10,365	**0**	7.00
8.00	4.00	ADMINISTRATIVE & GENERAL	MEDICAL DIRECTOR	39,098	39,098	**0**	8.00
9.00	0.00			0	0	**0**	9.00
10.00	**TOTALS (sum of lines 1-9). Transfer column 6, line 10 to Worksheet A-8, column 3, line 12.**			**1,816,174**	**1,681,764**	**134,410**	10.00

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 II 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	B		0.00	GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2.00	B		0.00	POWERBACK REHAB/LONGEVITY	100.00	PT OT ST	2.00
3.00	B		0.00	CSU/CARE SAVE	100.00	NURSING PURCHASED SERVICES	3.00
4.00	B		0.00	POWERBACK RESPIRATORY	100.00	RT	4.00
5.00	B		0.00	ALIGNMED PARTNERS	100.00	MEDICAL DIRECTOR	5.00
6.00			0.00		0.00		6.00
7.00			0.00		0.00		7.00
8.00			0.00		0.00		8.00
9.00			0.00		0.00		9.00
10.00			0.00		0.00		10.00

(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 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.
G. Other (financial or non-financial) specify:

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
		0	1.00	2.00	3.00	3A	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	1,801,836	1,801,836							1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT	42,214		42,214						2.00
3.00	EMPLOYEE BENEFITS	997,694	28,027	657	1,026,378					3.00
4.00	ADMINISTRATIVE & GENERAL	1,899,789	358,084	8,389	87,730	**2,353,992**	2,353,992			4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	635,306	71,792	1,682	26,458	**735,238**	156,909	892,147		5.00
6.00	LAUNDRY & LINEN SERVICE	154,520	30,018	703	0	**185,241**	39,533	19,927	244,701	6.00
7.00	HOUSEKEEPING	453,174	15,738	369	0	**469,281**	100,151	10,447	0	7.00
8.00	DIETARY	1,089,803	208,623	4,888	0	**1,303,314**	278,144	138,491	0	8.00
9.00	NURSING ADMINISTRATION	381,327	19,672	461	49,713	**451,173**	96,286	13,059	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	38,266	9,278	217	0	**47,761**	10,193	6,159	0	10.00
11.00	PHARMACY	0	0	0	0	**0**	0	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	59,445	7,675	180	11,904	**79,204**	16,903	5,095	0	12.00
13.00	SOCIAL SERVICE	208,652	6,315	148	39,954	**255,069**	54,435	4,192	0	13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	**0**	0	0	0	14.00
15.00	ACTIVITIES	137,972	0	0	26,499	**164,471**	35,100	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	4,405,986	975,065	22,843	784,120	**6,188,014**	1,320,609	647,281	244,701	30.00
31.00	NURSING FACILITY	0	0	0	0	**0**	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	**0**	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	**0**	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	16,608	0	0	0	**16,608**	3,544	0	0	40.00
41.00	LABORATORY	24,166	0	0	0	**24,166**	5,157	0	0	41.00
42.00	INTRAVENOUS THERAPY	18,401	0	0	0	**18,401**	3,927	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	37,236	0	0	0	**37,236**	7,947	0	0	43.00
44.00	PHYSICAL THERAPY	321,777	23,898	560	0	**346,235**	73,891	15,864	0	44.00
45.00	OCCUPATIONAL THERAPY	279,855	32,981	773	0	**313,609**	66,928	21,894	0	45.00
46.00	SPEECH PATHOLOGY	213,962	0	0	0	**213,962**	45,662	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	**0**	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,601	319	0	**13,920**	2,971	9,029	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	149,777	1,069	25	0	**150,871**	32,198	709	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	**0**	0	0	0	50.00
51.00	SUPPORT SURFACES	5,241	0	0	0	**5,241**	1,118	0	0	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	**0**	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC	0	0	0	0	**0**	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	**0**	0	0	0	61.00
62.00	FQHC									62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	**0**	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	**0**	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	**0**	0	0	0	71.00
72.00	CORF	0	0	0	0	**0**	0	0	0	72.00
73.00	CMHC	0	0	0	0	**0**	0	0	0	73.00
74.00	OTHER REIMBURSABLE COST	0	0	0	0	**0**	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW									82.00
83.00	HOSPICE	0	0	0	0	**0**	0	0	0	83.00
84.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	**0**	0	0	0	84.00

TROY HILLS CENTER Provider CCN: 315138	Period: From: 01/01/2024 To: 12/31/2024	Run Date Time: 5/13/2025 12:00 pm MCRIF32 **2540-10** Version: 10.23.179.0

COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
		0	1.00	2.00	3.00	3A	4.00	5.00	6.00	
89.00	SUBTOTALS (sum of lines 1-84)	**13,373,007**	**1,801,836**	**42,214**	**1,026,378**	**13,373,007**	**2,351,606**	**892,147**	**244,701**	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	**0**	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	11,182	0	0	0	**11,182**	2,386	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	**0**	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	**0**	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	**0**	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	**0**	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	**0**	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	**0**	0	0	0	99.00
100.00	TOTAL	**13,384,189**	**1,801,836**	**42,214**	**1,026,378**	**13,384,189**	**2,353,992**	**892,147**	**244,701**	100.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
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	Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING	579,879								7.00
8.00	DIETARY	93,189	1,813,138							8.00
9.00	NURSING ADMINISTRATION	8,787	0	569,305						9.00
10.00	CENTRAL SERVICES & SUPPLY	4,144	0	0	68,257					10.00
11.00	PHARMACY	0	0	0	0	0				11.00
12.00	MEDICAL RECORDS & LIBRARY	3,428	0	0	0	0	104,630			12.00
13.00	SOCIAL SERVICE	2,821	0	0	0	0	0	316,517		13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	ACTIVITIES	0	0	0	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	435,551	1,813,138	569,305	68,257	0	90,387	316,517	0	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	0	111	0	0	40.00
41.00	LABORATORY	0	0	0	0	0	238	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	137	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	11	0	0	43.00
44.00	PHYSICAL THERAPY	10,675	0	0	0	0	5,155	0	0	44.00
45.00	OCCUPATIONAL THERAPY	14,732	0	0	0	0	4,546	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	3,342	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,075	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	477	0	0	0	0	703	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	0	0	0	0	71.00
72.00	CORF	0	0	0	0	0	0	0	0	72.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
74.00	OTHER REIMBURSABLE COST	0	0	0	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
84.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	**579,879**	**1,813,138**	**569,305**	**68,257**	**0**	**104,630**	**316,517**	**0**	89.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
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	Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0				0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	**579,879**	**1,813,138**	**569,305**	**68,257**	**0**	**104,630**	**316,517**	**0**	100.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
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	Cost Center Description	ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total		
		15.00	16.00	17.00	18.00		
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	EMPLOYEE BENEFITS						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	CENTRAL SERVICES & SUPPLY						10.00
11.00	PHARMACY						11.00
12.00	MEDICAL RECORDS & LIBRARY						12.00
13.00	SOCIAL SERVICE						13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION						14.00
15.00	ACTIVITIES	199,571					15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	SKILLED NURSING FACILITY	199,571	**11,893,331**	0	**11,893,331**		30.00
31.00	NURSING FACILITY	0	**0**	0	**0**		31.00
32.00	ICF/IID	0	**0**	0	**0**		32.00
33.00	OTHER LONG TERM CARE	0	**0**	0	**0**		33.00
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	0	**20,263**	0	**20,263**		40.00
41.00	LABORATORY	0	**29,561**	0	**29,561**		41.00
42.00	INTRAVENOUS THERAPY	0	**22,465**	0	**22,465**		42.00
43.00	OXYGEN (INHALATION) THERAPY	0	**45,194**	0	**45,194**		43.00
44.00	PHYSICAL THERAPY	0	**451,820**	0	**451,820**		44.00
45.00	OCCUPATIONAL THERAPY	0	**421,709**	0	**421,709**		45.00
46.00	SPEECH PATHOLOGY	0	**262,966**	0	**262,966**		46.00
47.00	ELECTROCARDIOLOGY	0	**0**	0	**0**		47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	**31,995**	0	**31,995**		48.00
49.00	DRUGS CHARGED TO PATIENTS	0	**184,958**	0	**184,958**		49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	**0**	0	**0**		50.00
51.00	SUPPORT SURFACES	0	**6,359**	0	**6,359**		51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	**0**	0	**0**		52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	CLINIC	0	**0**	0	**0**		60.00
61.00	RURAL HEALTH CLINIC	0	**0**	0	**0**		61.00
62.00	FQHC						62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	**0**	0	**0**		63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	HOME HEALTH AGENCY COST	0	**0**	0	**0**		70.00
71.00	AMBULANCE	0	**0**	0	**0**		71.00
72.00	CORF	0	**0**	0	**0**		72.00
73.00	CMHC	0	**0**	0	**0**		73.00
74.00	OTHER REIMBURSABLE COST	0	**0**	0	**0**		74.00
SPECIAL PURPOSE COST CENTERS							
80.00	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	INTEREST EXPENSE						81.00
82.00	UTILIZATION REVIEW						82.00
83.00	HOSPICE	0	**0**	0	**0**		83.00
84.00	OTHER SPECIAL PURPOSE COST CENTERS	0	**0**	0	**0**		84.00
89.00	SUBTOTALS (sum of lines 1-84)	**199,571**	**13,370,621**	**0**	**13,370,621**		89.00
NONREIMBURSABLE COST CENTERS							

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COST ALLOCATION - GENERAL SERVICE COSTS

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	Cost Center Description	ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total		
		15.00	16.00	17.00	18.00		
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	**0**	0	**0**		90.00
91.00	BARBER AND BEAUTY SHOP	0	**13,568**	0	**13,568**		91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	**0**	0	**0**		92.00
93.00	NONPAID WORKERS	0	**0**	0	**0**		93.00
94.00	PATIENTS LAUNDRY	0	**0**	0	**0**		94.00
95.00	OTHER NONREIMBURSABLE COST CENTERS	0	**0**	0	**0**		95.00
98.00	Cross Foot Adjustments	0	**0**	0	**0**		98.00
99.00	Negative Cost Centers	0	**0**	0	**0**		99.00
100.00	TOTAL	**199,571**	**13,384,189**	**0**	**13,384,189**		100.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	MOVABLE EQUIPMENT	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
		0	1.00	2.00	2A	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
3.00	EMPLOYEE BENEFITS	0	28,027	657	**28,684**	28,684				3.00
4.00	ADMINISTRATIVE & GENERAL	0	358,084	8,389	**366,473**	2,452	368,925			4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	0	71,792	1,682	**73,474**	739	24,592	98,805		5.00
6.00	LAUNDRY & LINEN SERVICE	0	30,018	703	**30,721**	0	6,196	2,207	39,124	6.00
7.00	HOUSEKEEPING	0	15,738	369	**16,107**	0	15,696	1,157	0	7.00
8.00	DIETARY	0	208,623	4,888	**213,511**	0	43,592	15,338	0	8.00
9.00	NURSING ADMINISTRATION	0	19,672	461	**20,133**	1,389	15,090	1,446	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	9,278	217	**9,495**	0	1,597	682	0	10.00
11.00	PHARMACY	0	0	0	**0**	0	0	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	0	7,675	180	**7,855**	333	2,649	564	0	12.00
13.00	SOCIAL SERVICE	0	6,315	148	**6,463**	1,117	8,531	464	0	13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	**0**	0	0	0	0	14.00
15.00	ACTIVITIES	0	0	0	**0**	741	5,501	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	0	975,065	22,843	**997,908**	21,913	206,971	71,686	39,124	30.00
31.00	NURSING FACILITY	0	0	0	**0**	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	**0**	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	**0**	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	**0**	0	555	0	0	40.00
41.00	LABORATORY	0	0	0	**0**	0	808	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	**0**	0	615	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	**0**	0	1,245	0	0	43.00
44.00	PHYSICAL THERAPY	0	23,898	560	**24,458**	0	11,581	1,757	0	44.00
45.00	OCCUPATIONAL THERAPY	0	32,981	773	**33,754**	0	10,489	2,425	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	**0**	0	7,156	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	**0**	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,601	319	**13,920**	0	466	1,000	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	1,069	25	**1,094**	0	5,046	79	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	**0**	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	**0**	0	175	0	0	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	**0**	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC	0	0	0	**0**	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	**0**	0	0	0	0	61.00
62.00	FQHC									62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	**0**	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	**0**	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	**0**	0	0	0	0	71.00
72.00	CORF	0	0	0	**0**	0	0	0	0	72.00
73.00	CMHC	0	0	0	**0**	0	0	0	0	73.00
74.00	OTHER REIMBURSABLE COST	0	0	0	**0**	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW									82.00
83.00	HOSPICE	0	0	0	**0**	0	0	0	0	83.00
84.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	**0**	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	**0**	**1,801,836**	**42,214**	**1,844,050**	**28,684**	**368,551**	**98,805**	**39,124**	89.00

TROY HILLS CENTER	Period:	Run Date Time:	5/13/2025 12:00 pm
	From: 01/01/2024	MCRIF32	**2540-10**
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ALLOCATION OF CAPITAL RELATED COSTS

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	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	MOVABLE EQUIPMENT	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
		0	1.00	2.00	2A	3.00	4.00	5.00	6.00	
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	**0**	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	**0**	0	374	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	**0**	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	**0**	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	**0**	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	**0**	0	0	0	0	95.00
98.00	Cross Foot Adjustments								0	98.00
99.00	Negative Cost Centers		0	0	**0**	0	0	0	0	99.00
100.00	TOTAL	**0**	**1,801,836**	**42,214**	**1,844,050**	**28,684**	**368,925**	**98,805**	**39,124**	100.00

TROY HILLS CENTER Provider CCN: 315138	Period: From: 01/01/2024 To: 12/31/2024	Run Date Time: 5/13/2025 12:00 pm MCRIF32 **2540-10** Version: 10.23.179.0

ALLOCATION OF CAPITAL RELATED COSTS

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	Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING	32,960								7.00
8.00	DIETARY	5,297	277,738							8.00
9.00	NURSING ADMINISTRATION	499	0	38,557						9.00
10.00	CENTRAL SERVICES & SUPPLY	236	0	0	12,010					10.00
11.00	PHARMACY	0	0	0	0	0				11.00
12.00	MEDICAL RECORDS & LIBRARY	195	0	0	0	0	11,596			12.00
13.00	SOCIAL SERVICE	160	0	0	0	0	0	16,735		13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	ACTIVITIES	0	0	0	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	24,757	277,738	38,557	12,010	0	10,019	16,735	0	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	0	12	0	0	40.00
41.00	LABORATORY	0	0	0	0	0	26	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	15	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	1	0	0	43.00
44.00	PHYSICAL THERAPY	607	0	0	0	0	571	0	0	44.00
45.00	OCCUPATIONAL THERAPY	837	0	0	0	0	504	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	370	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	345	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	27	0	0	0	0	78	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	0	0	0	0	71.00
72.00	CORF	0	0	0	0	0	0	0	0	72.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
74.00	OTHER REIMBURSABLE COST	0	0	0	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
84.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	**32,960**	**277,738**	**38,557**	**12,010**	**0**	**11,596**	**16,735**	**0**	89.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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ALLOCATION OF CAPITAL RELATED COSTS

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	Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	0			0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	**32,960**	**277,738**	**38,557**	**12,010**	**0**	**11,596**	**16,735**	**0**	100.00

TROY HILLS CENTER Provider CCN: 315138	Period: From: 01/01/2024 To: 12/31/2024	Run Date Time: 5/13/2025 12:00 pm MCRIF32 **2540-10** Version: 10.23.179.0

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	ACTIVITIES	Subtotal	Post Step-Down Adjustments	Total		
		15.00	16.00	17.00	18.00		
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	EMPLOYEE BENEFITS						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	CENTRAL SERVICES & SUPPLY						10.00
11.00	PHARMACY						11.00
12.00	MEDICAL RECORDS & LIBRARY						12.00
13.00	SOCIAL SERVICE						13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION						14.00
15.00	ACTIVITIES	6,242					15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	SKILLED NURSING FACILITY	6,242	**1,723,660**	0	**1,723,660**		30.00
31.00	NURSING FACILITY	0	**0**	0	**0**		31.00
32.00	ICF/IID	0	**0**	0	**0**		32.00
33.00	OTHER LONG TERM CARE	0	**0**	0	**0**		33.00
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	0	**567**	0	**567**		40.00
41.00	LABORATORY	0	**834**	0	**834**		41.00
42.00	INTRAVENOUS THERAPY	0	**630**	0	**630**		42.00
43.00	OXYGEN (INHALATION) THERAPY	0	**1,246**	0	**1,246**		43.00
44.00	PHYSICAL THERAPY	0	**38,974**	0	**38,974**		44.00
45.00	OCCUPATIONAL THERAPY	0	**48,009**	0	**48,009**		45.00
46.00	SPEECH PATHOLOGY	0	**7,526**	0	**7,526**		46.00
47.00	ELECTROCARDIOLOGY	0	**0**	0	**0**		47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	**15,731**	0	**15,731**		48.00
49.00	DRUGS CHARGED TO PATIENTS	0	**6,324**	0	**6,324**		49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	**0**	0	**0**		50.00
51.00	SUPPORT SURFACES	0	**175**	0	**175**		51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	**0**	0	**0**		52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	CLINIC	0	**0**	0	**0**		60.00
61.00	RURAL HEALTH CLINIC	0	**0**	0	**0**		61.00
62.00	FQHC						62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	**0**	0	**0**		63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	HOME HEALTH AGENCY COST	0	**0**	0	**0**		70.00
71.00	AMBULANCE	0	**0**	0	**0**		71.00
72.00	CORF	0	**0**	0	**0**		72.00
73.00	CMHC	0	**0**	0	**0**		73.00
74.00	OTHER REIMBURSABLE COST	0	**0**	0	**0**		74.00
SPECIAL PURPOSE COST CENTERS							
80.00	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	INTEREST EXPENSE						81.00
82.00	UTILIZATION REVIEW						82.00
83.00	HOSPICE	0	**0**	0	**0**		83.00
84.00	OTHER SPECIAL PURPOSE COST CENTERS	0	**0**	0	**0**		84.00
89.00	SUBTOTALS (sum of lines 1-84)	**6,242**	**1,843,676**	**0**	**1,843,676**		89.00
NONREIMBURSABLE COST CENTERS							

TROY HILLS CENTER	Period:	Run Date Time:	5/13/2025 12:00 pm
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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
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	Cost Center Description	ACTIVITIES	Subtotal	Post Step-Down Adjustments	Total		
		15.00	16.00	17.00	18.00		
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	**0**	0	**0**		90.00
91.00	BARBER AND BEAUTY SHOP	0	**374**	0	**374**		91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	**0**	0	**0**		92.00
93.00	NONPAID WORKERS	0	**0**	0	**0**		93.00
94.00	PATIENTS LAUNDRY	0	**0**	0	**0**		94.00
95.00	OTHER NONREIMBURSABLE COST CENTERS	0	**0**	0	**0**		95.00
98.00	Cross Foot Adjustments	0	**0**	0	**0**		98.00
99.00	Negative Cost Centers	0	**0**	0	**0**		99.00
100.00	TOTAL	**6,242**	**1,844,050**	**0**	**1,844,050**		100.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
	From: 01/01/2024	MCRIF32 **2540-10**
Provider CCN: 315138	To: 12/31/2024	Version: 10.23.179.0

COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

PPS

	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
		1.00	2.00	3.00	4A	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	37,095								1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT		37,095							2.00
3.00	EMPLOYEE BENEFITS	577	577	5,125,313						3.00
4.00	ADMINISTRATIVE & GENERAL	7,372	7,372	438,088	-2,353,992	11,030,197				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	1,478	1,478	132,120	0	735,238	27,668			5.00
6.00	LAUNDRY & LINEN SERVICE	618	618	0	0	185,241	618	35,841		6.00
7.00	HOUSEKEEPING	324	324	0	0	469,281	324	0	26,726	7.00
8.00	DIETARY	4,295	4,295	0	0	1,303,314	4,295	0	4,295	8.00
9.00	NURSING ADMINISTRATION	405	405	248,244	0	451,173	405	0	405	9.00
10.00	CENTRAL SERVICES & SUPPLY	191	191	0	0	47,761	191	0	191	10.00
11.00	PHARMACY	0	0	0	0	0	0	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	158	158	59,445	0	79,204	158	0	158	12.00
13.00	SOCIAL SERVICE	130	130	199,514	0	255,069	130	0	130	13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	ACTIVITIES	0	0	132,326	0	164,471	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	20,074	20,074	3,915,576	0	6,188,014	20,074	35,841	20,074	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	16,608	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	24,166	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	18,401	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	37,236	0	0	0	43.00
44.00	PHYSICAL THERAPY	492	492	0	0	346,235	492	0	492	44.00
45.00	OCCUPATIONAL THERAPY	679	679	0	0	313,609	679	0	679	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	213,962	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	280	280	0	0	13,920	280	0	280	48.00
49.00	DRUGS CHARGED TO PATIENTS	22	22	0	0	150,871	22	0	22	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	5,241	0	0	0	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	0	0	0	0	71.00
72.00	CORF	0	0	0	0	0	0	0	0	72.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
74.00	OTHER REIMBURSABLE COST	0	0	0	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

PPS

	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
		1.00	2.00	3.00	4A	4.00	5.00	6.00	7.00	
84.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	**0**	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	**37,095**	**37,095**	**5,125,313**	**-2,353,992**	**11,019,015**	**27,668**	**35,841**	**26,726**	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	**0**	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	**0**	11,182	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	**0**	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	**0**	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	**0**	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	**0**	0	0	0	0	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, Part I)	1,801,836	42,214	1,026,378		2,353,992	892,147	244,701	579,879	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	48.573554	1.137997	0.200257		0.213413	32.244723	6.827404	21.697186	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			28,684		368,925	98,805	39,124	32,960	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.005597		0.033447	3.571093	1.091599	1.233256	105.00

TROY HILLS CENTER	Period:	Run Date Time: 5/13/2025 12:00 pm
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COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

PPS

	Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	ACTIVITIES (TOTAL PATIENT DAYS)	
		8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING									7.00
8.00	DIETARY	107,523								8.00
9.00	NURSING ADMINISTRATION	0	35,841							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	28,401						10.00
11.00	PHARMACY	0	0	0	0					11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	18,547,577				12.00
13.00	SOCIAL SERVICE	0	0	0	0	0	35,841			13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0		14.00
15.00	ACTIVITIES	0	0	0	0	0	0	0	35,841	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	107,523	35,841	28,401	0	16,022,667	35,841	0	35,841	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	19,718	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	42,246	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	24,233	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	1,938	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	913,766	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	805,964	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	592,381	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	124,610	0	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	54	0	0	0	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC		0	0		0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	0	0	0	0	71.00
72.00	CORF	0	0	0	0	0	0	0	0	72.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
74.00	OTHER REIMBURSABLE COST	0	0	0	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00

TROY HILLS CENTER	Period:	Run Date Time:	5/13/2025 12:00 pm
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COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

PPS

	Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	ACTIVITIES (TOTAL PATIENT DAYS)	
		8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	
84.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	**107,523**	**35,841**	**28,401**	**0**	**18,547,577**	**35,841**	**0**	**35,841**	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	0	0	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, Part I)	1,813,138	569,305	68,257	0	104,630	316,517	0	199,571	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	16.862792	15.884183	2.403331	0.000000	0.005641	8.831143	0.000000	5.568232	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	277,738	38,557	12,010	0	11,596	16,735	0	6,242	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	2.583057	1.075779	0.422872	0.000000	0.000625	0.466923	0.000000	0.174158	105.00

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RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS **Worksheet C**

PPS

	Cost Center Description	Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	RADIOLOGY	20,263	19,718	1.027640	40.00
41.00	LABORATORY	29,561	42,246	0.699735	41.00
42.00	INTRAVENOUS THERAPY	22,465	24,233	0.927042	42.00
43.00	OXYGEN (INHALATION) THERAPY	45,194	1,938	23.319917	43.00
44.00	PHYSICAL THERAPY	451,820	913,766	0.494459	44.00
45.00	OCCUPATIONAL THERAPY	421,709	805,964	0.523236	45.00
46.00	SPEECH PATHOLOGY	262,966	592,381	0.443914	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,995	0	0.000000	48.00
49.00	DRUGS CHARGED TO PATIENTS	184,958	124,610	1.484295	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	SUPPORT SURFACES	6,359	54	117.759259	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	52.00
OUTPATIENT SERVICE COST CENTERS					
60.00	CLINIC	0	0	0.000000	60.00
61.00	RURAL HEALTH CLINIC				61.00
62.00	FQHC				62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	63.00
71.00	AMBULANCE	0	0	0.000000	71.00
100.00	Total	**1,477,290**	**2,524,910**		100.00

TROY HILLS CENTER	Period:	Run Date Time:	5/13/2025 12:00 pm
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APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Worksheet D
Part I

Title XVIII Skilled Nursing Facility PPS

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

			Health Care Program Charges		Health Care Program Cost		
		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	1.027640	2,780	0	2,857	0	40.00
41.00	LABORATORY	0.699735	1,008	0	705	0	41.00
42.00	INTRAVENOUS THERAPY	0.927042	8,350	0	7,741	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	23.319917	701	0	16,347	0	43.00
44.00	PHYSICAL THERAPY	0.494459	232,972	0	115,195	0	44.00
45.00	OCCUPATIONAL THERAPY	0.523236	235,405	0	123,172	0	45.00
46.00	SPEECH PATHOLOGY	0.443914	198,515	0	88,124	0	46.00
47.00	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	1.484295	49,923	0	74,100	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0.000000	0		0		50.00
51.00	SUPPORT SURFACES	117.759259	10	0	1,178	0	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	CLINIC	0.000000	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC						61.00
62.00	FQHC						62.00
63.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	63.00
71.00	AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		**729,664**	**0**	**429,419**	**0**	100.00

(1) For titles V and XIX use columns 1, 2 and 4 only.
(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

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APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Worksheet D
Parts II-III

Title XVIII | Skilled Nursing Facility | PPS

PART II - APPORTIONMENT OF VACCINE COST

		1.00	
1.00	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.484295	1.00
2.00	Program vaccine charges (From your records, or the PS&R)	3,781	2.00
3.00	Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	5,612	3.00

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH

	Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	20,263	0	0.000000	2,857	0	40.00
41.00	LABORATORY	29,561	0	0.000000	705	0	41.00
42.00	INTRAVENOUS THERAPY	22,465	0	0.000000	7,741	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	45,194	0	0.000000	16,347	0	43.00
44.00	PHYSICAL THERAPY	451,820	0	0.000000	115,195	0	44.00
45.00	OCCUPATIONAL THERAPY	421,709	0	0.000000	123,172	0	45.00
46.00	SPEECH PATHOLOGY	262,966	0	0.000000	88,124	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,995	0	0.000000	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	184,958	0	0.000000	74,100	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	SUPPORT SURFACES	6,359	0	0.000000	1,178	0	51.00
52.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	52.00
100.00	Total (Sum of lines 40 - 52)	**1,477,290**	**0**		**429,419**	**0**	100.00

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COMPUTATION OF INPATIENT ROUTINE COSTS

Worksheet D-1
Part I

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	35,841	1.00
2.00	Private room days	108	2.00
3.00	Inpatient days including private room days applicable to the Program	2,869	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	**11,893,331**	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	15,878,049	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.749042	7.00
8.00	Enter private room charges from your records	53,882	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	498.91	9.00
10.00	Enter semi-private room charges from your records	15,824,167	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	442.84	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	56.07	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	42.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	4,536	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	11,888,795	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	331.71	16.00
17.00	Program routine service cost (Line 3 times line 16)	951,676	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	**951,676**	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	1,723,660	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	48.09	21.00
22.00	Program capital related cost (Line 3 times line 21)	137,970	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	813,706	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	**813,706**	25.00
26.00	Enter the per diem limitation (1)		26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
		1.00	
1.00	Total SNF inpatient days	35,841	1.00
2.00	Program inpatient days (see instructions)	2,869	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)	0.080048	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII

Worksheet E
Part I

Title XVIII | Skilled Nursing Facility | PPS

		1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT			
1.00	Inpatient PPS amount (See Instructions)	2,198,473	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)	0	2.00
3.00	Subtotal (Sum of lines 1 and 2)	**2,198,473**	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	384,744	5.00
6.00	Allowable bad debts (From your records)	109,983	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	106,616	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	71,489	8.00
9.00	Recovery of bad debts - for statistical records only	0	9.00
10.00	Utilization review	0	10.00
11.00	Subtotal (See instructions)	**1,885,218**	11.00
12.00	Interim payments (See instructions)	1,838,265	12.00
13.00	Tentative adjustment	0	13.00
14.00	OTHER adjustment (See instructions)	0	14.00
14.50	Demonstration payment adjustment amount before sequestration	0	14.50
14.55	Demonstration payment adjustment amount after sequestration	0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)	1,430	14.75
14.99	Sequestration amount (see instructions)	36,275	14.99
15.00	Balance due provider/program (see Instructions)	**9,248**	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY			
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	5,612	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	**5,612**	19.00
20.00	Medicare Part B ancillary charges (See instructions)	3,781	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	3,781	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinsurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	24.01
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)	**3,781**	25.00
26.00	Interim payments (See instructions)	2,334	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	76	28.99
29.00	Balance due provider/program (see instructions)	**1,371**	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY

Worksheet E
Part II

Title XIX Skilled Nursing Facility PPS

		1.00	
COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient ancillary services (see Instructions)	0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)	0	2.00
3.00	Outpatient services	0	3.00
4.00	Inpatient routine services (see instructions)	0	4.00
5.00	Utilization review--physicians' compensation (from provider records)	0	5.00
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
8.00	SUBTOTAL (Line 6 minus line 7)	**0**	8.00
9.00	Primary payor amounts	0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)	**0**	10.00
REASONABLE CHARGES			
11.00	Inpatient ancillary service charges	0	11.00
12.00	Outpatient service charges	0	12.00
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
CUSTOMARY CHARGES			
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	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			
20.00	Cost of covered services (see Instructions)	0	20.00
21.00	Deductibles	0	21.00
22.00	Subtotal (Line 20 minus line 21)	**0**	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (Line 22 minus line 23)	**0**	24.00
25.00	Allowable bad debts (from your records)	0	25.00
26.00	Subtotal (sum of lines 24 and 25)	**0**	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit	0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization	0	28.00
29.00	Other Adjustments (see instructions) Specify	0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)	0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)	**0**	31.00
32.00	Interim payments	0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)	**0**	33.00

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **Worksheet E-1**

Title XVIII Skilled Nursing Facility PPS

	DESCRIPTION	Inpatient Part A		Part 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		1,777,454		2,334	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/24/2024	60,811		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
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		**60,811**		**0**	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		**1,838,265**		**2,334**	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE 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 - 5.98)		**0**		**0**	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		9,248		1,371	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		**1,847,513**		**3,705**	7.00

	Contractor Name	Contractor Number	
	1.00	2.00	
8.00			8.00

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

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

Worksheet G

PPS

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	1,821	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,013,631	0	0	0	4.00
5.00	Other receivables	2,242	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-415,195	0	0	0	6.00
7.00	Inventory	49,086	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	**1,651,585**	**0**	**0**	**0**	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	134,397	0	0	0	13.00
14.00	Less: Accumulated depreciation	-96,677	0	0	0	14.00
15.00	Buildings	3,972,631	0	0	0	15.00
16.00	Less Accumulated depreciation	-2,046,507	0	0	0	16.00
17.00	Leasehold improvements	1,527,506	0	0	0	17.00
18.00	Less: Accumulated Amortization	-1,094,371	0	0	0	18.00
19.00	Fixed equipment	183,474	0	0	0	19.00
20.00	Less: Accumulated depreciation	-153,163	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	748,063	0	0	0	23.00
24.00	Less: Accumulated depreciation	-673,049	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	**2,502,304**	**0**	**0**	**0**	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	-9,772,079	0	0	0	31.00
32.00	Other assets	0	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	**-9,772,079**	**0**	**0**	**0**	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	**-5,618,190**	**0**	**0**	**0**	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,181,276	0	0	0	35.00
36.00	Salaries, wages, and fees payable	0	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0				40.00
41.00	Due to other funds	1,463	0	0	0	41.00
42.00	Other current liabilities	2,356,363	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	**3,539,102**	**0**	**0**	**0**	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	6,993,300	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	APIC DISTRIBUTIONS; R/E EARNINGS	-14,703,152	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	**-7,709,852**	**0**	**0**	**0**	50.00

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

Worksheet G

PPS

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	**-4,170,750**	**0**	**0**	**0**	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-1,447,440				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	**-1,447,440**	**0**	**0**	**0**	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	**-5,618,190**	**0**	**0**	**0**	60.00

( ) = contra amount

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STATEMENT OF CHANGES IN FUND BALANCES **Worksheet G-1**

PPS

		General Fund		Special Purpose Fund		Endowment Fund		Plant Fund		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
1.00	Fund balances at beginning of period		0		0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-1,447,440							2.00
3.00	Total (sum of line 1 and line 2)		**-1,447,440**		**0**		**0**		**0**	3.00
4.00	Additions (credit adjustments)									4.00
5.00		0		0		0		0		5.00
6.00		0		0		0		0		6.00
7.00		0		0		0		0		7.00
8.00		0		0		0		0		8.00
9.00		0		0		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		**0**		**0**		**0**		**0**	10.00
11.00	Subtotal (line 3 plus line 10)		**-1,447,440**		**0**		**0**		**0**	11.00
12.00	Deductions (debit adjustments)									12.00
13.00		0		0		0		0		13.00
14.00		0		0		0		0		14.00
15.00		0		0		0		0		15.00
16.00		0		0		0		0		16.00
17.00		0		0		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		**0**		**0**		**0**		**0**	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		**-1,447,440**		**0**		**0**		**0**	19.00

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2
Part I
PPS

PART I - PATIENT REVENUES

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	16,022,667		**16,022,667**	1.00
2.00	NURSING FACILITY	0		**0**	2.00
3.00	ICF/IID	0		**0**	3.00
4.00	OTHER LONG TERM CARE	0		**0**	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	**16,022,667**		**16,022,667**	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	2,534,289	0	**2,534,289**	6.00
7.00	CLINIC		0	**0**	7.00
8.00	HOME HEALTH AGENCY COST		0	**0**	8.00
9.00	AMBULANCE		0	**0**	9.00
10.00	RURAL HEALTH CLINIC		0	**0**	10.00
10.10	FQHC		0	**0**	10.10
11.00	CMHC		0	**0**	11.00
11.10	CORF		0	**0**	11.10
12.00	HOSPICE	0	0	**0**	12.00
13.00	OTHER (SPECIFY)	0	0	**0**	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	**18,556,956**	**0**	**18,556,956**	14.00

PART II - OPERATING EXPENSES

		1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		**14,022,651**	1.00
2.00	Add (Specify)	0		2.00
3.00		0		3.00
4.00		0		4.00
5.00		0		5.00
6.00		0		6.00
7.00		0		7.00
8.00	Total Additions (Sum of lines 2 - 7)		**0**	8.00
9.00	Deduct (Specify)	0		9.00
10.00		0		10.00
11.00		0		11.00
12.00		0		12.00
13.00		0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)		**0**	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)		**14,022,651**	15.00

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES **Worksheet G-3**

PPS

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	18,556,956	1.00
2.00	Less: contractual allowances and discounts on patients accounts	6,005,632	2.00
3.00	Net patient revenues (Line 1 minus line 2)	12,551,324	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	14,022,651	4.00
5.00	Net income from service to patients (Line 3 minus 4)	**-1,471,327**	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	23,887	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	**23,887**	25.00
26.00	Total (Line 5 plus line 25)	**-1,447,440**	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	**0**	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	**-1,447,440**	31.00