

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).

<b>SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY</b>	<b>PROVIDER CCN:</b> 31-5423	<b>PERIOD:</b> <b>FROM: 01/01/2024</b> <b>TO: 12/31/2024</b>	<b>WORKSHEET S PARTS I II &amp; III</b>
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**PART I - COST REPORT STATUS**

<b>Provider use only</b>	1. <input checked="" type="checkbox"/> Electronically prepared cost report	<b>Date:</b> 05/15/2025	<b>Time:</b> 09:19:49 AM
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report.		0
	3.0.1 <input type="checkbox"/> No Medicare Utilization Enter "Y" for yes or leave blank for no		0
<b>Contractor use only:</b>	4. <input type="checkbox"/> Cost Report Status [ 1 ] As Submitted: [ 2 ] Settled without audit [ 3 ] Settled with audit [ 4 ] Reopened [ 5 ] Amended	6. Contractor No. _____	
	5. Date Received _____	7. <input type="checkbox"/> First Cost Report for this Provider CCN	
		8. <input type="checkbox"/> Last Cost Report for this Provider CCN	
		9. <input type="checkbox"/> NPR Date: _____	
		10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened	
		11. Contractor Vendor Code _____	
		12. Medicare Utilization Enter "F" for full, "L" for low, or "N" for no utilization _____	

**PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY**

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 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 HAMILTON GROVE HEALTHCARE #31-5423 for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 and to the best of my knowledge and belief, it is a true, correct and complete statement 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.

ECR ENCRYPTION:

05/15/2025 09:19:49 AM

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	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	<i>Avi Maierovits</i>	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	Avi Maierovits		2
3	Signatory Title	Controller		3
4	Signature date	05/15/2025		4

**PART III - SETTLEMENT SUMMARY**

	TITLE V 1	TITLE XVIII		TITLE XIX 4	
		A	B		
		2	3		
1	SKILLED NURSING FACILITY	(129,152)	538		1
2	NURSING FACILITY			0	2
3	ICF/IID				3
4	SNF - BASED HHA	0	0		4
5	SNF - BASED RHC		0		5
6	SNF - BASED FQHC				6
7	SNF - BASED CMHC		0		7
100	TOTAL	(129,152)	538	0	100

The above amounts represent "due to" or "due from" the applicable Program for the element of the above complex indicated. (Indicate Overpayments in Brackets.)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

<b>SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA</b>	<b>PROVIDER CCN:</b> 31-5423	<b>PERIOD:</b> FROM: 01/01/2024 TO: 12/31/2024	<b>WORKSHEET S-2 PART I</b>
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**Skilled Nursing Facility and Skilled Nursing Facility Complex Address:**

1	Street:	2300 HAMILTON AVENUE	P.O. Box:					1
2	City:	TRENTON	State:	NJ	Zip Code:	08619		2
3	County:	MERCER	CBSA Code:	45940	Urban / Rural:	U		3

**SNF and SNF-Based Component Identification:**

	Component	Component Name	Provider CCN:	Date Certified	Payment System			
					(P, O, or N)			
					V	XVIII	XIX	
0	1	2	3	4	5	6		
4	SNF	HAMILTON GROVE HEALTHCARE	31-5423	12/01/1997	N	P	N	4
5	Nursing Facility					//////////		5
6	ICF/IID				//////////	//////////		6
7	SNF-Based HHA							7
8	SNF-Based RHC							8
9	SNF-Based FQHC							9
10	SNF-Based CMHC							10
11	SNF-Based OLTC		//////////	//////////	//////////	//////////	//////////	11
12	SNF-Based HOSPICE				//////////	//////////	//////////	12
13	OTHER (specify)				//////////	//////////	//////////	13
14	Cost Reporting Period (mm/dd/yyyy)			FROM: 01/01/2024	TO: 12/31/2024			14
15	Type of Control	5						15

**Type of Freestanding Skilled Nursing Facility**

		Y / N	
16	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	Y	16
17	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	17
18	Are there any costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10? If yes, complete Worksheet A-8-1.	Y	18

**Miscellaneous Cost Reporting information**

19	Is this a low Medicare utilization cost report, enter "Y" for yes, or "N" for no.	N	19
19.01	If the response to line 19 is "Y", does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)		19.01

**Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20-22.**

20	Straight Line	301,058	//////////	20
21	Declining Balance		//////////	21
22	Sum of the Year's Digits		//////////	22
23	Sum of line 20 through 22	301,058	//////////	23
24	If depreciation is funded, enter the balance as of the end of the period.			24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)		Y	25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)		N	26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies		N	27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports		N	28

In Lieu of CMS Form 2540-10

<b>SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX</b>	<b>PROVIDER CCN:</b>	<b>PERIOD</b>	<b>WORKSHEET S-2</b>
<b>IDENTIFICATION DATA</b>	<b>31-5423</b>	<b>FROM: 01/01/2024</b> <b>TO: 12/31/2024</b>	<b>PART I (Cont.)</b>

If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges enter "Y" for each component and type of service that qualifies for the exemption.

		Part A	Part B	Other	
29	Skilled Nursing Facility	N	N	//////////	29
30	Nursing Facility	//////////	//////////		30
31	I C F / I I D	//////////	//////////		31
32	SNF-Based HHA			//////////	32
33	SNF-Based RHC	//////////		//////////	33
34	SNF-Based FQHC	//////////		//////////	34
35	SNF-Based CMHC	//////////	N	//////////	35
36	SNF-Based OLTC	//////////	//////////	//////////	36

				Y / N	
37	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.			N	37
38	Are you legally-required to carry malpractice insurance?			Y	38
39	Is the malpractice a "claims-made:", or "occurrence" policy? If the policy is "claims-made" enter 1. If policy is "occurrence", enter 2.			1	39

	//////////	Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:	25,959			41
	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center?			Y / N	
42	Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.			N	42
43	Are there home office costs as defined in CMS Pub. 15-1, chapter 10?			N	43
44	If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1.				44

	If this facility is part of a chain organization, enter the name and address of the home office on the lines below				
45	Name:	Contractor name	Contractor Number		45
46	Street:	PO Box			46
47	City:	State:	Zip Code:		47

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S-2 Part II
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General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No

For all the dates responses the format will be (mm/dd/yyyy)

Completed by All Skilled Nursing Facilities

Provider Organization and Operation		1 Y/N	2 Date		
1	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
2	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
3	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

Financial Data and Reports		1 Y/N	2 Type	3 Date	
4	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
5	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

Approved Educational Activities		1 Y/N	2 Legal Oper.	
6	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
7	Were costs claimed for Allied Health Programs? (Y/N) see instructions.		N	////
8	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.		N	////

Bad Debts		1 Y/N	2 Y/N	
9	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.		Y	9
10	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
11	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		N	11

Bed Complement		1 Y/N	2 Y/N	
12	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		N	12

PS&R Data		1 Y/N	2 Date	3 Y/N	4 Date	
		Part A	Part A	Part B	Part B	
13	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.)	Y	04/21/2025	Y	04/21/2025	13
14	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.	N		N		14
15	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
16	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R information? If "Y", see Instructions.	N	////	N	////	16
17	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: _____	N	////	N	////	17
18	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N	////	N	////	18

COST REPORT PREPARER CONTACT INFORMATION							
19	First name	Abi	Last name	Goldenberg	Title	Partner	19
20	Employer	Martin Friedman CPA, PC					20
21	Phone number	718-338-6900	Email address	agoldenberg@mfandco.com			21

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

PROVIDER CCN:  
31-5423

PERIOD:  
FROM: 01/01/2024  
TO: 12/31/2024

WORKSHEET S-3  
PART I

Component	Number of Beds	Bed Days Available	Inpatient Days / Visits					Total
			Title V	Title XVIII	Title XIX	Other		
			3	4	5	6	7	
1 Skilled Nursing Facility	218	79,788	////	////	8,227	52,568	11,308	72,103
2 Nursing Facility			////	////				0
3 ICF/IID			////	////				0
4 Home Health Agency			////	////				0
5 Other Long Term Care			////	////				0
6 SNF-Based CMHC			////	////				0
7 Hospice			////	////				0
8 TOTAL (Sum Lines 1-7)	218	79,788	////	////	8,227	52,568	11,308	72,103

Component	Discharges					Average Length of Stay			
	Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Total
	8	9	10	11	12	13	14	15	16
1 Skilled Nursing Facility	////	159	163	219	541	////	51.74	322.50	133.28
2 Nursing Facility	////	////			0	////	////	0.00	0.00
3 ICF/IID	////	////			0	////	////	0.00	0.00
4 Home Health Agency	////	////	////	////	////	////	////	////	////
5 Other Long Term Care	////	////	////		0	////	////	////	0.00
6 SNF-Based CMHC	////	////	////	////	////	////	////	////	////
7 Hospice	////				0	////	0.00	0.00	0.00
8 TOTAL (Sum Lines 1-7)	////	159	163	219	541	////	51.74	322.50	133.28

Component	Admissions					Full Time Equivalent	
	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers
	17	18	19	20	21	22	23
1 Skilled Nursing Facility	////	192	111	229	532	171.68	
2 Nursing Facility	////	////			0		
3 ICF/IID	////	////			0		
4 Home Health Agency	////	////	////	////	////		
5 Other Long Term Care	////	////	////		0		
6 SNF-Based CMHC	////	////	////	////	////		
7 Hospice	////				0		
8 TOTAL (Sum Lines 1-7)	////	192	111	229	532	171.68	0.00

SNF WAGE INDEX INFORMATION      PROVIDER CCN: 31-5423      PERIOD: FROM: 01/01/2024 TO: 12/31/2024      WORKSHEET S-3 PARTS II & III

PART II DIRECT SALARIES		Amount Reported	Reclass. of Salaries from Wkst A-6	Adjusted Salaries	Paid Hrs Related to col.3	Average Hrly Wage	
		1	2	3	4	5	
1	Total salary (See Instructions)	9,408,065	0	9,408,065	357,095.50	26.35	1
2	Physician salaries-Part A			0		0.00	2
3	Physician salaries-Part B			0		0.00	3
4	Home office personnel			0		0.00	4
5	Sum of lines 2 thru 4	0	0	0	0.00	0.00	5
6	Revised wages (line 1 minus line 5)	9,408,065	0	9,408,065	357,095.50	26.35	6
7	Other Long Term Care	0	0	0		0.00	7
8	HHA	0	0	0		0.00	8
9	CMHC	0	0	0		0.00	9
10	Hospice	0	0	0		0.00	10
11	Other excluded areas	0	0	0		0.00	11
12	Subtotal Excluded salary (Sum of lines 7-11)	0	0	0	0.00	0.00	12
13	Total Adjusted Salaries (line 6 minus line 12)	9,408,065	0	9,408,065	357,095.50	26.35	13
OTHER WAGES AND RELATED COSTS		////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	
14	Contract Labor: Patient Related & Mgmt	1,599,527		1,599,527	23,917.00	66.88	14
15	Contract Labor: Physician services-Part A			0		0.00	15
16	Home office salaries & wage related costs			0		0.00	16
WAGE RELATED COSTS		////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	
17	Wage related costs core. (See Part IV)	1,950,190		1,950,190	////////////////////	////////////////////	17
18	Wage related costs other (See Part IV)	0		0	////////////////////	////////////////////	18
19	Wage related costs (excluded units)			0	////////////////////	////////////////////	19
20	Physicians Part A - WRC			0	////////////////////	////////////////////	20
21	Physicians Part B - WRC			0	////////////////////	////////////////////	21
22	Total Adj. Wage Related costs (see instructions)	1,950,190	0	1,950,190	////////////////////	////////////////////	22

PART III - OVERHEAD COST - DIRECT SALARIES							
		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1	2	3	4	5	
1	Employee Benefits	0	0	0		0.00	1
2	Administrative & General	728,828	0	728,828	19,049.00	38.26	2
3	Plant Operation, Maintenance & Repairs	120,913	0	120,913	4,731.50	25.55	3
4	Laundry & Linen Service	0	0	0		0.00	4
5	Housekeeping	593,660	0	593,660	36,313.00	16.35	5
6	Dietary	952,947	0	952,947	49,420.25	19.28	6
7	Nursing Administration	641,268	0	641,268	11,151.75	57.50	7
8	Central Services and Supply	0	0	0		0.00	8
9	Pharmacy	0	0	0		0.00	9
10	Medical Records & Medical Records Library	0	0	0		0.00	10
11	Social Service	208,493	0	208,493	6,044.00	34.50	11
12	Nursing and Allied Health Education Activities	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	12
13	Other General Service Cost	264,925	0	264,925	14,211.25	18.64	13
14	Total (sum lines 1 thru 13)	3,511,034	0	3,511,034	140,920.75	<b>24.91</b>	14

**MED-CALC SYSTEMS**

In Lieu of CMS Form 2540-10

<b>SNF WAGE RELATED COSTS</b>	<b>PROVIDER CCN:</b> 31-5423	<b>PERIOD:</b> <b>FROM: 01/01/2024</b> <b>TO: 12/31/2024</b>	<b>WORKSHEET</b> <b>S-3</b> <b>PART IV</b>
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**PART IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
<b>RETIREMENT COST</b>			
1	401K Employer Contributions	21,952	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>			
5	401K/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
<b>HEALTH AND INSURANCE COST</b>			
8	Health Insurance (Purchased or Self Funded)	808,069	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accidental Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	272,822	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)		16
<b>TAXES</b>			
17	FICA-Employers Portion Only	707,638	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	136,800	20
<b>OTHER</b>			
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement	2,909	23
24	Total Wage Related cost (Sum of lines 1 -23)	1,950,190	24

**Part B Other than Core Related Cost**

		Amount Reported	
25			25

SNF REPORTING OF DIRECT CARE EXPENDITURES		PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET S-3 PART V	
Occupational Category		Amount Reported 1	Fringe Benefits 2	Adjusted Salaries (col. 1 + col. 2) 3	Paid Hours Related to Salary in col. 3 4	Average Hourly Wage (col. 3 ÷ col. 4) 5
<b>Direct Salaries</b>		////	////	////	////	////
<b>Nursing Occupations</b>		////	////	////	////	////
1	Registered Nurses (RNs)	580,959	120,427	701,386	13,596.00	51.59 1
2	Licensed Practical Nurses (LPNs)	2,106,600	436,675	2,543,275	59,200.75	42.96 2
3	Certified Nursing Assistants/Nursing Assistants/Aides	3,209,472	665,289	3,874,761	143,378.00	27.02 3
4	Total Nursing (sum of lines 1 through 3)	5,897,031	1,222,391	7,119,422	216,174.75	32.93 4
5	Physical Therapists			-		0.00 5
6	Physical Therapy Assistants			-		0.00 6
7	Physical Therapy Aides			-		0.00 7
8	Occupational Therapists			-		0.00 8
9	Occupational Therapy Assistants			-		0.00 9
10	Occupational Therapy Aides			-		0.00 10
11	Speech Therapists			-		0.00 11
12	Respiratory Therapists			-		0.00 12
13	Other Medical Staff			-		0.00 13
<b>Contract Labor</b>		////	////	////	////	//// /
<b>Nursing Occupations</b>		////	////	////	////	//// /
14	Registered Nurses (RNs)		////	-		0.00 14
15	Licensed Practical Nurses (LPNs)	542,083	////	542,083	9,866.00	54.94 15
16	Certified Nursing Assistants/Nursing Assistants/Aides	2,590	////	2,590	73.00	35.48 16
17	Total Nursing (sum of lines 14 through 16)	544,673	////	544,673	9,939.00	54.80 17
18	Physical Therapists	408,802	////	408,802	5,761.00	70.96 18
19	Physical Therapy Assistants		////	-		0.00 19
20	Physical Therapy Aides		////	-		0.00 20
21	Occupational Therapists	477,731	////	477,731	6,258.00	76.34 21
22	Occupational Therapy Assistants		////	-		0.00 22
23	Occupational Therapy Aides		////	-		0.00 23
24	Speech Therapists	168,321	////	168,321	1,959.00	85.92 24
25	Respiratory Therapists		////	-		0.00 25
26	Other Medical Staff		////	-		0.00 26

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER CCN: 31-5423			PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET A	
COST CENTER (Omit Cents)			SALARIES	OTHER	TOTAL ( Col 1 + Col 2 )	RECLASSI- FICATIONS Increase/Decrease ( Fr Wkst A-6 )	RECLASSIFIED TRIAL BALANCE ( Col 3 +/- Col 4 )	ADJUSTMENTS TO EXPENSES Increase/Decrease ( Fr Wkst A-8 )	NET EXPENSES FOR COST ALLOCATION ( Col 5 +/- Col 6 )
A	B	C	1	2	3	4	5	6	7
GENERAL SERVICE COST CENTERS									
1	0100	Capital-Related Costs - Building & Fixture		5,994,605	5,994,605	0	5,994,605	(3,715,880)	2,278,725
2	0200	Capital-Related Costs - Movable Equipment		0	0	0	0	0	0
3	0300	Employee Benefits	0	1,950,191	1,950,191	0	1,950,191	0	1,950,191
4	0400	Administrative and General	728,828	3,388,345	4,117,173	0	4,117,173	(744,180)	3,372,993
5	0500	Plant Operation, Maintenance and Repairs	120,913	712,367	833,280	0	833,280	0	833,280
6	0600	Laundry and Linen Service	0	87,943	87,943	0	87,943	0	87,943
7	0700	Housekeeping	593,660	131,857	725,517	0	725,517	0	725,517
8	0800	Dietary	952,947	633,647	1,586,594	0	1,586,594	0	1,586,594
9	0900	Nursing Administration	641,268	771	642,039	0	642,039	0	642,039
10	1000	Central Services and Supply	0	509,848	509,848	0	509,848	0	509,848
11	1100	Pharmacy	0	0	0	0	0	0	0
12	1200	Medical Records and Library	0	0	0	0	0	0	0
13	1300	Social Service	208,493	0	208,493	0	208,493	0	208,493
14	1400	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0
15	1500	Other General Service Cost	264,925	21,745	286,670	0	286,670	0	286,670
INPATIENT ROUTINE SERVICE COST CENTERS									
30	3000	Skilled Nursing Facility	5,897,031	573,909	6,470,940	0	6,470,940	(328)	6,470,612
31	3100	Nursing Facility	0	0	0	0	0	0	0
32	3200	ICF/IID	0	0	0	0	0	0	0
33	3300	Other Long Term Care	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS									
40	4000	Radiology	0	11,833	11,833	0	11,833	0	11,833
41	4100	Laboratory	0	30,008	30,008	0	30,008	0	30,008
42	4200	Intravenous Therapy	0	16,415	16,415	0	16,415	0	16,415
43	4300	Oxygen (Inhalation) Therapy	0	23,920	23,920	0	23,920	0	23,920
44	4400	Physical Therapy	0	1,054,854	1,054,854	(646,052)	408,802	0	408,802
45	4500	Occupational Therapy	0	0	0	477,731	477,731	0	477,731
46	4600	Speech Pathology	0	0	0	168,321	168,321	0	168,321
47	4700	Electrocardiology	0	0	0	0	0	0	0
48	4800	Medical Supplies Charged to Patients	0	0	0	0	0	0	0
49	4900	Drugs Charged to Patients	0	300,795	300,795	0	300,795	0	300,795
50	5000	Dental Care - Title XIX only	0	0	0	0	0	0	0
51	5100	Support Surfaces	0	0	0	0	0	0	0
52	5200	Other Ancillary Service Cost Center	0	0	0	0	0	0	0

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER CCN: 31-5423			PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET A	
COST CENTER (Omit Cents)			SALARIES	OTHER	TOTAL ( Col 1 + Col 2 )	RECLASSI- FICATIONS Increase/Decrease ( Fr Wkst A-6 )	RECLASSIFIED TRIAL BALANCE ( Col 3 +/- Col 4 )	ADJUSTMENTS TO EXPENSES Increase/Decrease ( Fr Wkst A-8 )	NET EXPENSES FOR COST ALLOCATION ( Col 5 +/- Col 6 )
A	B	C	1	2	3	4	5	6	7
52.01	5201	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0
52.02	5202	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS									
60	6000	Clinic	0	0	0	0	0	0	0
61	6100	Rural Health Clinic	0	0	0	0	0	0	0
62	6200	FQHC	0	0	0	0	0	0	0
63	6300	Other Outpatient Service Cost	0	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS									
70	7000	Home Health Agency Cost	0	0	0	0	0	0	0
71	7100	Ambulance	0	0	0	0	0	0	0
72	7200	Outpatient Rehabilitation	0	0	0	0	0	0	0
73	7300	CMHC	0	0	0	0	0	0	0
74	7400	Other Reimbursable Cost	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS									
80	8000	Malpractice Premiums & Paid Losses		0	0	0	0	0	-0-
81	8100	Interest Expense		0	0	0	0	0	-0-
82	8200	Utilization Review -- SNF	0	0	0	0	0	0	-0-
83	8300	Hospice	0	0	0	0	0	0	0
84	8400	Other Special Purpose Cost I	0	0	0	0	0	0	0
84.01	8401	Other Special Purpose Cost II	0	0	0	0	0	0	0
89		SUBTOTALS (sum of lines 1 through 84)	9,408,065	15,443,053	24,851,118	0	24,851,118	(4,460,388)	20,390,730
NON REIMBURSABLE COST CENTERS									
90	9000	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0
91	9100	Barber and Beauty Shop	0	0	0	0	0	0	0
92	9200	Physicians' Private Offices	0	9,600	9,600	0	9,600	0	9,600
93	9300	Nonpaid Workers	0	0	0	0	0	0	0
94	9400	Patients Laundry	0	0	0	0	0	0	0
95	9500	Other Nonreimbursable Cost	0	0	0	0	0	0	0
100		TOTAL	9,408,065	15,452,653	24,860,718	0	24,860,718	(4,460,388)	20,400,330

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1) 1	INCREASE			DECREASE				
			COST CENTER 2	LINE NO. 3	SALARY 4	NON-SALARY 5	COST CENTER 6	LINE NO. 7	SALARY 8	NON-SALARY 9
1	RECLASS OT	A	Occupational Therapy	45		477,731	Physical Therapy	44		477,731
2	RECLASS ST	B	Speech Pathology	46		168,321	Physical Therapy	44		168,321
3										
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71										
72										
100	<b>TOTAL RECLASSIFICATIONS</b>				0	646,052			0	646,052

(1) A LETTER (A, B, etc.) MUST BE ENTERED ON EACH LINE TO IDENTIFY EACH RECLASSIFICATION ENTRY.  
 (2) TRANSFER TO WORKSHEET A, COLUMN 4, LINE AS APPROPRIATE.

	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET A-7
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ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES  
ASSET BALANCES

Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets
		Purchases	Donation	Total			
		1	2	3			
1 Land				0		0	
2 Land Improvements				0		0	
3 Buildings and Fixtures				0		0	
4 Building Improvements	4,361,668	51,937		51,937		4,413,605	
5 Fixed Equipment				0		0	
6 Movable Equipment	115,025	2,590		2,590	65,897	51,718	
7 Subtotal (sum of lines 1-6)	<b>4,476,693</b>	<b>54,527</b>	<b>0</b>	<b>54,527</b>	<b>65,897</b>	<b>4,465,323</b>	0
8 Reconciling Items				0		0	
9 Total (line 7 minus line 8)	4,476,693	54,527	0	54,527	65,897	4,465,323	0

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024
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(1) DESCRIPTION	(2) BASIS* FOR ADJ	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
		AMOUNT	COST CENTER	LINE #
1 Investment income on restricted funds (Chapter 2)	B	(60,162)	Administrative and General	4
2 Trade, quantity and time discounts on purchases (Chapter 8)				
3 Refunds and rebates of expenses (Chapter 8)				
4 Rental of provider space by suppliers (Chapter 8)				
5 Telephone services (pay stations excluded) (Chapter 21)				
6 Television and radio service (Chapter 21)				
7 Parking lot (Chapter 21)				
8 Remuneration applicable to provider-based physician adjustment	////////// A-8-2	////////// 0	//////////	//////////
9 Home office costs (Chapter 21)				
10 Sale of scrap, waste, etc. (Chapter 23)				
11 Nonallowable costs related to certain Capital expenditures (Chapter 24)	//////////	//////////	//////////	//////////
12 Adjustment resulting from transactions with related organizations (Chapter 10)	////////// A-8-1	////////// (3,921,508)	//////////	//////////
13 Laundry and Linen service				
14 Revenue - Employee meals				
15 Cost of meals - Guests				
16 Sale of medical supplies to other than patients				
17 Sale of drugs to other than patients				
18 Sale of medical records and abstracts	B	(97)	Administrative and General	4
19 Vending machines				
20 Income from imposition of interest, finance or penalty charges (Chapter 21)	//////////	//////////	//////////	//////////
21 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	//////////	//////////	//////////	//////////
22 Utilization review--physicians' compensation (chapter 21)			Utilization Review -- SNF	82
23 Depreciation--buildings and fixtures			Capital-Related Costs - Building & Fixture	1
24 Depreciation--movable equipment			Capital-Related Costs - Moveable Equipment	2
25 Don,Misc,ProAds,Pens	A	(478,621)	Administrative and General	4
25.01				
25.02				
25.03				
25.04				
A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW)		//////////	0	//////////
100	TOTAL	//////////	(4,460,388)	//////////

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024
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(1) DESCRIPTION	(2) BASIS* FOR ADJ	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
		AMOUNT	COST CENTER	LINE #

**ADDITIONAL ADJUSTMENTS**

25.05				
25.06				
25.07				
25.08				
25.09				
25.10				
25.11				
25.12				
25.13				
25.14				
25.15				
25.16				
25.17				
25.18				
25.19				
25.20				
25.21				
25.22				
25.23				
25.24				
25.25				

SUBTOTAL OF ADDITIONAL ADJUSTMENTS

0

- (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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	<b>WORKSHEET A-8-1</b>
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**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	2	3	4	5	6
1	3	Employee Benefits	Self Insurance	889,204	889,204	0
2	10	Central Services and Supply	Med Supplies	305,447	305,447	0
3	43	Oxygen (Inhalation) Therapy	Oxygen	8,842	8,842	0
4	10	Central Services and Supply	OTC Drugs	20,866	20,866	0
5	8	Dietary	Dietary	634,405	634,405	0
6	5	Plant Operation, Maintenance and R	Maintenance	156,999	156,999	0
7	6	Laundry and Linen Service	Diapers	87,943	87,943	0
8	4	Administrative and General	Office Supplies	15,664	15,664	0
9	4	Administrative and General	Office Support	1,038,941	1,244,241	(205,300)
9.01	1	Capital-Related Costs - Building &	Rent	1,846,008	5,561,888	(3,715,880)
9.02	30	Skilled Nursing Facility	Nursing	4,209	4,537	(328)
9.03						0
9.04						0
9.05						0
9.06						0
9.07						0
9.08						0
9.09						0
9.10						0
<b>10 TOTAL</b>				<b>5,008,528</b>	<b>8,930,036</b>	<b>(3,921,508)</b>

**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.

Description	(1) Symbol	Name	Percentage of Ownership	Related Organization(s)		
				Name	Percentage of Ownership	Type of Business
				4	5	6
1	A	M Feigenbaum	34.00	Dynamic Health	50.00	Office Support
2	A	C Feigenbaum	4.00	Dynamic Health	50.00	Office Support
3	A	M Feigenbaum	34.00	Ocean Dietary	50.00	Purchasing
4	A	C Feigenbaum	4.00	Ocean Dietary	50.00	Purchasing
5	A	M Feigenbaum	34.00	Ocean Healthcr	100.00	Self Insurance
6	A	Hamilton Grove	100.00	Haminton Ave Realty	100.00	Realty
7						
8						
9						
10						
10.01						
10.02						
10.03						
10.04						
10.05						

(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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS				PROVIDER CCN: 31-5423		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET A-8-2	
	Wkst A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider Component Hrs	Unadjusted R C E Limit	5 Percent of Unadjusted R C E Limit
	1	2	3	4	5	6	7	8	9
1								0	0
2								0	0
3								0	0
4								0	0
5								0	0
6								0	0
7								0	0
8								0	0
9								0	0
10								0	0
11								0	0
100	<b>TOTAL</b>		<b>0</b>	<b>0</b>	<b>0</b>	////////////////////	<b>0</b>	<b>0</b>	<b>0</b>

	Wkst A Line No.	Cost Center / Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of Col 12	Physician Cost of Malpractice Insurance	Provider Component Share of Column 14	Adjusted R C E Limit	R C E Disallowance	Adjustment
	10	11	12	13	14	15	16	17	18
1				0		0	0	0	0
2				0		0	0	0	0
3				0		0	0	0	0
4				0		0	0	0	0
5				0		0	0	0	0
6				0		0	0	0	0
7				0		0	0	0	0
8				0		0	0	0	0
9				0		0	0	0	0
10				0		0	0	0	0
11				0		0	0	0	0
100	<b>TOTAL</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

COST ALLOCATION GENERAL SERVICE COSTS		PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B PART I					
COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	OTHER ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE	
	0	1	2	3	3a	4.00	5	6	
<b>GENERAL SERVICE COST CENTERS</b>									
1	Capital-Related Costs - Building & Fixture	2,278,725	2,278,725						
2	Capital-Related Costs - Movable Equipment	0	////////////////////	0					
3	Employee Benefits	1,950,191	0	0	1,950,191				
4	Administrative and General	3,372,993	0	0	151,078	3,524,071	3,524,071		
5	Plant Operation, Maintenance and Repairs	833,280	0	0	25,064	858,344	179,238	1,037,582	
6	Laundry and Linen Service	87,943	0	0	0	87,943	18,364	0	
7	Housekeeping	725,517	0	0	123,059	848,576	177,198	0	
8	Dietary	1,586,594	0	0	197,535	1,784,129	372,558	0	
9	Nursing Administration	642,039	0	0	132,928	774,967	161,827	0	
10	Central Services and Supply	509,848	0	0	0	509,848	106,465	0	
11	Pharmacy	0	0	0	0	0	0	0	
12	Medical Records and Library	0	0	0	0	0	0	0	
13	Social Service	208,493	0	0	43,218	251,711	52,562	0	
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	
15	Other General Service Cost	286,670	0	0	54,916	341,586	71,329	0	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30	Skilled Nursing Facility	6,470,612	2,249,487	0	1,222,393	9,942,492	2,076,176	1,024,269	
31	Nursing Facility	0	0	0	0	0	0	0	
32	ICF/IID	0	0	0	0	0	0	0	
33	Other Long Term Care	0	0	0	0	0	0	0	
<b>ANCILLARY SERVICE COST CENTERS</b>									
40	Radiology	11,833	0	0	0	11,833	2,471	0	
41	Laboratory	30,008	0	0	0	30,008	6,266	0	
42	Intravenous Therapy	16,415	0	0	0	16,415	3,428	0	
43	Oxygen (Inhalation) Therapy	23,920	0	0	0	23,920	4,995	0	
44	Physical Therapy	408,802	29,238	0	0	438,040	91,471	13,313	
45	Occupational Therapy	477,731	0	0	0	477,731	99,759	0	
46	Speech Pathology	168,321	0	0	0	168,321	35,148	0	
47	Electrocardiology	0	0	0	0	0	0	0	
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	
49	Drugs Charged to Patients	300,795	0	0	0	300,795	62,811	0	
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	
51	Support Surfaces	0	0	0	0	0	0	0	
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	

COST ALLOCATION GENERAL SERVICE COSTS		PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B PART I					
COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	OTHER ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE	
	0	1	2	3	3a	4.00	5	6	
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic	0	0	0	0	0	0	0	
61	Rural Health Clinic	0	0	0	0	0	0	0	
62	FQHC	0	0	0	0	0	0	0	
63	Other Outpatient Service Cost	0	0	0	0	0	0	0	
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost	0	0	0	0	0	0	0	
71	Ambulance	0	0	0	0	0	0	0	
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	
73	CMHC	0	0	0	0	0	0	0	
74	Other Reimbursable Cost	0	0	0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS									
83	Hospice	0	0	0	0	0	0	0	
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	
89	SUBTOTALS (sum of lines 1 through 84)	20,390,730	2,278,725	0	1,950,191	20,390,730	3,522,066	1,037,582	106,307
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	
91	Barber and Beauty Shop	0	0	0	0	0	0	0	
92	Physicians' Private Offices	9,600	0	0	0	9,600	2,005	0	
93	Nonpaid Workers	0	0	0	0	0	0	0	
94	Patients Laundry	0	0	0	0	0	0	0	
95	Other Nonreimbursable Cost	0	0	0	0	0	0	0	
98	Cross Foot Adjustments	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	
99	Negative Cost Center		0	0	0	0	0	0	
100	TOTAL	20,400,330	2,278,725	0	1,950,191	20,400,330	3,524,071	1,037,582	106,307

COST ALLOCATION GENERAL SERVICE COSTS		PROVIDER CCN: 31-5423			PERIOD: FROM: 01/01/2024 TO: 12/31/2024			WORKSHEET B PART I (cont.)	
COST CENTER		HOUSE-KEEPING	DIETARY	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH
		7	8	9	10	11	12	13	14
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture								
2	Capital-Related Costs - Movable Equipment								
3	Employee Benefits								
4	Administrative and General								
5	Plant Operation, Maintenance and Repairs								
6	Laundry and Linen Service								
7	Housekeeping	1,025,774							
8	Dietary	0	2,156,687						
9	Nursing Administration	0	0	936,794					
10	Central Services and Supply	0	0	0	616,313				
11	Pharmacy	0	0	0	0	0			
12	Medical Records and Library	0	0	0	0	0	0		
13	Social Service	0	0	0	0	0	0	304,273	
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	0	0	0	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	1,012,612	2,156,687	936,794	616,313	0	0	304,273	0
31	Nursing Facility	0	0	0	0	0	0	0	0
32	ICF/IID	0	0	0	0	0	0	0	0
33	Other Long Term Care	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS									
40	Radiology	0	0	0	0	0	0	0	0
41	Laboratory	0	0	0	0	0	0	0	0
42	Intravenous Therapy	0	0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	0	0
44	Physical Therapy	13,162	0	0	0	0	0	0	0
45	Occupational Therapy	0	0	0	0	0	0	0	0
46	Speech Pathology	0	0	0	0	0	0	0	0
47	Electrocardiology	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0
49	Drugs Charged to Patients	0	0	0	0	0	0	0	0
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0

COST ALLOCATION GENERAL SERVICE COSTS		PROVIDER CCN: 31-5423		PERIOD: FROM: 01/01/2024 TO: 12/31/2024			WORKSHEET B PART I (cont.)		
COST CENTER		HOUSE-KEEPING	DIETARY	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH
		7	8	9	10	11	12	13	14
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS									
60	Clinic	0	0	0	0	0	0	0	0
61	Rural Health Clinic	0	0	0	0	0	0	0	0
62	FQHC	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost	0	0	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost	0	0	0	0	0	0	0	0
71	Ambulance	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0
73	CMHC	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS									
83	Hospice	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	1,025,774	2,156,687	936,794	616,313	0	0	304,273	0
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	0	0	0	0	0	0	0	0
93	Nonpaid Workers	0	0	0	0	0	0	0	0
94	Patients Laundry	0	0	0	0	0	0	0	0
95	Other Nonreimbursable Cost	0	0	0	0	0	0	0	0
98	Cross Foot Adjustments	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////
99	Negative Cost Center	0	0	0	0	0	0	0	0
100	TOTAL	1,025,774	2,156,687	936,794	616,313	0	0	304,273	0

ALLOCATION OF CAPITAL-RELATED COSTS		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		PROVIDER CCN: 31-5423		WORKSHEET B PART II			
COST CENTER		DIRECTLY ASSIGNED	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE
		0	1	2	2a	3	4	5	6
<b>GENERAL SERVICE COST CENTERS</b>									
1	Capital-Related Costs - Building & Fixture	////	////	////	////				
2	Capital-Related Costs - Movable Equipment	////	////	////	////				
3	Employee Benefits		0	0	0	0			
4	Administrative and General		0	0	0	0	0		
5	Plant Operation, Maintenance and Repairs		0	0	0	0	0	0	
6	Laundry and Linen Service		0	0	0	0	0	0	0
7	Housekeeping		0	0	0	0	0	0	0
8	Dietary		0	0	0	0	0	0	0
9	Nursing Administration		0	0	0	0	0	0	0
10	Central Services and Supply		0	0	0	0	0	0	0
11	Pharmacy		0	0	0	0	0	0	0
12	Medical Records and Library		0	0	0	0	0	0	0
13	Social Service		0	0	0	0	0	0	0
14	Nursing and Allied Health Education Activities		0	0	0	0	0	0	0
15	Other General Service Cost		0	0	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30	Skilled Nursing Facility		2,249,487	0	2,249,487	0	0	0	0
31	Nursing Facility		0	0	0	0	0	0	0
32	ICF/IID		0	0	0	0	0	0	0
33	Other Long Term Care		0	0	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>									
40	Radiology		0	0	0	0	0	0	0
41	Laboratory		0	0	0	0	0	0	0
42	Intravenous Therapy		0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy		0	0	0	0	0	0	0
44	Physical Therapy		29,238	0	29,238	0	0	0	0
45	Occupational Therapy		0	0	0	0	0	0	0
46	Speech Pathology		0	0	0	0	0	0	0
47	Electrocardiology		0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients		0	0	0	0	0	0	0
49	Drugs Charged to Patients		0	0	0	0	0	0	0
50	Dental Care - Title XIX only		0	0	0	0	0	0	0
51	Support Surfaces		0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center		0	0	0	0	0	0	0
52.01	Other Ancillary Service Cost Center II		0	0	0	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		PROVIDER CCN: 31-5423		WORKSHEET B PART II			
COST CENTER		DIRECTLY ASSIGNED	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE
		0	1	2	2a	3	4	5	6
52.02	Other Ancillary Service Cost Center III		0	0	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>									
60	Clinic		0	0	0	0	0	0	0
61	Rural Health Clinic		0	0	0	0	0	0	0
62	FQHC		0	0	0	0	0	0	0
63	Other Outpatient Service Cost		0	0	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>									
70	Home Health Agency Cost		0	0	0	0	0	0	0
71	Ambulance		0	0	0	0	0	0	0
72	Outpatient Rehabilitation		0	0	0	0	0	0	0
73	CMHC		0	0	0	0	0	0	0
74	Other Reimbursable Cost		0	0	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>									
83	Hospice		0	0	0	0	0	0	0
84	Other Special Purpose Cost I		0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II		0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	0	2,278,725	0	2,278,725	0	0	0	0
<b>NON REIMBURSABLE COST CENTERS</b>									
90	Gift, Flower, Coffee Shop & Canteen		0	0	0	0	0	0	0
91	Barber and Beauty Shop		0	0	0	0	0	0	0
92	Physicians' Private Offices		0	0	0	0	0	0	0
93	Nonpaid Workers		0	0	0	0	0	0	0
94	Patients Laundry		0	0	0	0	0	0	0
95	Other Nonreimbursable Cost		0	0	0	0	0	0	0
98	Cross Foot Adjustments		////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////
99	Negative Cost Center		0	0	0	0	0	0	0
100	TOTAL	0	2,278,725	0	2,278,725	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS										PROVIDER CCN: 31-5423
COST CENTER		HOUSE-KEEPING	DIETARY	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	
		7	8	9	10	11	12	13	14	
<b>GENERAL SERVICE COST CENTERS</b>										
1	Capital-Related Costs - Building & Fixture									
2	Capital-Related Costs - Movable Equipment									
3	Employee Benefits									
4	Administrative and General									
5	Plant Operation, Maintenance and Repairs									
6	Laundry and Linen Service									
7	Housekeeping	0								
8	Dietary	0	0							
9	Nursing Administration	0	0	0						
10	Central Services and Supply	0	0	0	0					
11	Pharmacy	0	0	0	0	0				
12	Medical Records and Library	0	0	0	0	0	0			
13	Social Service	0	0	0	0	0	0	0		
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0	
15	Other General Service Cost	0	0	0	0	0	0	0	0	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>										
30	Skilled Nursing Facility	0	0	0	0	0	0	0	0	
31	Nursing Facility	0	0	0	0	0	0	0	0	
32	ICF/IID	0	0	0	0	0	0	0	0	
33	Other Long Term Care	0	0	0	0	0	0	0	0	
<b>ANCILLARY SERVICE COST CENTERS</b>										
40	Radiology	0	0	0	0	0	0	0	0	
41	Laboratory	0	0	0	0	0	0	0	0	
42	Intravenous Therapy	0	0	0	0	0	0	0	0	
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	0	0	
44	Physical Therapy	0	0	0	0	0	0	0	0	
45	Occupational Therapy	0	0	0	0	0	0	0	0	
46	Speech Pathology	0	0	0	0	0	0	0	0	
47	Electrocardiology	0	0	0	0	0	0	0	0	
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0	
49	Drugs Charged to Patients	0	0	0	0	0	0	0	0	
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0	
51	Support Surfaces	0	0	0	0	0	0	0	0	
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0	
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0	

ALLOCATION OF CAPITAL-RELATED COSTS						PROVIDER CCN: 31-5423				
COST CENTER		HOUSE-KEEPING	DIETARY	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	
		7	8	9	10	11	12	13	14	
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0	
<b>OUTPATIENT SERVICE COST CENTERS</b>										
60	Clinic	0	0	0	0	0	0	0	0	
61	Rural Health Clinic	0	0	0	0	0	0	0	0	
62	FQHC	0	0	0	0	0	0	0	0	
63	Other Outpatient Service Cost	0	0	0	0	0	0	0	0	
<b>OTHER REIMBURSABLE COST CENTERS</b>										
70	Home Health Agency Cost	0	0	0	0	0	0	0	0	
71	Ambulance	0	0	0	0	0	0	0	0	
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0	
73	CMHC	0	0	0	0	0	0	0	0	
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0	
<b>SPECIAL PURPOSE COST CENTERS</b>										
83	Hospice	0	0	0	0	0	0	0	0	
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0	
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0	
89	SUBTOTALS (sum of lines 1 through 84)	0	0	0	0	0	0	0	0	
<b>NON REIMBURSABLE COST CENTERS</b>										
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	
92	Physicians' Private Offices	0	0	0	0	0	0	0	0	
93	Nonpaid Workers	0	0	0	0	0	0	0	0	
94	Patients Laundry	0	0	0	0	0	0	0	0	
95	Other Nonreimbursable Cost	0	0	0	0	0	0	0	0	
98	Cross Foot Adjustments	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	
99	Negative Cost Center	0	0	0	0	0	0	0	0	
100	TOTAL	0	0	0	0	0	0	0	0	

COST ALLOCATION STATISTICAL BASIS		PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B-1					
COST CENTER	CAP.REL. BLDG/FIX (SQUARE FEET)	CAP.REL. MOV.EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS GROSS SALARIES	RECONCILIATION *	ADMIN & GENERAL (ACCUM COST)	PLANT OP. MAINT/REP. (SQUARE FEET)	LNDRY/LIN SERVICE (PATIENT DAYS)	HOUSE-KEEPING (SQUARE FEET)	
	0	1	2	3	4.00a	4.00	5	6	7

GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture	121,580							
2	Capital-Related Costs - Movable Equipment		0						
3	Employee Benefits		0	9,408,065					
4	Administrative and General		0	728,828	(3,524,071)	16,876,259			
5	Plant Operation, Maintenance and Repairs		0	120,913		858,344	121,580		
6	Laundry and Linen Service		0	0		87,943	0	72,103	
7	Housekeeping		0	593,660		848,576	0		121,580
8	Dietary		0	952,947		1,784,129	0		0
9	Nursing Administration		0	641,268		774,967	0		0
10	Central Services and Supply		0	0		509,848	0		0
11	Pharmacy		0	0		0	0		0
12	Medical Records and Library		0	0		0	0		0
13	Social Service		0	208,493		251,711	0		0
14	Nursing and Allied Health Education Activities		0	0		0	0		0
15	Other General Service Cost		0	264,925		341,586	0		0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	120,020	0	5,897,031		9,942,492	120,020	72,103	120,020
31	Nursing Facility		0	0		0	0	0	0
32	ICF/IID		0	0		0	0	0	0
33	Other Long Term Care		0	0		0	0	0	0
ANCILLARY SERVICE COST CENTERS									
40	Radiology		0	0		11,833	0		0
41	Laboratory		0	0		30,008	0		0
42	Intravenous Therapy		0	0		16,415	0		0
43	Oxygen (Inhalation) Therapy		0	0		23,920	0		0
44	Physical Therapy	1,560	0	0		438,040	1,560		1,560
45	Occupational Therapy		0	0		477,731	0		0
46	Speech Pathology		0	0		168,321	0		0
47	Electrocardiology		0	0		0	0		0
48	Medical Supplies Charged to Patients		0	0		0	0		0
49	Drugs Charged to Patients		0	0		300,795	0		0
50	Dental Care - Title XIX only		0	0		0	0		0
51	Support Surfaces		0	0		0	0		0
52	Other Ancillary Service Cost Center		0	0		0	0		0
52.01	Other Ancillary Service Cost Center II		0	0		0	0		0
52.02	Other Ancillary Service Cost Center III		0	0		0	0		0
OUTPATIENT SERVICE COST CENTERS									

COST ALLOCATION STATISTICAL BASIS		PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B-1						
COST CENTER		CAP.REL. BLDG/FIX (SQUARE FEET)	CAP.REL. MOV.EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS GROSS SALARIES	RECONCILIATION *	ADMIN & GENERAL (ACCUM COST)	PLANT OP. MAINT/REP. (SQUARE FEET)	LNDRY/LIN SERVICE (PATIENT DAYS)	HOUSE-KEEPING (SQUARE FEET)	
		0	1	2	3	4.00a	4.00	5	6	7
60	Clinic	//////////		0	0		0	0		0
61	Rural Health Clinic	//////////					0			
62	FQHC	//////////					0			
63	Other Outpatient Service Cost	//////////		0	0		0	0		0
OTHER REIMBURSABLE COST CENTERS		//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
70	Home Health Agency Cost	//////////		0	0		0	0	0	0
71	Ambulance	//////////		0	0		0	0		0
72	Outpatient Rehabilitation	//////////		0	0		0	0		0
73	CMHC	//////////		0	0		0	0		0
74	Other Reimbursable Cost	//////////		0	0		0	0		0
SPECIAL PURPOSE COST CENTERS		//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
83	Hospice	//////////		0	0		0	0		0
84	Other Special Purpose Cost I	//////////		0	0		0	0		0
84.01	Other Special Purpose Cost II	//////////		0	0		0	0		0
89	SUBTOTALS (sum of lines 1 through 84)	//////////	121,580	0	9,408,065	(3,524,071)	16,866,659	121,580	72,103	121,580
NON REIMBURSABLE COST CENTERS		//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
90	Gift, Flower, Coffee Shop & Canteen	//////////		0	0		0	0		0
91	Barber and Beauty Shop	//////////		0	0		0	0		0
92	Physicians' Private Offices	//////////		0	0		9,600	0		0
93	Nonpaid Workers	//////////		0	0		0	0		0
94	Patients Laundry	//////////		0	0		0	0		0
95	Other Nonreimbursable Cost	//////////		0	0		0	0		0
98	Cross Foot Adjustment	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
99	Negative Cost Center	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
102	Cost to Be Allocated (Per Worksheet B, Part I)	//////////	2,278,725	0	1,950,191	//////////	3,524,071	1,037,582	106,307	1,025,774
103	Unit Cost Multiplier (Worksheet B, Part I)	//////////	18.742597	0.000000	0.207289	//////////	0.208818	8.534150	1.474377	8.437029
104	Cost to Be Allocated (Per Worksheet B, Part II)	//////////	//////////	//////////	0	//////////	0	0	0	0
105	Unit Cost Multiplier (Worksheet B, Part II)	//////////	//////////	//////////	0.000000	//////////	0.000000	0.000000	0.000000	0.000000

\* may zero out accum.cost stat at col.4 instead of using reconcil.

COST ALLOCATION STATISTICAL BASIS		PROVIDER CCN: 31-5423					PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET B-1 (cont.)	
COST CENTER	DIETARY (MEALS SERVED)	NURSING ADMIN. (PATIENT DAYS)	CENTRAL SVC & SUPP (PATIENT DAYS)	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)	SUBTOTAL	
	8	9	10	11	12	13	14	15	16	
<b>GENERAL SERVICE COST CENTERS</b>										
1	Capital-Related Costs - Building & Fixture	////	////	////	////	////	////	////	////	
2	Capital-Related Costs - Movable Equipment	////	////	////	////	////	////	////	////	
3	Employee Benefits	////	////	////	////	////	////	////	////	
4	Administrative and General	////	////	////	////	////	////	////	////	
5	Plant Operation, Maintenance and Repairs	////	////	////	////	////	////	////	////	
6	Laundry and Linen Service	////	////	////	////	////	////	////	////	
7	Housekeeping	////	////	////	////	////	////	////	////	
8	Dietary	216,309	////	////	////	////	////	////	////	
9	Nursing Administration	////	72,103	////	////	////	////	////	////	
10	Central Services and Supply	////	////	72,103	////	////	////	////	////	
11	Pharmacy	////	////	////	0	////	////	////	////	
12	Medical Records and Library	////	////	////	////	0	////	////	////	
13	Social Service	////	////	////	////	72,103	////	////	////	
14	Nursing and Allied Health Education Activities	////	////	////	////	////	0	////	////	
15	Other General Service Cost	////	////	////	////	////	////	72,103	////	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>										
30	Skilled Nursing Facility	216,309	72,103	72,103	0	0	72,103	72,103	////	
31	Nursing Facility	0	0	0	0	0	0	0	////	
32	ICF/IID	0	0	0	0	0	0	0	////	
33	Other Long Term Care	0	0	0	0	0	0	0	////	
<b>ANCILLARY SERVICE COST CENTERS</b>										
40	Radiology	////	////	////	////	////	////	////	////	
41	Laboratory	////	////	////	////	////	////	////	////	
42	Intravenous Therapy	////	////	////	////	////	////	////	////	
43	Oxygen (Inhalation) Therapy	////	////	////	////	////	////	////	////	
44	Physical Therapy	////	////	////	////	////	////	////	////	
45	Occupational Therapy	////	////	////	////	////	////	////	////	
46	Speech Pathology	////	////	////	////	////	////	////	////	
47	Electrocardiology	////	////	////	////	////	////	////	////	
48	Medical Supplies Charged to Patients	////	////	////	////	////	////	////	////	
49	Drugs Charged to Patients	////	////	////	////	////	////	////	////	
50	Dental Care - Title XIX only	////	////	////	////	////	////	////	////	
51	Support Surfaces	////	////	////	////	////	////	////	////	
52	Other Ancillary Service Cost Center	////	////	////	////	////	////	////	////	
52.01	Other Ancillary Service Cost Center II	////	////	////	////	////	////	////	////	
52.02	Other Ancillary Service Cost Center III	////	////	////	////	////	////	////	////	
<b>OUTPATIENT SERVICE COST CENTERS</b>										

COST ALLOCATION STATISTICAL BASIS		PROVIDER CCN: 31-5423		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET B-1 (cont.)			
COST CENTER	DIETARY (MEALS SERVED)	NURSING ADMIN. (PATIENT DAYS)	CENTRAL SVC & SUPP (PATIENT DAYS)	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)	SUBTOTAL
	8	9	10	11	12	13	14	15	16
60	Clinic	////							////
61	Rural Health Clinic								
62	FQHC								
63	Other Outpatient Service Cost								////
OTHER REIMBURSABLE COST CENTERS		////	////	////	////	////	////	////	////
70	Home Health Agency Cost	0	0	0	0	0	0	0	////
71	Ambulance								////
72	Outpatient Rehabilitation								////
73	CMHC								
74	Other Reimbursable Cost								////
SPECIAL PURPOSE COST CENTERS		////	////	////	////	////	////	////	////
83	Hospice								
84	Other Special Purpose Cost I								////
84.01	Other Special Purpose Cost II								
89	SUBTOTALS (sum of lines 1 through 84)	216,309	72,103	72,103	0	0	72,103	0	72,103
NON REIMBURSABLE COST CENTERS		////	////	////	////	////	////	////	////
90	Gift, Flower, Coffee Shop & Canteen								////
91	Barber and Beauty Shop								////
92	Physicians' Private Offices								////
93	Nonpaid Workers								////
94	Patients Laundry								////
95	Other Nonreimbursable Cost								////
98	Cross Foot Adjustment	////	////	////	////	////	////	////	////
99	Negative Cost Center	////	////	////	////	////	////	////	////
102	Cost to Be Allocated (Per Worksheet B, Part I)	2,156,687	936,794	616,313	0	0	304,273	0	412,915
103	Unit Cost Multiplier (Worksheet B, Part I)	9.970399	12.992441	8.547675	0.000000	0.000000	4.219977	0.000000	5.726738
104	Cost to Be Allocated (Per Worksheet B, Part II)	0	0	0	0	0	0	0	0
105	Unit Cost Multiplier (Worksheet B, Part II)	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN: 31-5423	PERIOD: <b>FROM: 01/01/2024</b> <b>TO: 12/31/2024</b>	<b>WORKSHEET</b> <b>B-2</b>
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DESCRIPTION -1-	WORKSHEET B PART NO. LINE NO. (1 or 2) -2- -3-		AMOUNT -4-
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RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN:	PERIOD :	WORKSHEET C
	31-5423	FROM: 01/01/2024 TO: 12/31/2024	

Cost Center	TOTAL (From Wkst B, Pt. I, Col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)
	1	2	3

ANCILLARY SERVICE COST CENTERS:

40	Radiology	14,304	11,833	1.208823
41	Laboratory	36,274	30,008	1.208811
42	Intravenous Therapy	19,843	44,029	0.450680
43	Oxygen ( Inhalation ) Therapy	28,915	23,920	1.208821
44	Physical Therapy	555,986	816,705	0.680767
45	Occupational Therapy	577,490	954,412	0.605074
46	Speech Pathology	203,469	336,271	0.605074
47	Electrocardiology	0	0	0.000000
48	Medical Supplies Charged	0	0	0.000000
49	Drugs Charged to Patients	363,606	390,462	0.931220
50	Dental Care - Title XIX only	0	0	0.000000
51	Support Surfaces	0	0	0.000000
52	Other Ancillary Service Cost Center	0	0	0.000000
52.01	Other Ancillary Service Cost Center II	0	0	0.000000
52.02	Other Ancillary Service Cost Center III	0	0	0.000000

OUTPATIENT SERVICE COST CENTERS

60	Clinic	0	0	0.000000
61	Rural Health Clinic	00000000000000000000	00000000000000000000	00000000000000000000
62	FQHC	00000000000000000000	00000000000000000000	00000000000000000000
63	Other Outpatient Service Cost	0	0	0.000000
71	Ambulance	0	0	0.000000
100	TOTAL	1,799,887	2,607,640	////////////////////

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10				
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST		PROVIDER CCN : 31-5423	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D		
Check <input type="checkbox"/> Title V (1)                      Check One: <input checked="" type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> Other One: <input checked="" type="checkbox"/> Title XVIII <input type="checkbox"/> PPS - Must also complete Part II <input type="checkbox"/> Title XIX (1)						
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST		RATIO OF COST TO CHARGES  (WS C, col 3)  1	HEALTH CARE PROGRAM CHARGES		HEALTH CARE PROGRAM COST	
			PART A	PART B	PART A	PART B
			2	3	4	5
<b>ANCILLARY SERVICE COST CENTERS:</b>						
40	Radiology	1.208823	3,100		3,747	0
41	Laboratory	1.208811	21,357		25,817	0
42	Intravenous Therapy	0.450680	43,268		19,500	0
43	Oxygen ( Inhalation ) Therapy	1.208821	0		0	0
44	Physical Therapy	0.680767	333,855		227,277	0
45	Occupational Therapy	0.605074	424,868		257,077	0
46	Speech Pathology	0.605074	187,572		113,495	0
47	Electrocardiology	0.000000	0		0	0
48	Medical Supplies Charged	0.000000	0		0	0
49	Drugs Charged to Patients	0.931220	384,471		358,027	0
50	Dental Care - Title XIX only	0.000000	////////////////////	////////////////////	0	////////////////////
51	Support Surfaces	0.000000	0		0	0
52	Other Ancillary Service Cost Center	0.000000	0		0	0
52.01	Other Ancillary Service Cost Center II	0.000000	0		0	0
52.02	Other Ancillary Service Cost Center III	0.000000	0		0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
60	Clinic	0.000000	0		0	0
61	Rural Health Clinic	0.000000			0	0
62	FQHC	0.000000			0	0
63	Other Outpatient Service Cost	0.000000	0		0	0
71	Ambulance	0.000000	////////////////////	////////////////////		
	(2)					
100	Total (Sum of lines 40 - 71)		1,398,491	0	1,004,940	0
(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.						

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10	
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN : 31-5423	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D

Check  Title V (1)                      Check One:                       SNF                       NF                       ICF/IID                       Other  
 One:  Title XVIII                       PPS - Must also complete Part II  
 Title XIX (1)

PART II - APPORTIONMENT OF VACCINE COST		
1	Drugs charged to patients - ratio of cost to charges ( From Worksheet C, column 3, line 49)	0.931220
2	Program vaccine charges ( From your records, or the P S & R.) --->	3,025
3	Program costs ( Line 1 X line 2) ( Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	2,817

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

		Total Cost (From Worksheet B, Part I, Col 18)	Nursing & Allied Health (From Wkst. B, Part I, Column 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 & Allie health Costs fo Pass Through (Col. 3 X Col. 4)
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
40	Radiology	14,304	0	0.000000	3,747	0
41	Laboratory	36,274	0	0.000000	25,817	0
42	Intravenous Therapy	19,843	0	0.000000	19,500	0
43	Oxygen ( Inhalation ) Therapy	28,915	0	0.000000	0	0
44	Physical Therapy	555,986	0	0.000000	227,277	0
45	Occupational Therapy	577,490	0	0.000000	257,077	0
46	Speech Pathology	203,469	0	0.000000	113,495	0
47	Electro cardiology	0	0	0.000000	0	0
48	Medical Supplies	0	0	0.000000	0	0
49	Drugs Charged to Patients	363,606	0	0.000000	358,027	0
50	Dental Care - Title XIX only	0	0	0.000000	0	0
51	Support Surfaces	0	0	0.000000	0	0
52	Other Ancillary Service Cost Center	0	0	0.000000	0	0
52.01	Other Ancillary Service Cost Center II	0	0	0.000000	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0.000000	0	0
100	Total ( Sum of lines 40 - 52)	1,799,887	0	////////////////////////////////////	1,004,940	0

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST		PROVIDER CCN :	PERIOD :		WORKSHEET D
		31-5423	FROM: 01/01/2024 TO: 12/31/2024		
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST					
Check <input type="checkbox"/> Title V (1)		Check One: <input type="checkbox"/> SNF		<input checked="" type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> Other	
One: <input type="checkbox"/> Title XVIII		<input type="checkbox"/> PPS - Must also complete Part II			
<input checked="" type="checkbox"/> Title XIX (1)					
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST		HEALTH CARE PROGRAM INPATIENT CHARGES		HEALTH CARE PROGRAM INPATIENT COST	
		RATIO OF COST TO CHARGES			
		PART A		PART B	
		PART A		PART B	
		1		2	
		3		4	
		5			
ANCILLARY SERVICE COST CENTERS:					
		////////////////////////////////////		////////////////////////////////////	
40	Radiology	1.208823		0	////////////////////////////////////
41	Laboratory	1.208811		0	////////////////////////////////////
42	Intravenous Therapy	0.450680		0	////////////////////////////////////
43	Oxygen ( Inhalation ) Therapy	1.208821		0	////////////////////////////////////
44	Physical Therapy	0.680767		0	////////////////////////////////////
45	Occupational Therapy	0.605074		0	////////////////////////////////////
46	Speech Pathology	0.605074		0	////////////////////////////////////
47	Electro cardiology	0.000000		0	////////////////////////////////////
48	Medical Supplies Charged	0.000000		0	////////////////////////////////////
49	Drugs Charged to Patients	0.931220		0	////////////////////////////////////
50	Dental Care - Title XIX only	0.000000		0	////////////////////////////////////
51	Support Surfaces	0.000000		0	////////////////////////////////////
52	Other Ancillary Service Cost Center	0.000000		0	////////////////////////////////////
52.01	Other Ancillary Service Cost Center II	0.000000		0	////////////////////////////////////
52.02	Other Ancillary Service Cost Center III	0.000000		0	////////////////////////////////////
OUTPATIENT SERVICE COST CENTERS					
		////////////////////////////////////		////////////////////////////////////	
60	Clinic	0.000000		0	////////////////////////////////////
61	Rural Health Clinic	0.000000		0	////////////////////////////////////
62	FQHC	0.000000		0	////////////////////////////////////
63	Other Outpatient Service Cost	0.000000		0	////////////////////////////////////
71	Ambulance	0.000000		0	////////////////////////////////////
		////////////////////////////////////		////////////////////////////////////	
100	Total (Sum of lines 40 - 71)		0	0	////////////////////////////////////

(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.

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10	
COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN : 31-5423	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D-1 PARTS I & II
Check One:	<input type="checkbox"/> Title V	<input checked="" type="checkbox"/> Title XVIII	<input type="checkbox"/> Title XIX
Check One:	<input checked="" type="checkbox"/> SNF	<input type="checkbox"/> NF	<input type="checkbox"/> ICF/IID

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	72,103
2	Private room days	
3	Inpatient days including private room days applicable to the Program	8,227
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	18,588,838

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	25,770,924
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.721310
8	Enter private room charges from your records	
9	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00
10	Enter semi-private room charges from your records	
11	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00
12	Average per diem private room charge differential (Line 9 minus line 11)	0.00
13	Average per diem private room cost differential ( Line 7 times line 12 )	0.00
14	Private room cost differential adjustment (Line 2 times line 13)	0
15	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	18,588,838

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	257.81
17	Program routine service cost (Line 3 times line 16)	2,121,003
18	Medically necessary private room cost applicable to program (line 4 times line 13)	0
19	Total program general inpatient routine service cost (Line 17 plus line 18)	2,121,003
20	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/MR)	2,249,487
21	Per diem capital related costs (Line 20 divided by line 1)	31.20
22	Program capital related cost (Line 3 times line 21)	256,682
23	Inpatient routine service cost (Line 19 minus line 22)	1,864,321
24	Aggregate charges to beneficiaries for excess costs (From provider records)	
25	Total program routine service costs for comparison to the cost limitation ( Line 23 minus line 24 )	1,864,321
26	Enter the per diem limitation (1)	N/A
27	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	N/A
28	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)	
	(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	

PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH

1	Total inpatient days	72,103
2	Program inpatient days. (see instructions)	8,227
3	Total Nursing & Allied Health costs. ( see instructions)	0
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	0.114101
5	Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4)	0

COMPUTATION OF INPATIENT ROUTINE COSTS Check One:	PROVIDER CCN :	PERIOD :	WORKSHEET D-1 PARTS I & II
	31-5423	FROM: 01/01/2024 TO: 12/31/2024	
	<input type="checkbox"/> Title XVIII	<input checked="" type="checkbox"/> Title XIX	
Check One:	<input checked="" type="checkbox"/> NF	<input type="checkbox"/> ICF/IID	

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	0
2	Private room days	
3	Inpatient days including private room days applicable to the Program	0
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	0

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.000000
8	Enter private room charges from your records	
9	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00
10	Enter semi-private room charges from your records	
11	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private roo	0.00
12	Average per diem private room charge differential (Line 9 minus line 11)	0.00
13	Average per diem private room cost differential ( Line 7 times line 12 )	0.00
14	Private room cost differential adjustment (Line 2 times line 13)	0
15	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	0

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	0.00
17	Program routine service cost (Line 3 times line 16)	0
18	Medically necessary private room cost applicable to program (line 4 times line 13)	0
19	Total program general inpatient routine service cost (Line 17 plus line 18)	0
20	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/MR)	0
21	Per diem capital related costs (Line 20 divided by line 1)	0.00
22	Program capital related cost (Line 3 times line 21)	0
23	Inpatient routine service cost (Line 19 minus line 22)	0
24	Aggregate charges to beneficiaries for excess costs (From provider records)	
25	Total program routine service costs for comparison to the cost limitation ( Line 23 minus line 24 )	0
26	Enter the per diem limitation (1)	
27	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	0
28	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)	0
	(Transfer to Worksheet E, Part II, line 4) (See instructions)	
	(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	

PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH

1	Total inpatient days	
2	Program inpatient days. (see instructions)	
3	Total Nursing & Allied Health costs. ( see instructions)	
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	
5	Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4)	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	PROVIDER CCN : 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	<b>WORKSHEET E PART I</b>
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**PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT**

1	Inpatient PPS amount (See Instructions)	6,177,640
2	Nursing and Allied Health Education Activities (pass through payments)	0
3	Subtotal ( Sum of lines 1 and 2)	6,177,640
4	Primary payor amounts	( 0 )
5	Coinsurance	( 1,232,568 )
6	Allowable bad debts (from your records)	498,540
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	292,732
8	Adjusted reimbursable bad debts. (See instructions)	324,051
9	Recovery of bad debts - for statistical records only	
10	Utilization review	0
11	Subtotal (See instructions)	5,269,123
12	Interim payments (See instructions)	5,292,892
13	Tentative adjustment	
14	Other Adjustments (See Instructions)	
14.50	Demonstration payment adjustment amount before sequestration	0
14.55	Demonstration payment adjustment amount after sequestration	0
14.75	Sequestration for non-claims based amounts (see instructions)	6,481
14.99	Sequestration amount (see instructions)	98,902
15	Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14)	<b>(129,152)</b>
	(Indicate overpayment in parentheses) (See Instructions)	
16	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	

**PART B - ANCILLARY SERVICES COMPUTATION OF REIMBURSEMENT - LESSER OF COST OR CHARGES, TITLE XVIII ONLY**

17	Ancillary services Part B	0
18	Vaccine cost (From Wkst D, Part II, line 3)	2,817
19	Total reasonable costs (Sum of lines 17 and 18)	2,817
20	Medicare Part B ancillary charges (See instructions)	3,025
21	Cost of covered services (Lesser of line 19 or line 20)	2,817
22	Primary payor amounts	( 0 )
23	Coinsurance and deductibles	( 0 )
24	Allowable bad debts (from your records)	
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	
24.02	Reimbursable bad debts (see instructions)	0
25	Subtotal (Sum of lines 21 and 24.02, minus lines 22 and 23)	2,817
26	Interim payments (See instructions)	2,223
27	Tentative adjustment	
28	Other Adjustments (See Instructions)	
28.50	Demonstration payment adjustment amount before sequestration	0
28.55	Demonstration payment adjustment amount after sequestration	0
28.99	Sequestration amount (see instructions)	56
29	Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28)	<b>538</b>
	(Indicate overpayments in parentheses) (See Instructions)	
30	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	<b>WORKSHEET E-1</b>
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Description	Inpatient Part A		Part B			
	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
	1	2	3	4		
1 Total interim payments paid to provider	////////////////////////////////////	4,846,171	////////////////////////////////////	2,223		
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.	////////////////////////////////////	375,000	////////////////////////////////////			
3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE," or enter a zero (1)	Program to Provider	.01	05/23/24	71,721		
		.02				
		.03				
		.04				
		.05				
	Provider to Program *	.50				
		.51				
		.52				
		.53				
		.54				
SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99	////////////////////////////////////	71,721	////////////////////////////////////	0
4 TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) Transfer to Wkst E, Part I line 12 for Part A, and line 26 for Part B.)			////////////////////////////////////	5,292,892	////////////////////////////////////	2,223
			////////////////////////////////////		////////////////////////////////////	

TO BE COMPLETED BY CONTRACTOR

5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Program to Provider	.01				
		.02				
		.03				
	Provider to Program	.50				
		.51				
		.52				
SUBTOTAL (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99	////////////////////////////////////		////////////////////////////////////	
6 Determine net settlement amount (balance due) based on the cost report. (1)	Program to provider	.01				
	Provider to program	.50				
7 TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)			////////////////////////////////////		////////////////////////////////////	
8 Name of Contractor	Contractor Number					

(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.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	<b>WORKSHEET E</b> <b>PART II</b> <b>TITLE XIX</b>
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Check one:  Title V  Title XIX

Check one:  SNF  NF  ICF/IID

COMPUTATION OF NET COST OF COVERED SER PART A - INPATIENT SERVICES

1	Inpatient ancillary services (see Instructions)	0
2	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)	0
3	Outpatient services	0
4	Inpatient routine services (see instructions)	0
5	Utilization review--physicians' compensation (from provider records)	
6	Cost of covered services (Sum of lines 1 - 5)	0
7	Differential in charges between semiprivate accommodations and less than semiprivate accommodations	
8	SUBTOTAL (Line 6 minus line 7)	0
9	Primary payor amounts	
10	Total Reasonable Cost (Line 8 minus line 9)	0

REASONABLE CHARGES

11	Inpatient ancillary service charges	0
12	Outpatient service charges	0
13	Inpatient routine service charges	
14	Differential in charges between semiprivate accommodations and less than semiprivate accommodations	
15	Total reasonable charges	0

CUSTOMARY CHARGES:

16	Aggregate amount actually collected from patients liable for payment for services on a charge basis	
17	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	
18	Ratio of line 16 to line 17 (not to exceed 1.000000)	1.000000
19	Total customary charges (see instructions)	0

COMPUTATION OF REIMBURSEMENT SETTLEMENT:

20	Cost of covered services (see Instructions)	0
21	Deductibles	
22	Subtotal (Line 20 minus line 21)	0
23	Coinsurance	
24	Subtotal (Line 22 minus line 23)	0
25	Allowable bad debts (from your records)	
26	Subtotal (sum of lines 24 and 25)	0
27	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit	
28	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization	
29		
30	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets ( if minus, enter amount in parentheses)	
31	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)	0
32	Interim payments	
33	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)	0

BALANCE SHEET	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	<b>WORKSHEET G</b>	
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4

ASSETS

CURRENT ASSETS					
1	Cash on hand and in banks	1,988,314			
2	Temporary investments	0			
3	Notes receivable	0			
4	Accounts receivable	3,623,674			
5	Other receivables	0			
6	Less: allowances for uncollectible notes and A/R	0			
7	Inventory	0			
8	Prepaid expenses	203,726			
9	Other current assets	0			
10	Due from other funds	0			
11	<b>TOTAL CURRENT ASSETS</b>	<b>5,815,714</b>	<b>0</b>	<b>0</b>	<b>0</b>
	(Sum of lines 1 - 10)				

FIXED ASSETS					
12	Land	0			
13	Land improvements	0			
14	Less: Accumulated depreciation	0			
15	Buildings	0			
16	Less Accumulated depreciation	0			
17	Leasehold improvements	4,413,605			
18	Less: Accumulated Amortization	0			
19	Fixed equipment	0			
20	Less: Accumulated depreciation	0			
21	Automobiles and trucks	0			
22	Less: Accumulated depreciation	0			
23	Major movable equipment	51,718			
24	Less: Accumulated depreciation	(3,061,077)			
25	Minor equipment - Depreciable	0			
26	Minor equipment nondepreciable	0			
27	Other fixed assets	0			
28	<b>TOTAL FIXED ASSETS</b>	<b>1,404,246</b>	<b>0</b>	<b>0</b>	<b>0</b>
	(Sum of lines 12 - 27)				

OTHER ASSETS					
29	Investments	0			
30	Deposits on leases	0			
31	Due from owners/officers	0			
32	Other assets	20,053			
33	<b>TOTAL OTHER ASSETS</b>	<b>20,053</b>	<b>0</b>	<b>0</b>	<b>0</b>
	(Sum of lines 29 - 32)				
34	<b>TOTAL ASSETS</b>	<b>7,240,013</b>	<b>0</b>	<b>0</b>	<b>0</b>
	(Sum of lines 11, 28 and 33)				

BALANCE SHEET	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G (cont'd)
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LIABILITIES & FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4

CURRENT LIABILITIES

35	Accounts payable	1,017,585			
36	Salaries, wages & fees payable	600,629			
37	Payroll taxes payable	295,731			
38	Notes & loans payable (Short term)	0			
39	Deferred income	0			
40	Accelerated payments	0	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
41	Due to other funds	0			
42	Other current liabilities	0			
43	TOTAL CURRENT LIABILITIES	1,913,945	0	0	0
	(Sum of lines 35 - 42)				

LONG TERM LIABILITIES

44	Mortgage payable	0			
45	Notes payable	0			
46	Unsecured loans	500,388			
47	Loans from owners:	0			
48	Other long term liabilities	0			
49	Other (Specify)	0			
50	TOTAL LONG TERM LIABILITIES	500,388	0	0	0
	(Sum of lines 44 - 49)				
51	TOTAL LIABILITIES	2,414,333	0	0	0
	(Sum of lines 43 and 50)				

CAPITAL ACCOUNTS

52	General fund balance	4,825,680	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
53	Specific purpose fund		0	////////////////////////////////////	////////////////////////////////////
54	Donor created - EFB restricted		////////////////////////////////////	0	////////////////////////////////////
55	Donor created - EFB unrestricted		////////////////////////////////////	0	////////////////////////////////////
56	Governing body created - EFB		////////////////////////////////////	0	////////////////////////////////////
57	PFB - invested in plant		////////////////////////////////////	////////////////////////////////////	0
58	PFB - reserve for plant improvement		////////////////////////////////////	////////////////////////////////////	0
59	TOTAL FUND BALANCES	4,825,680	0	0	0
	(Sum of lines 52 thru 58)				
60	TOTAL LIABILITIES & FUND BALANCES	7,240,013	0	0	0
	(Sum of lines 51 and 59)				

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-1
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		General Fund		Specific Purpose Fund		Endowment Fund		Plant Fund	
		1	2	3	4	5	6	7	8
1	Fund balances at beginning of period	////////////////////////////////////	4,061,639	////////////////////////////////////		////////////////////////////////////		////////////////////////////////////	
2	Net income (loss) (From Wkst. G-3, line 31)	////////////////////////////////////	850,041	////////////////////////////////////		////////////////////////////////////		////////////////////////////////////	
3	Total (Sum of line 1 and line 2)	////////////////////////////////////	4,911,680	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0
4	Additions (Credit adjustments)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
5		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
6		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
7		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
8		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
9		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
10	Total additions (Sum of lines 5 - 9)	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0
11	Subtotal (Line 3 plus line 10)	////////////////////////////////////	4,911,680	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0
12	Deductions (Debit adjustments)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
13	Members Drawings	86,000	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
14		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
15		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
16		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
17		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
18	Total deductions (Sum of lines 13 - 17)	////////////////////////////////////	86,000	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0
19	Fund balance at end of period per	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
	balance sheet (Line 11 - line 18)	////////////////////////////////////	4,825,680	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-2 PARTS I/II
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PART I - PATIENT REVENUES

REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL
		1	2	3
GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Skilled Nursing Facility	25,770,924		25,770,924
2	Nursing facility	0		0
3	ICF-IID	0		0
4	Other long term care	0		0
5	Total general inpatient care services	25,770,924		25,770,924
	(Sum of lines 1 - 4)			

ALL OTHER CARE SERVICES				
6	Ancillary services	2,633,851	0	2,633,851
7	Clinic		0	0
8	Home Health Agency		0	0
9	Ambulance		0	0
10	RHC/FQHC		0	0
11	CMHC		0	0
12	Hospice	0	0	0
13	Other Svc Revenues	0	0	0
14	Total Patient Revenues (Sum of lines 5 - 13)	28,404,775	0	28,404,775
	(Transfer column 3 to Worksheet G-3, Line 1)			

PART II - OPERATING EXPENSES

1	Operating Expenses ( Per Worksheet A, Col. 3, Line 100 )		24,860,718
2			
3			
4			
5			
6			
7			
8	Total Additions ( Sum of lines 2 - 7 )		0
9			
10			
11			
12			
13			
14	Total Deductions ( Sum of lines 9 - 13 )		0
15	Total Operating Expenses ( Sum of lines 1 and 8, minus line 14 )		24,860,718

STATEMENT OF REVENUES & EXPENSES	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-3
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1	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	28,404,775
2	Less: contractual allowances and discounts on patients accounts	( 2,815,671 )
3	Net patient revenues (Line 1 minus line 2)	25,589,104
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	24,860,718
5	Net income from service to patients (Line 3 minus 4)	728,386
////////	OTHER INCOME:	////////
6	Contributions, donations, bequests, etc	0
7	Income from investments	60,162
8	Revenues from communications (Telephone and Internet service)	0
9	Revenue from television and radio service	0
10	Purchase discounts	0
11	Rebates and refunds of expenses	0
12	Parking lot receipts	0
13	Revenue from laundry and linen service	0
14	Revenue from meals sold to employees and guests	0
15	Revenue from rental of living quarters	0
16	Revenue from sale of medical and surgical supplies to other than patients	0
17	Revenue from sale of drugs to other than patients	0
18	Revenue from sale of medical records and abstracts	97
19	Tuition (fees, sale of textbooks, uniforms, etc.)	0
20	Revenue from gifts, flower, coffee shops, canteen	0
21	Rental of vending machines	0
22	Rental of skilled nursing space	0
23	Governmental appropriations	0
24	Prior Year Income	61,396
24.50	COVID-19 PHE Funding	0
25	Total other income (Sum of lines 6 - 24)	121,655
26	Total (Line 5 plus line 25)	850,041
27		0
28		0
29		0
30	Total other expenses (Sum of lines 27 - 29)	0
31	Net income (or loss) for the period (Line 26 minus line 30)	850,041