

Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: 31-5010	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S PARTS I II & III
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date:	05/15/2025	Time:	09:11:22 AM
	2. ☐ Manually prepared cost report				
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report.				0
	3.0.1 ☐ No Medicare Utilization Enter "Y" for yes or leave blank for no				0
Contractor use only:	4. ☐ Cost Report Status	6. Contractor No. _____			
	☐ As Submitted:	7. ☐ First Cost Report for this Provider CCN			
	☐ Settled without audit	8. ☐ Last Cost Report for this Provider CCN			
	☐ Settled with audit	9. ☐ NPR Date: _____			
	☐ Reopened	10. ☐ If line 4, column 1 is "4": Enter number of times reopened			
	☐ Amended	11. Contractor Vendor Code _____			
5. Date Received	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 ELMORA HILLS HEALTHCARE AND REHAB #31-5010 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 09:11:22 AM
mqNIFeTZaW1J2UpODt3a0P2lm0uUJ0
2UDK30JVzc6solOKSuGh6J6ygZSFXF
Vemi0GjDmh0xnPmh

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Avi Maierovits		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	TITLE XVIII		TITLE XIX	
			A	B		
			2	3		
1	SKILLED NURSING FACILITY	//////////	86,758	(1,450)		1
2	NURSING FACILITY	//////////	//////////	//////////	0	2
3	I C F / 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		86,758	(1,450)	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.

MED-CALC SYSTEMS				In Lieu of CMS Form 2540-10						
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX				PROVIDER CCN:		PERIOD:		WORKSHEET S-2		
IDENTIFICATION DATA				31-5010		FROM: 01/01/2024		PART I		
TO: 12/31/2024										
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:										
1	Street:	225 WEST JERSEY STREET	P.O. Box:						1	
2	City:	ELIZABETH	State:	NJ	Zip Code:	07202			2	
3	County:	UNION	CBSA Code:	35084	Urban / Rural:	U			3	
SNF and SNF-Based Component Identification:										
						Payment System				
						(P, O, or N)				
	Component	Component Name	Provider CCN:	Date Certified		V	XVIII	XIX		
	0	1	2	3		4	5	6		
4	SNF	ELMORA HILLS HEALTHCARE AN	31-5010	01/01/1967		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					179,488	////////////////////		20	
21	Declining Balance						////////////////////		21	
22	Sum of the Year's Digits						////////////////////		22	
23	Sum of line 20 through 22					179,488	////////////////////		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	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX		PROVIDER CCN: 31-5010	PERIOD FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S-2 PART I (Cont.)
IDENTIFICATION DATA				

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:	466,222			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: 31-5010	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
		1 Y/N	2 Date	3 V / I	
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	6
7	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N	/////////////////	7
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	/////////////////	8

Bad Debts		1 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		N	
12	Have total beds available changed from prior cost reporting period? If "Y", see instructions.	N	12

		1 Y/N	2 Date	3 Y/N	4 Date	
PS&R Data		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			PROVIDER CCN:		PERIOD:		WORKSHEET S-3		
SKILLED NURSING FACILITY HEALTH CARE COMPLEX			31-5010		FROM: 01/01/2024		PART I		
STATISTICAL DATA					TO: 12/31/2024				

Component			Number of Beds	Bed Days Available		Inpatient Days / Visits				
						Title V	Title XVIII	Title XIX	Other	Total
						3	4	5	6	7
1	Skilled Nursing Facility		200	73,200	////////////////	////////////////	10,196	42,770	13,910	66,876
2	Nursing Facility				////////////////	////////////////	////////////////			0
3	ICF/IID				////////////////	////////////////	////////////////			0
4	Home Health Agency		////////////////	////////////////	////////////////	////////////////				0
5	Other Long Term Care				////////////////	////////////////	////////////////	////////////////		0
6	SNF-Based CMHC		////////////////	////////////////	////////////////	////////////////	////////////////	////////////////	////////////////	////////////////
7	Hospice				////////////////	////////////////				0
8	TOTAL (Sum Lines 1-7)		200	73,200	////////////////	////////////////	10,196	42,770	13,910	66,876

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	////////////////	220	146	344	710	////////////////	46.35	292.95	94.19
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)	////////////////	220	146	344	710	////////////////	46.35	292.95	94.19

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		////////////////	223	71	433	727		179.65	
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)		////////////////	223	71	433	727		179.65	0.00

SNF WAGE INDEX INFORMATION

PROVIDER CCN:
31-5010PERIOD:
FROM: 01/01/2024
TO: 12/31/2024WORKSHEET 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)	10,420,005	0	10,420,005	373,679.55	27.88	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)	10,420,005	0	10,420,005	373,679.55	27.88	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)	10,420,005	0	10,420,005	373,679.55	27.88	13
OTHER WAGES AND RELATED COSTS		////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	
14	Contract Labor: Patient Related & Mgmt	1,270,593		1,270,593	18,283.48	69.49	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)	2,123,018		2,123,018	////////////////////	////////////////////	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)	2,123,018	0	2,123,018	////////////////////	////////////////////	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	592,562	0	592,562	16,458.25	36.00	2
3	Plant Operation, Maintenance & Repairs	271,880	0	271,880	12,768.75	21.29	3
4	Laundry & Linen Service	28,842	0	28,842	1,698.50	16.98	4
5	Housekeeping	271,764	0	271,764	14,596.50	18.62	5
6	Dietary	917,271	0	917,271	45,700.50	20.07	6
7	Nursing Administration	271,829	0	271,829	4,117.50	66.02	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	154,381	0	154,381	4,286.00	36.02	11
12	Nursing and Allied Health Education Activities	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	12
13	Other General Service Cost	350,754	0	350,754	21,185.00	16.56	13
14	Total (sum lines 1 thru 13)	2,859,283	0	2,859,283	120,811.00	23.67	14

MED-CALC SYSTEMS

In Lieu of CMS Form 2540-10

SNF WAGE RELATED COSTS	PROVIDER CCN: 31-5010	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S-3 PART IV
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PART IV - Wage Related Cost
Part A - Core List

		Amount Reported	
RETIREMENT COST			
1	401K Employer Contributions	31,943	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
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):			
5	401K/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
HEALTH AND INSURANCE COST			
8	Health Insurance (Purchased or Self Funded)	967,346	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	180,903	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)		16
TAXES			
17	FICA-Employers Portion Only	771,776	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	136,067	20
OTHER			
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement	34,983	23
24	Total Wage Related cost (Sum of lines 1 -23)	2,123,018	24

Part B Other than Core Related Cost
Amount Reported

25			25
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SNF REPORTING OF DIRECT CARE EXPENDITURES		PROVIDER CCN: 31-5010		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	
Direct Salaries		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////
Nursing Occupations		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////
1	Registered Nurses (RNs)	1,452,531	295,945	1,748,476	27,104.75	64.51	1
2	Licensed Practical Nurses (LPNs)	2,547,589	519,057	3,066,646	64,623.35	47.45	2
3	Certified Nursing Assistants/Nursing Assistants/Aides	3,397,046	692,129	4,089,175	160,990.45	25.40	3
4	Total Nursing (sum of lines 1 through 3)	7,397,166	1,507,131	8,904,297	252,718.55	35.23	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
Contract Labor		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	/
Nursing Occupations		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	/
14	Registered Nurses (RNs)	515	////////////////////////////////////	515	7.15	72.03	14
15	Licensed Practical Nurses (LPNs)	10,314	////////////////////////////////////	10,314	205.60	50.17	15
16	Certified Nursing Assistants/Nursing Assistants/Aides	17,963	////////////////////////////////////	17,963	743.73	24.15	16
17	Total Nursing (sum of lines 14 through 16)	28,792	////////////////////////////////////	28,792	956.48	30.10	17
18	Physical Therapists	567,486	////////////////////////////////////	567,486	7,339.00	77.32	18
19	Physical Therapy Assistants		////////////////////////////////////	-		0.00	19
20	Physical Therapy Aides		////////////////////////////////////	-		0.00	20
21	Occupational Therapists	505,773	////////////////////////////////////	505,773	8,156.00	62.01	21
22	Occupational Therapy Assistants		////////////////////////////////////	-		0.00	22
23	Occupational Therapy Aides		////////////////////////////////////	-		0.00	23
24	Speech Therapists	168,543	////////////////////////////////////	168,543	1,832.00	92.00	24
25	Respiratory Therapists		////////////////////////////////////	-		0.00	25
26	Other Medical Staff		////////////////////////////////////	-		0.00	26

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER CCN: 31-5010			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	////////////////////////////////////	2,692,533	2,692,533	0	2,692,533	(1,483,647)	1,208,886
2	0200	Capital-Related Costs - Movable Equipment	////////////////////////////////////	0	0	0	0	0	0
3	0300	Employee Benefits	0	2,123,019	2,123,019	0	2,123,019	0	2,123,019
4	0400	Administrative and General	592,562	4,986,994	5,579,556	0	5,579,556	(1,280,564)	4,298,992
5	0500	Plant Operation, Maintenance and Repairs	271,880	677,001	948,881	0	948,881	0	948,881
6	0600	Laundry and Linen Service	28,842	115,814	144,656	0	144,656	0	144,656
7	0700	Housekeeping	271,764	428,398	700,162	0	700,162	0	700,162
8	0800	Dietary	917,271	714,707	1,631,978	0	1,631,978	0	1,631,978
9	0900	Nursing Administration	271,829	950	272,779	0	272,779	0	272,779
10	1000	Central Services and Supply	0	497,346	497,346	0	497,346	0	497,346
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	154,381	0	154,381	0	154,381	0	154,381
14	1400	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0
15	1500	Other General Service Cost	350,754	68,882	419,636	0	419,636	0	419,636
INPATIENT ROUTINE SERVICE COST CENTERS			////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
30	3000	Skilled Nursing Facility	7,560,722	128,874	7,689,596	0	7,689,596	(459)	7,689,137
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	49,184	49,184	0	49,184	0	49,184
41	4100	Laboratory	0	29,171	29,171	0	29,171	0	29,171
42	4200	Intravenous Therapy	0	7,185	7,185	0	7,185	0	7,185
43	4300	Oxygen (Inhalation) Therapy	0	21,764	21,764	0	21,764	0	21,764
44	4400	Physical Therapy	0	1,241,802	1,241,802	(674,316)	567,486	0	567,486
45	4500	Occupational Therapy	0	0	0	505,773	505,773	0	505,773
46	4600	Speech Pathology	0	0	0	168,543	168,543	0	168,543
47	4700	Electrocardiology	0	0	0	0	0	0	0
48	4800	Medical Supplies Charged to Patients	0	0	0	1,373	1,373	0	1,373
49	4900	Drugs Charged to Patients	0	415,660	415,660	(1,373)	414,287	0	414,287
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: 31-5010			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)	10,420,005	14,199,284	24,619,289	0	24,619,289	(2,764,670)	21,854,619
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	13,250	13,250	0	13,250	0	13,250
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	10,420,005	14,212,534	24,632,539	0	24,632,539	(2,764,670)	21,867,869

		INCREASE					DECREASE			
EXPLANATION OF RECLASSIFICATION ENTRY		CODE (1)	COST CENTER	LINE NO.	SALARY	NON-SALARY	COST CENTER	LINE NO.	SALARY	NON-SALARY
		1	2	3	4	5	6	7	8	9
1	RECLASS MED SUP	A	Medical Supplies Charged to P	48		1,373	Drugs Charged to Patie	49		1,373
2	RECLASS OT	B	Occupational Therapy	45		505,773	Physical Therapy	44		505,773
3	RECLASS ST	C	Speech Pathology	46		168,543	Physical Therapy	44		168,543
4										
5										
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72										
100	TOTAL RECLASSIFICATIONS	////////	////////////////////////////////////	////////	0	675,689	////////////////////////////////////	////////	0	675,689

(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:	PERIOD:	WORKSHEET A-7
		31-5010	FROM: 01/01/2024 TO: 12/31/2024	

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	4	5	6	7
1	Land				0		0	
2	Land Improvements				0		0	
3	Buildings and Fixtures				0		0	
4	Building Improvements	3,101,602			0	178,389	2,923,213	
5	Fixed Equipment				0		0	
6	Movable Equipment	35,310			0	24,320	10,990	
7	Subtotal (sum of lines 1-6)	3,136,912	0	0	0	202,709	2,934,203	0
8	Reconciling Items				0		0	
9	Total (line 7 minus line 8)	3,136,912	0	0	0	202,709	2,934,203	0

(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	(52,771)	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	(1,732,661)	//////////	//////////
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	(267)	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	(978,971)	Administrative and General	4
25.01					
25.02					
25.03					
25.04					
A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW)		//////////	0	//////////	//////////
100	TOTAL	//////////	(2,764,670)	//////////	//////////

(1)		(2) BASIS* FOR ADJ	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
DESCRIPTION			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: 31-5010	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET A-8-1
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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	1,007,962	1,007,962	0
2		10	Central Services and Supply	Med Supplies	288,111	288,111	0
3		43	Oxygen (Inhalation) Therapy	Oxygen	13,657	13,657	0
4		10	Central Services and Supply	OTC Drugs	37,483	37,483	0
5		8	Dietary	Dietary	712,637	712,637	0
6		5	Plant Operation, Maintenance and R	Maintenance	89,089	89,089	0
7		6	Laundry and Linen Service	Diapers	115,814	115,814	0
8		4	Administrative and General	Office Supplies	20,859	20,859	0
9		4	Administrative and General	Office Support	1,257,838	1,506,393	(248,555)
9.01		1	Capital-Related Costs - Building &	Rent	1,024,353	2,508,000	(1,483,647)
9.02		30	Skilled Nursing Facility	Nursing	5,888	6,347	(459)
9.03							0
9.04							0
9.05							0
9.06							0
9.07							0
9.08							0
9.09							0
9.10							0
10 TOTAL					4,573,691	6,306,352	(1,732,661)

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.

	Descrip tion	(1)	Name	Percentage of Ownership	Related Organization(s)		
		Symbol			Name	Percentage of Ownership	Type of Business
		1	2	3	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	Elmora Hills	100.00	Jersey Wesy 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: 31-5010		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET A-8-2	
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	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	TOTAL		0	0	0	////////////////////////////////////	0	0	0

	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	TOTAL		0	0	0	0	0	0	0

COST ALLOCATION GENERAL SERVICE COSTS			PROVIDER CCN: 31-5010	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
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture	1,208,886	1,208,886						
2	Capital-Related Costs - Movable Equipment	0	////////////////////	0					
3	Employee Benefits	2,123,019	0	0	2,123,019				
4	Administrative and General	4,298,992	78,212	0	120,732	4,497,936	4,497,936		
5	Plant Operation, Maintenance and Repairs	948,881	115,814	0	55,394	1,120,089	290,047	1,410,136	
6	Laundry and Linen Service	144,656	0	0	5,876	150,532	38,980	0	189,512
7	Housekeeping	700,162	12,189	0	55,371	767,722	198,802	16,936	0
8	Dietary	1,631,978	139,156	0	186,889	1,958,023	507,030	193,355	0
9	Nursing Administration	272,779	0	0	55,384	328,163	84,978	0	0
10	Central Services and Supply	497,346	4,876	0	0	502,222	130,050	6,774	0
11	Pharmacy	0	0	0	0	0	0	0	0
12	Medical Records and Library	0	0	0	0	0	0	0	0
13	Social Service	154,381	0	0	31,454	185,835	48,122	0	0
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	419,636	3,291	0	71,464	494,391	128,023	4,573	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	7,689,137	804,826	0	1,540,455	10,034,418	2,598,403	1,118,298	189,512
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	49,184	0	0	0	49,184	12,736	0	0
41	Laboratory	29,171	0	0	0	29,171	7,554	0	0
42	Intravenous Therapy	7,185	0	0	0	7,185	1,861	0	0
43	Oxygen (Inhalation) Therapy	21,764	0	0	0	21,764	5,636	0	0
44	Physical Therapy	567,486	20,254	0	0	587,740	152,195	28,142	0
45	Occupational Therapy	505,773	24,418	0	0	530,191	137,293	33,929	0
46	Speech Pathology	168,543	1,381	0	0	169,924	44,002	1,919	0
47	Electrocardiology	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	1,373	0	0	0	1,373	356	0	0
49	Drugs Charged to Patients	414,287	4,469	0	0	418,756	108,437	6,210	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: 31-5010	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	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)	21,854,619	1,208,886	0	2,123,019	21,854,619	4,494,505	1,410,136	189,512
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	13,250	0	0	0	13,250	3,431	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
100	TOTAL	21,867,869	1,208,886	0	2,123,019	21,867,869	4,497,936	1,410,136	189,512

COST ALLOCATION GENERAL SERVICE COSTS				PROVIDER CCN: 31-5010	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	983,460							
8	Dietary	136,489	2,794,897						
9	Nursing Administration	0	0	413,141					
10	Central Services and Supply	4,782	0	0	643,828				
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	233,957	
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	3,228	0	0	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	789,406	2,794,897	413,141	643,828	0	0	233,957	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	19,866	0	0	0	0	0	0	0
45	Occupational Therapy	23,950	0	0	0	0	0	0	0
46	Speech Pathology	1,355	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	4,384	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: 31-5010	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)	983,460	2,794,897	413,141	643,828	0	0	233,957	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	983,460	2,794,897	413,141	643,828	0	0	233,957	0

ALLOCATION OF CAPITAL-RELATED COSTS		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		PROVIDER CCN: 31-5010	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
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture	////////////////////	////////////////////	////////////////////	////////////////////				
2	Capital-Related Costs - Movable Equipment	////////////////////	////////////////////	////////////////////	////////////////////				
3	Employee Benefits		0	0	0	0			
4	Administrative and General		78,212	0	78,212	0	78,212		
5	Plant Operation, Maintenance and Repairs		115,814	0	115,814	0	5,044	120,858	
6	Laundry and Linen Service		0	0	0	0	678	0	678
7	Housekeeping		12,189	0	12,189	0	3,457	1,452	0
8	Dietary		139,156	0	139,156	0	8,817	16,572	0
9	Nursing Administration		0	0	0	0	1,478	0	0
10	Central Services and Supply		4,876	0	4,876	0	2,262	581	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	837	0	0
14	Nursing and Allied Health Education Activities		0	0	0	0	0	0	0
15	Other General Service Cost		3,291	0	3,291	0	2,226	392	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility		804,826	0	804,826	0	45,180	95,844	678
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
ANCILLARY SERVICE COST CENTERS									
40	Radiology		0	0	0	0	221	0	0
41	Laboratory		0	0	0	0	131	0	0
42	Intravenous Therapy		0	0	0	0	32	0	0
43	Oxygen (Inhalation) Therapy		0	0	0	0	98	0	0
44	Physical Therapy		20,254	0	20,254	0	2,647	2,412	0
45	Occupational Therapy		24,418	0	24,418	0	2,387	2,908	0
46	Speech Pathology		1,381	0	1,381	0	765	165	0
47	Electrocardiology		0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients		0	0	0	0	6	0	0
49	Drugs Charged to Patients		4,469	0	4,469	0	1,886	532	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: 31-5010	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
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)	0	1,208,886	0	1,208,886	0	78,152	120,858	678
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		0	0	0	0	60	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	1,208,886	0	1,208,886	0	78,212	120,858	678

ALLOCATION OF CAPITAL-RELATED COSTS						PROVIDER CCN: 31-5010			
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	17,098							
8	Dietary	2,373	166,918						
9	Nursing Administration	0	0	1,478					
10	Central Services and Supply	83	0	0	7,802				
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	837	
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	56	0	0	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	13,725	166,918	1,478	7,802	0	0	837	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	345	0	0	0	0	0	0	0
45	Occupational Therapy	416	0	0	0	0	0	0	0
46	Speech Pathology	24	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	76	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: 31-5010			
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
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)	17,098	166,918	1,478	7,802	0	0	837	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	17,098	166,918	1,478	7,802	0	0	837	0

COST ALLOCATION STATISTICAL BASIS		PROVIDER CCN: 31-5010	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	RECONCI- LIATION *	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	//////////	59,508	//////////	//////////	//////////	//////////	//////////	//////////	//////////
2	Capital-Related Costs - Movable Equipment	//////////	//////////	0	//////////	//////////	//////////	//////////	//////////	//////////
3	Employee Benefits	//////////		0	10,420,005	//////////	//////////	//////////	//////////	//////////
4	Administrative and General	//////////	3,850	0	592,562	(4,497,936)	17,369,933	//////////	//////////	//////////
5	Plant Operation, Maintenance and Repairs	//////////	5,701	0	271,880		1,120,089	49,957	//////////	//////////
6	Laundry and Linen Service	//////////		0	28,842		150,532	0	66,876	//////////
7	Housekeeping	//////////	600	0	271,764		767,722	600		49,357
8	Dietary	//////////	6,850	0	917,271		1,958,023	6,850		6,850
9	Nursing Administration	//////////		0	271,829		328,163	0		0
10	Central Services and Supply	//////////	240	0	0		502,222	240		240
11	Pharmacy	//////////		0	0		0	0		0
12	Medical Records and Library	//////////		0	0		0	0		0
13	Social Service	//////////		0	154,381		185,835	0		0
14	Nursing and Allied Health Education Activities	//////////		0	0		0	0		0
15	Other General Service Cost	//////////	162	0	350,754		494,391	162		162
INPATIENT ROUTINE SERVICE COST CENTERS		//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
30	Skilled Nursing Facility	//////////	39,618	0	7,560,722		10,034,418	39,618	66,876	39,618
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		49,184	0		0
41	Laboratory	//////////		0	0		29,171	0		0
42	Intravenous Therapy	//////////		0	0		7,185	0		0
43	Oxygen (Inhalation) Therapy	//////////		0	0		21,764	0		0
44	Physical Therapy	//////////	997	0	0		587,740	997		997
45	Occupational Therapy	//////////	1,202	0	0		530,191	1,202		1,202
46	Speech Pathology	//////////	68	0	0		169,924	68		68
47	Electrocardiology	//////////		0	0		0	0		0
48	Medical Supplies Charged to Patients	//////////		0	0		1,373	0		0
49	Drugs Charged to Patients	//////////	220	0	0		418,756	220		220
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: 31-5010	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	RECONCI- LIATION *	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)	//////////	59,508	0	10,420,005	(4,497,936)	17,356,683	49,957	66,876	49,357
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		13,250	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)	//////////	1,208,886	0	2,123,019	//////////	4,497,936	1,410,136	189,512	983,460
103	Unit Cost Multiplier (Worksheet B, Part I)	//////////	20.314680	0.000000	0.203745	//////////	0.258950	28.226995	2.833782	19.925441
104	Cost to Be Allocated (Per Worksheet B, Part II)	//////////	//////////	//////////	0	//////////	78,212	120,858	678	17,098
105	Unit Cost Multiplier (Worksheet B, Part II)	//////////	//////////	//////////	0.000000	//////////	0.004503	2.419241	0.010138	0.346415

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

COST ALLOCATION STATISTICAL BASIS						PROVIDER CCN: 31-5010	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
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	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
8	Dietary	200,628	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
9	Nursing Administration		66,876	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
10	Central Services and Supply			66,876	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
11	Pharmacy				0	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
12	Medical Records and Library					0	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
13	Social Service						66,876	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
14	Nursing and Allied Health Education Activities							0	////////////////////////////////////	////////////////////////////////////
15	Other General Service Cost								66,876	////////////////////////////////////
INPATIENT ROUTINE SERVICE COST CENTERS		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
30	Skilled Nursing Facility	200,628	66,876	66,876	0	0	66,876		66,876	////////////////////////////////////
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	////////////////////////////////////
ANCILLARY SERVICE COST CENTERS		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
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									////////////////////////////////////
OUTPATIENT SERVICE COST CENTERS		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////

COST ALLOCATION STATISTICAL BASIS						PROVIDER CCN: 31-5010	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)	200,628	66,876	66,876	0	0	66,876	0	66,876	////////////////////////////////////
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)	2,794,897	413,141	643,828	0	0	233,957	0	630,215	////////////////////////////////////
103	Unit Cost Multiplier (Worksheet B, Part I)	13.930742	6.177717	9.627191	0.000000	0.000000	3.498370	0.000000	9.423635	////////////////////////////////////
104	Cost to Be Allocated (Per Worksheet B, Part II)	166,918	1,478	7,802	0	0	837	0	5,965	////////////////////////////////////
105	Unit Cost Multiplier (Worksheet B, Part II)	0.831978	0.022101	0.116664	0.000000	0.000000	0.012516	0.000000	0.089195	////////////////////////////////////

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN: 31-5010	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B-2
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WORKSHEET B					
DESCRIPTION		PART NO. (1 or 2)	LINE NO.	AMOUNT	
-1-		-2-	-3-	-4-	
1					
2					
3					
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0

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN: 31-5010	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET C
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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	61,920	49,184	1.258946
41	Laboratory	36,725	35,741	1.027531
42	Intravenous Therapy	9,046	7,185	1.259012
43	Oxygen (Inhalation) Therapy	27,400	21,764	1.258960
44	Physical Therapy	787,943	1,010,075	0.780084
45	Occupational Therapy	725,363	900,229	0.805754
46	Speech Pathology	217,200	299,991	0.724022
47	Electrocardiology	0	0	0.000000
48	Medical Supplies Charged	1,729	1,373	1.259286
49	Drugs Charged to Patients	537,787	683,822	0.786443
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	2,405,113	3,009,364	////////////////////////////////////

MED-CALC SYSTEMS			In Lieu of CMS Form 2540-10						
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST			PROVIDER CCN :	PERIOD :	WORKSHEET D				
			31-5010	FROM: 01/01/2024 TO: 12/31/2024					
Check [] Title V (1) Check One: [X] SNF [] NF [] ICF/IID [] Other One: [X] Title XVIII [] Title XIX (1) [] PPS - Must also complete Part II									
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST			RATIO OF COST TO CHARGES		HEALTH CARE PROGRAM CHARGES		HEALTH CARE PROGRAM COST		
			(WS C, col 3)		PART A		PART B		
			1		2		3		
				PART B		PART A		PART B	
				4		5			
ANCILLARY SERVICE COST CENTERS:									
40	Radiology	1.258946	5,172		6,511	0			
41	Laboratory	1.027531	35,741		36,725	0			
42	Intravenous Therapy	1.259012	0		0	0			
43	Oxygen (Inhalation) Therapy	1.258960	0		0	0			
44	Physical Therapy	0.780084	390,570		304,677	0			
45	Occupational Therapy	0.805754	304,106		245,035	0			
46	Speech Pathology	0.724022	131,209		94,998	0			
47	Electrocardiology	0.000000	0		0	0			
48	Medical Supplies Charged	1.259286	0		0	0			
49	Drugs Charged to Patients	0.786443	676,897		532,341	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			
OUTPATIENT SERVICE COST CENTERS									
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)		1,543,695	0	1,220,287	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 : 31-5010	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)		0.786443
2	Program vaccine charges (From your records, or the P S & R.) --->		6,925
3	Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)		5,446

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 fr Pass Through (Col. 3 X Col. 4)
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
40	Radiology	61,920	0	0.000000	6,511	0
41	Laboratory	36,725	0	0.000000	36,725	0
42	Intravenous Therapy	9,046	0	0.000000	0	0
43	Oxygen (Inhalation) Therapy	27,400	0	0.000000	0	0
44	Physical Therapy	787,943	0	0.000000	304,677	0
45	Occupational Therapy	725,363	0	0.000000	245,035	0
46	Speech Pathology	217,200	0	0.000000	94,998	0
47	Electro cardiology	0	0	0.000000	0	0
48	Medical Supplies	1,729	0	0.000000	0	0
49	Drugs Charged to Patients	537,787	0	0.000000	532,341	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)	2,405,113	0	////////////////////////////////////	1,220,287	0

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST		PROVIDER CCN :	PERIOD :		WORKSHEET D
		31-5010	FROM: 01/01/2024 TO: 12/31/2024		
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST					
Check ☐ Title V (1) Check One: ☐ SNF ☒ NF ☐ ICF/IID ☐ Other					
One: ☐ Title XVIII ☒ Title XIX (1) ☐ PPS - Must also complete Part II					
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST		RATIO OF COST TO CHARGES	HEALTH CARE PROGRAM INPATIENT CHARGES		HEALTH CARE PROGRAM INPATIENT COST
			PART A	PART B	PART A PART B
		1	2	3	4 5
ANCILLARY SERVICE COST CENTERS:		////////////////////////////////	////////////////////////////////	////////////////////////////////	////////////////////////////////
40	Radiology	1.258946		////////////////////////////////	0 //////////////////////////////////
41	Laboratory	1.027531		////////////////////////////////	0 //////////////////////////////////
42	Intravenous Therapy	1.259012		////////////////////////////////	0 //////////////////////////////////
43	Oxygen (Inhalation) Therapy	1.258960		////////////////////////////////	0 //////////////////////////////////
44	Physical Therapy	0.780084		////////////////////////////////	0 //////////////////////////////////
45	Occupational Therapy	0.805754		////////////////////////////////	0 //////////////////////////////////
46	Speech Pathology	0.724022		////////////////////////////////	0 //////////////////////////////////
47	Electro cardiology	0.000000		////////////////////////////////	0 //////////////////////////////////
48	Medical Supplies Charged	1.259286		////////////////////////////////	0 //////////////////////////////////
49	Drugs Charged to Patients	0.786443		////////////////////////////////	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 : 31-5010	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D-1 PARTS I & II
Check One:	☐ Title V ☒ Title XVIII ☐ Title XIX		
Check One:	☒ SNF ☐ NF ☐ ICF/IID		

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	66,876
2	Private room days	
3	Inpatient days including private room days applicable to the Program	10,196
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	19,446,075

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	26,084,135
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.745514
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)	19,446,075

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	290.78
17	Program routine service cost (Line 3 times line 16)	2,964,793
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)	2,964,793
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)	1,143,253
21	Per diem capital related costs (Line 20 divided by line 1)	17.10
22	Program capital related cost (Line 3 times line 21)	174,352
23	Inpatient routine service cost (Line 19 minus line 22)	2,790,441
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)	2,790,441
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	66,876
2	Program inpatient days. (see instructions)	10,196
3	Total Nursing & Allied Health costs. (see instructions)	0
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	0.152461
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
	31-5010	FROM: 01/01/2024 TO: 12/31/2024	
	☐ Title XVIII	☒ Title XIX	
Check One:	☒ NF	☐ 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 room days, line 2)	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 : 31-5010	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET E PART I
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PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

1	Inpatient PPS amount (See Instructions)	8,224,962
2	Nursing and Allied Health Education Activities (pass through payments)	0
3	Subtotal (Sum of lines 1 and 2)	8,224,962
4	Primary payor amounts (	0)
5	Coinsurance (	1,501,520)
6	Allowable bad debts (from your records)	780,750
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	457,342
8	Adjusted reimbursable bad debts. (See instructions)	507,488
9	Recovery of bad debts - for statistical records only	
10	Utilization review	0
11	Subtotal (See instructions)	7,230,930
12	Interim payments (See instructions)	6,999,553
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)	10,150
14.99	Sequestration amount (see instructions)	134,469
15	Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14)	86,758
	(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)	5,446
19	Total reasonable costs (Sum of lines 17 and 18)	5,446
20	Medicare Part B ancillary charges (See instructions)	6,925
21	Cost of covered services (Lesser of line 19 or line 20)	5,446
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)	5,446
26	Interim payments (See instructions)	6,787
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)	109
29	Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28)	(1,450)
	(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: 31-5010	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET E-1
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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			////////////////////////////////	6,588,973	////////////////////////////////	6,787		
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.			////////////////////////////////	373,686	////////////////////////////////			
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	05/22/24	36,894		
				.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	////////////////////////////////	36,894	////////////////////////////////	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.)			////////////////////////////////	6,999,553	////////////////////////////////	6,787		
			////////////////////////////////		////////////////////////////////			

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: 31-5010	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET E PART II TITLE XIX
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: 31-5010	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND
	1	2	3
			PLANT FUND
			4

ASSETS

CURRENT ASSETS					
1	Cash on hand and in banks	1,545,206			
2	Temporary investments	0			
3	Notes receivable	0			
4	Accounts receivable	4,174,639			
5	Other receivables	0			
6	Less: allowances for uncollectible notes and A/R	0			
7	Inventory	0			
8	Prepaid expenses	513,485			
9	Other current assets	0			
10	Due from other funds	35,702			
11	TOTAL CURRENT ASSETS	6,269,032	0	0	0
	(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	2,923,213			
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	10,990			
24	Less: Accumulated depreciation	(1,622,980)			
25	Minor equipment - Depreciable	0			
26	Minor equipment nondepreciable	0			
27	Other fixed assets	0			
28	TOTAL FIXED ASSETS	1,311,223	0	0	0
	(Sum of lines 12 - 27)				

OTHER ASSETS					
29	Investments	0			
30	Deposits on leases	0			
31	Due from owners/officers	1,017,780			
32	Other assets	12,800			
33	TOTAL OTHER ASSETS	1,030,580	0	0	0
	(Sum of lines 29 - 32)				
34	TOTAL ASSETS	8,610,835	0	0	0
	(Sum of lines 11, 28 and 33)				

LIABILITIES & FUND BALANCES	GENERAL	SPECIFIC	ENDOWMENT	PLANT
	FUND	PURPOSE FUND	FUND	FUND
	1	2	3	4

35	Accounts payable	1,515,966			
36	Salaries, wages & fees payable	826,084			
37	Payroll taxes payable	93,225			
38	Notes & loans payable (Short term)	0			
39	Deferred income	9,854			
40	Accelerated payments	0	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
41	Due to other funds	0			
42	Other current liabilities	0			
43	TOTAL CURRENT LIABILITIES	2,445,129	0	0	0
	(Sum of lines 35 - 42)				

44	Mortgage payable	0			
45	Notes payable	0			
46	Unsecured loans	997,795			
47	Loans from owners:	0			
48	Other long term liabilities	0			
49	Other (Specify)	0			
50	TOTAL LONG TERM LIABILITIES	997,795	0	0	0
	(Sum of lines 44 - 49)				
51	TOTAL LIABILITIES	3,442,924	0	0	0
	(Sum of lines 43 and 50)				

52	General fund balance	5,167,911			
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	5,167,911	0	0	0
	(Sum of lines 52 thru 58)				
60	TOTAL LIABILITIES & FUND BALANCES	8,610,835	0	0	0
	(Sum of lines 51 and 59)				

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: 31-5010	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	////////////////////////////////////	4,260,381	////////////////////////////////////		////////////////////////////////////		////////////////////////////////////	
2	Net income (loss) (From Wkst. G-3, line 31)	////////////////////////////////////	907,530	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
3	Total (Sum of line 1 and line 2)	////////////////////////////////////	5,167,911	////////////////////////////////////	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)	////////////////////////////////////	5,167,911	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0
12	Deductions (Debit adjustments)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
13			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
14			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
15			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
16			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
17			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
18	Total deductions (Sum of lines 13 - 17)	////////////////////////////////////	0		0	////////////////////////////////////	0	////////////////////////////////////	0
19	Fund balance at end of period per	////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////	
	balance sheet (Line 11 - line 18)	////////////////////////////////////	5,167,911	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: 31-5010	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	26,084,135	////////////////////////////////////	26,084,135
2	Nursing facility	0	////////////////////////////////////	0
3	ICF-IID	0	////////////////////////////////////	0
4	Other long term care	0	////////////////////////////////////	0
5	Total general inpatient care services	26,084,135	////////////////////////////////////	26,084,135
	(Sum of lines 1 - 4)			
ALL OTHER CARE SERVICES				
6	Ancillary services	3,101,840	0	3,101,840
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)	29,185,975	0	29,185,975
	(Transfer column 3 to Worksheet G-3, Line 1)			

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 100)	////////////////////////////////////	24,632,539
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)	////////////////////////////////////	24,632,539

STATEMENT OF REVENUES & EXPENSES	PROVIDER CCN: 31-5010	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)	29,185,975
2	Less: contractual allowances and discounts on patients accounts (	3,701,293)
3	Net patient revenues (Line 1 minus line 2)	25,484,682
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	24,632,539
5	Net income from service to patients (Line 3 minus 4)	852,143
////////	OTHER INCOME:	////////
6	Contributions, donations, bequests, etc	0
7	Income from investments	52,771
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	267
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	2,349
24.50	COVID-19 PHE Funding	0
25	Total other income (Sum of lines 6 - 24)	55,387
26	Total (Line 5 plus line 25)	907,530
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)	907,530