MED-CALC SYSTEMS In Lieu of CMS Form 2540-10

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

OMB NO. 0938-0463

Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	**PROVIDER CCN:** **31-5229**	**PERIOD:** **FROM: 01/01/2024** **TO: 12/31/2024**	**WORKSHEET S** **PARTS I II & III**

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — **Date:** 05/27/2025 **Time:** 02:46:08 PM
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
   - [1] As Submitted:
   - [2] Settled without audit
   - [3] Settled with audit
   - [4] Reopened
   - [5] Amended
5. Date Received

6. Contractor No. _____
7. [ ] First Cost Report for this Provider CCN
8. [ ] Last Cost Report for this Provider CCN
9. [ ] NPR Date: _____
10. [ ] If line 4, column 1 is "4": Enter number of times reopened
11. Contractor Vendor Code _____
12. Medicare Utilization Enter "F" for full, "L" for low, or "N" for no utilization _____

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

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PHOENIX CENTER FOR REHABILITATION #31-5229 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:
05/27/2025 02:46:08 PM
I1IjYAXQ8FO4SJEx8FSuKRokVoRMz0
cpEt:01XWVeGqHQuePWcuRIwv5HBId
fbxm0gj:Jt0DBGIS

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1			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				2
3	Signatory Title				3
4	Signature date				4

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX	
		1	2	3	4	
1	**SKILLED NURSING FACILITY**		11,351	0		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**		11,351	0	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.)

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10		
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD: FROM: 01/01/2024	WORKSHEET S-2 PART I
IDENTIFICATION DATA	31-5229	TO: 12/31/2024	

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	1433 RINGWOOD AVENUE	P.O. Box:					1
2	City:	HASKELL	State:	NJ	Zip Code:	07420		2
3	County:	PASSAIC	CBSA Code:	35614	Urban / Rural:	U		3

SNF and SNF-Based Component Identification:

	Component	Component Name	Provider CCN:	Date Certified		Payment System (P, O, or N) V	XVIII	XIX	
	0	1	2	3		4	5	6	
4	S N F	PHOENIX CENTER FOR REHAI	31-5229	05/27/1986		N	P	N	4
5	Nursing Facility						//////////		5
6	I C F / I I D					//////////	//////////		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	1,028,104	//////////	20
21	Declining Balance		//////////	21
22	Sum of the Year's Digits		//////////	22
23	Sum of line 20 through 22	1,028,104	//////////	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)		N	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:	PERIOD	WORKSHEET S-2
		FROM: 01/01/2024	PART I (Cont.)
IDENTIFICATION DATA	31-5229	TO: 12/31/2024	

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 "occurence", enter 2.			1	39

	//////////////////////////////// ////////////////////////////////	Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:	486,831			41

		Y / N	
	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center?		
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

MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S-2 Part II

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

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

	PS&R Data	1 Y/N Part A	2 Date Part A	3 Y/N Part B	4 Date 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	05/15/2025	Y	########	13
14	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N		14
15	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N	//////////// //////////// ////////////	N	//////////// //////////// ////////////	15
16	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R information? If "Y", see Instructions.	N	//////////// ////////////	N	//////////// ////////////	16
17	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:_____	N	//////////// ////////////	N	//////////// ////////////	17
18	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N	////////////	N	////////////	18

COST REPORT PREPARER CONTACT INFORMATION

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

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

PROVIDER CCN: 31-5229

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

WORKSHEET S-3 PART I

	Component		Number of Beds	Bed Days Available		Inpatient Days / Visits: Title V	Title XVIII	Title XIX	Other	Total
			1	2		3	4	5	6	7
1	Skilled Nursing Facility		235	86,010			6,167	63,240	5,512	74,919
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)		235	86,010			6,167	63,240	5,512	74,919

	Component	Discharges: Title V	Title XVIII	Title XIX	Other	Total	Average Length of Stay: Title V	Title XVIII	Title XIX	Total
		8	9	10	11	12	13	14	15	16
1	Skilled Nursing Facility		51	229	99	379		120.92	276.16	197.68
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)		51	229	99	379		120.92	276.16	197.68

	Component		Admissions: Title V	Title XVIII	Title XIX	Other	Total		Full Time Equivalent: Employees on Payroll	Nonpaid Workers
			17	18	19	20	21		22	23
1	Skilled Nursing Facility			47	51	366	464		276.55	
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)			47	51	366	464		276.55	0.00

SNF WAGE INDEX INFORMATION | **PROVIDER CCN:** 31-5229 | PERIOD: FROM: 01/01/2024 TO: 12/31/2024 | **WORKSHEET S-3 PARTS II & III**

	PART II DIRECT SALARIES	Amount Reported	Reclass.of Salaries from Wkst A-6	Adjusted Salaries	Paid Hrs Related to col.3	Average Hrly Wage	
		1	2	3	4	5	
1	Total salary (See Instructions)	19,085,925	0	19,085,925	575,226.67	33.18	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)	19,085,925	0	19,085,925	575,226.67	33.18	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	19,085,925	0	19,085,925	575,226.67	33.18	13
	OTHER WAGES AND RELATED COSTS	////////////	////////////	////////////	////////////	////////////	
14	Contract Labor: Patient Related & Mgmt	992,984		992,984	18,439.00	53.85	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)	3,106,162		3,106,162	////////////	////////////	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 instruction	3,106,162	0	3,106,162	////////////	////////////	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	446,482	0	446,482	10,919.30	40.89	2
3	Plant Operation, Maintenance & Repairs	277,033	0	277,033	10,970.38	25.25	3
4	Laundry & Linen Service	62,841	0	62,841	3,128.75	20.09	4
5	Housekeeping	970,451	0	970,451	54,639.02	17.76	5
6	Dietary	770,134	0	770,134	36,129.14	21.32	6
7	Nursing Administration	809,913	0	809,913	9,137.03	88.64	7
8	Central Services and Supply	65,176	0	65,176	3,103.00	21.00	8
9	Pharmacy	0	0	0		0.00	9
10	Medical Records & Medical Records Library	6,775	0	6,775	257.25	26.34	10
11	Social Service	482,864	0	482,864	11,860.67	40.71	11
12	Nursing and Allied Health Education Activities	////////////	////////////	////////////	////////////	////////////	12
13	Other General Service Cost	391,274	0	391,274	18,260.06	21.43	13
14	Total (sum lines 1 thru 13)	4,282,943	0	4,282,943	158,404.60	**27.04**	14

SNF WAGE RELATED COSTS	PROVIDER CCN: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S-3 PART IV

PART IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		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)	876,022	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	415,504	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	1,397,522	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	417,114	20
	OTHER		
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 -23)	3,106,162	24

Part B Other than Core Related Cost		**Amount Reported**	
25			25

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10					
SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER CCN: 31-5229		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET S-3 PART V	
	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
Occupational Category	1	2	3	4	5	
Direct Salaries	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////
Nursing Occupations	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////
1 Registered Nurses (RNs)	2,006,513	326,552	2,333,065	43,696.30	53.39	1
2 Licensed Practical Nurses (LPNs)	4,584,746	746,150	5,330,896	96,406.21	55.30	2
3 Certified Nursing Assistants/Nursing Assistants/Aides	5,221,510	849,781	6,071,291	210,407.90	28.85	3
4 Total Nursing (sum of lines 1 through 3)	11,812,769	1,922,483	13,735,252	350,510.41	39.19	4
5 Physical Therapists	213,542	34,753	248,295	4,288.00	57.90	5
6 Physical Therapy Assistants	162,008	26,366	188,374	3,416.75	55.13	6
7 Physical Therapy Aides	288,651	46,977	335,628	4,362.50	76.93	7
8 Occupational Therapists	135,844	22,108	157,952	3,603.60	43.83	8
9 Occupational Therapy Assistants			-		0.00	9
10 Occupational Therapy Aides	98,927	16,100	115,027	2,687.25	42.80	10
11 Speech Therapists	124,482	20,259	144,741	2,213.50	65.39	11
12 Respiratory Therapists			-		0.00	12
13 Other Medical Staff			-		0.00	13
Contract Labor	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	/
Nursing Occupations	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	/
14 Registered Nurses (RNs)	126,775	////////////////////////	126,775	1,686.00	75.19	14
15 Licensed Practical Nurses (LPNs)	610,913	////////////////////////	610,913	9,801.00	62.33	15
16 Certified Nursing Assistants/Nursing Assistants/Aides	254,501	////////////////////////	254,501	6,952.00	36.61	16
17 Total Nursing (sum of lines 14 through 16)	992,189	////////////////////////	992,189	18,439.00	53.81	17
18 Physical Therapists		////////////////////////	-		0.00	18
19 Physical Therapy Assistants		////////////////////////	-		0.00	19
20 Physical Therapy Aides		////////////////////////	-		0.00	20
21 Occupational Therapists		////////////////////////	-		0.00	21
22 Occupational Therapy Assistants		////////////////////////	-		0.00	22
23 Occupational Therapy Aides		////////////////////////	-		0.00	23
24 Speech Therapists		////////////////////////	-		0.00	24
25 Respiratory Therapists		////////////////////////	-		0.00	25
26 Other Medical Staff		////////////////////////	-		0.00	26

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: 31-5229 | 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		6,791,372	**6,791,372**	0	**6,791,372**	(1,281,636)	**5,509,736**
2	0200	Capital-Related Costs - Movable Equipment		0	**0**	0	**0**	0	**0**
3	0300	Employee Benefits	0	3,106,162	**3,106,162**	0	**3,106,162**	0	**3,106,162**
4	0400	Administrative and General	446,482	4,483,389	**4,929,871**	0	**4,929,871**	2,919	**4,932,790**
5	0500	Plant Operation, Maintenance and Repairs	277,033	877,827	**1,154,860**	0	**1,154,860**	0	**1,154,860**
6	0600	Laundry and Linen Service	62,841	167,575	**230,416**	0	**230,416**	0	**230,416**
7	0700	Housekeeping	970,451	116,674	**1,087,125**	0	**1,087,125**	0	**1,087,125**
8	0800	Dietary	770,134	902,185	**1,672,319**	0	**1,672,319**	0	**1,672,319**
9	0900	Nursing Administration	809,913	176,456	**986,369**	0	**986,369**	0	**986,369**
10	1000	Central Services and Supply	65,176	1,485,776	**1,550,952**	0	**1,550,952**	0	**1,550,952**
11	1100	Pharmacy	0	0	**0**	0	**0**	0	**0**
12	1200	Medical Records and Library	6,775	0	**6,775**	0	**6,775**	0	**6,775**
13	1300	Social Service	482,864	0	**482,864**	0	**482,864**	0	**482,864**
14	1400	Nursing and Allied Health Education Activities	0	0	**0**	0	**0**	0	**0**
15	1500	Other General Service Cost	391,274	88,564	**479,838**	0	**479,838**	0	**479,838**
INPATIENT ROUTINE SERVICE COST CENTERS									
30	3000	Skilled Nursing Facility	11,875,199	1,362,473	**13,237,672**	0	**13,237,672**	0	**13,237,672**
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	14,657	**14,657**	0	**14,657**	0	**14,657**
41	4100	Laboratory	0	33,258	**33,258**	0	**33,258**	0	**33,258**
42	4200	Intravenous Therapy	0	0	**0**	5,000	**5,000**	0	**5,000**
43	4300	Oxygen (Inhalation) Therapy	1,865,979	1,655,552	**3,521,531**	(21,000)	**3,500,531**	0	**3,500,531**
44	4400	Physical Therapy	664,201	661	**664,862**	0	**664,862**	0	**664,862**
45	4500	Occupational Therapy	273,121	0	**273,121**	0	**273,121**	0	**273,121**
46	4600	Speech Pathology	124,482	135	**124,617**	0	**124,617**	0	**124,617**
47	4700	Electrocardiology	0	0	**0**	0	**0**	0	**0**
48	4800	Medical Supplies Charged to Patients	0	13,753	**13,753**	16,000	**29,753**	0	**29,753**
49	4900	Drugs Charged to Patients	0	277,294	**277,294**	0	**277,294**	0	**277,294**
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: 31-5229 | 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)	19,085,925	21,553,763	**40,639,688**	0	**40,639,688**	(1,278,717)	**39,360,971**
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	157,316	**157,316**	0	**157,316**	0	**157,316**
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	**19,085,925**	**21,711,079**	**40,797,004**	**0**	**40,797,004**	**(1,278,717)**	**39,518,287**

MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10

RECLASSIFICATIONS | PROVIDER CCN: 31-5229 | PERIOD: FROM: 01/01/2024 TO: 12/31/2024 | WORKSHEET A-6

			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 IV	A	Intravenous Therapy	42		5,000	Oxygen (Inhalation) Th	43		5,000
2	RECLASS MED SUPP	B	Medical Supplies Charged to	48		16,000	Oxygen (Inhalation) Th	43		16,000
3										
4										
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9										
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72										
###	**TOTAL RECLASSIFICATIONS**	//////////	//////////////////////////////////////	//////////	0	21,000	//////////////////////////////	//////////	0	21,000

(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:	
		FROM: 01/01/2024	WORKSHEET A-7
	31-5229	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	4,825,303	320,711		**320,711**		**5,146,014**	
5	Fixed Equipment				**0**		**0**	
6	Movable Equipment	179,126			**0**		**179,126**	
7	Subtotal (sum of lines 1-6)	**5,004,429**	**320,711**	**0**	**320,711**	**0**	**5,325,140**	0
8	Reconciling Items				**0**		**0**	
9	Total (line 7 minus line 8)	5,004,429	320,711	0	320,711	0	5,325,140	0

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024

WORKSHEET A-8

	(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	(17,989)	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. (Chapter23)				
11	Nonallowable costs related to certain	////////////	////////////	////////////	////////////
	Capital expenditures (Chapter 24)				
12	Adjustment resulting from transactions	////////////	////////////	////////////	////////////
	with related organizations (Chapter 10)	A-8-1	(1,281,636)	////////////	////////////
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				
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	20,908	Administrative and General	4
25.01					
25.02					
25.03					
25.04					
	A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW)	////////////	0	////////////	////////////
100	TOTAL	////////////	(1,278,717)	////////////	////////////

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024

WORKSHEET A-8

	(1) DESCRIPTION	(2) BASIS* FOR ADJ	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
			AMOUNT	COST CENTER	LINE #
	ADDITIONAL ADJUSTMENTS				
25.05					
25.06					
25.07					
25.08					
25.09					
25.10					
25.11					
25.12					
25.13					
25.14					
25.15					
25.16					
25.17					
25.18					
25.19					
25.20					
25.21					
25.22					
25.23					
25.24					
25.25					

SUBTOTAL OF ADDITIONAL ADJUSTMENTS 0

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	**WORKSHEET A-8-1**

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		1	Capital-Related Costs - Building	Rent		5,378,587	(5,378,587)
2		1	Capital-Related Costs - Building	Mortgage Interest	3,341,679		3,341,679
3		1	Capital-Related Costs - Building	Depreciation	259,974		259,974
4		1	Capital-Related Costs - Building	Property Insurance	85,561		85,561
5		1	Capital-Related Costs - Building	Property Taxes	409,737		409,737
6							0
7							0
8							0
9							0
9.01							0
9.02							0
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					4,096,951	5,378,587	(1,281,636)

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

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

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

					Related Organization(s)		
	Description	(1) Symbol	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business
		1	2	3	4	5	6
1		A	Phoenix Center	100.00	North Jersey Realty	100.00	Realty
2							
3							
4							
5							
6							
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: 31-5229 | PERIOD: FROM: 01/01/2024 TO: 12/31/2024 | **WORKSHEET A-8-2**

	Wkst A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider Component Hrs	Unadjusted R C E Limit	5 Percent of Unadjusted R C E Limit
	1	2	3	4	5	6	7	8	9
1								0	0
2								0	0
3								0	0
4								0	0
5								0	0
6								0	0
7								0	0
8								0	0
9								0	0
10								0	0
11								0	0
100	**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: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024		**WORKSHEET B PART I**						PROVIDER CCN: 31-5229
	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	HOUSE-KEEPING	DIETARY	NURSING ADMIN.
		0	1	2	3	3a	4.00	5	6	7	8	9
GENERAL SERVICE COST CENTERS												
1	Capital-Related Costs - Building & Fixture	5,509,736	5,509,736									
2	Capital-Related Costs - Movable Equipment	0	//////////////////////	0								
3	Employee Benefits	3,106,162	0	0	3,106,162							
4	Administrative and General	4,932,790	800,290	0	72,663	5,805,743	5,805,743					
5	Plant Operation, Maintenance and Repairs	1,154,860	141,023	0	45,086	1,340,969	230,932	1,571,901				
6	Laundry and Linen Service	230,416	155,905	0	10,227	396,548	68,291	53,644	518,483			
7	Housekeeping	1,087,125	121,700	0	157,937	1,366,762	235,374	41,874	0	1,644,010		
8	Dietary	1,672,319	439,872	0	125,336	2,237,527	385,331	151,351	0	168,535	2,942,744	
9	Nursing Administration	986,369	0	0	131,810	1,118,179	192,565	0	0	0	0	1,310,744
10	Central Services and Supply	1,550,952	0	0	10,607	1,561,559	268,921	0	0	0	0	0
11	Pharmacy	0	0	0	0	0	0	0	0	0	0	0
12	Medical Records and Library	6,775	0	0	1,103	7,878	1,357	0	0	0	0	0
13	Social Service	482,864	64,210	0	78,584	625,658	107,746	22,094	0	24,602	0	0
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0	0	0	0
15	Other General Service Cost	479,838	114,979	0	63,678	658,495	113,401	39,562	0	44,054	0	0
INPATIENT ROUTINE SERVICE COST CENTERS												
30	Skilled Nursing Facility	13,237,672	3,314,219	0	1,932,646	18,484,537	3,183,283	1,140,355	518,483	1,269,829	2,942,744	1,310,744
31	Nursing Facility	0	0	0	0	0	0	0	0	0	0	0
32	ICF/IID	0	0	0	0	0	0	0	0	0	0	0
33	Other Long Term Care	0	0	0	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS												
40	Radiology	14,657	0	0	0	14,657	2,524	0	0	0	0	0
41	Laboratory	33,258	0	0	0	33,258	5,727	0	0	0	0	0
42	Intravenous Therapy	5,000	3,000	0	0	8,000	1,378	1,032	0	1,150	0	0
43	Oxygen (Inhalation) Therapy	3,500,531	0	0	303,681	3,804,212	655,135	0	0	0	0	0
44	Physical Therapy	664,862	198,152	0	108,096	971,110	167,238	68,180	0	75,921	0	0
45	Occupational Therapy	273,121	96,016	0	44,449	413,586	71,225	33,037	0	36,788	0	0
46	Speech Pathology	124,617	12,002	0	20,259	156,878	27,016	4,130	0	4,599	0	0
47	Electrocardiology	0	0	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	29,753	0	0	0	29,753	5,124	0	0	0	0	0
49	Drugs Charged to Patients	277,294	48,368	0	0	325,662	56,083	16,642	0	18,532	0	0
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0	0	0	0

COST ALLOCATION GENERAL SERVICE COSTS	PROVIDER CCN: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	**WORKSHEET B PART I**	PROVIDER CCN: 31-5229

	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	HOUSE-KEEPING	DIETARY	NURSING ADMIN.
		0	1	2	3	3a	4.00	5	6	7	8	9
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0	0	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS												
60	Clinic	0	0	0	0	0	0	0	0	0	**0**	0
61	Rural Health Clinic	0	0	0	0	0	0	0	0	0	0	0
62	FQHC	0	0	0	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost	0	0	0	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	0	0	0
71	Ambulance	0	0	0	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0	0	0	0
73	CMHC	0	0	0	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS												
83	Hospice	0	0	0	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	39,360,971	5,509,736	0	3,106,162	39,360,971	5,778,651	1,571,901	518,483	1,644,010	2,942,744	1,310,744
NON REIMBURSABLE COST CENTERS												
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	157,316	0	0	0	157,316	27,092	0	0	0	0	0
93	Nonpaid Workers	0	0	0	0	0	0	0	0	0	0	0
94	Patients Laundry	0	0	0	0	0	0	0	0	0	0	0
95	Other Nonreimbursable Cost	0	0	0	0	0	0	0	0	0	0	0
98	Cross Foot Adjustments	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////
99	Negative Cost Center		0	0	0	0	0	0	0	0	0	0
100	TOTAL	39,518,287	5,509,736	0	3,106,162	39,518,287	5,805,743	1,571,901	518,483	1,644,010	2,942,744	1,310,744

COST ALLOCATION
GENERAL SERVICE COSTS

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

WORKSHEET B
PART I
(cont.)

	COST CENTER	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	OTHER GEN. SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		10	11	12	13	14	15	16	17	18
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									
9	Nursing Administration									
10	Central Services and Supply	1,830,480								
11	Pharmacy	0	0							
12	Medical Records and Library	0	0	9,235						
13	Social Service	0	0	0	780,100					
14	Nursing and Allied Health Education Activities	0	0	0	0	0				
15	Other General Service Cost	0	0	0	0	0	855,512			
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Skilled Nursing Facility	1,830,480	0	9,235	780,100	0	855,512	32,325,302	0	32,325,302
31	Nursing Facility	0	0	0	0	0	0	0	0	0
32	ICF/IID	0	0	0	0	0	0	0	0	0
33	Other Long Term Care	0	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS										
40	Radiology	0	0	0	0	0	0	17,181	0	17,181
41	Laboratory	0	0	0	0	0	0	38,985	0	38,985
42	Intravenous Therapy	0	0	0	0	0	0	11,560	0	11,560
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	4,459,347	0	4,459,347
44	Physical Therapy	0	0	0	0	0	0	1,282,449	0	1,282,449
45	Occupational Therapy	0	0	0	0	0	0	554,636	0	554,636
46	Speech Pathology	0	0	0	0	0	0	192,623	0	192,623
47	Electrocardiology	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	34,877	0	34,877
49	Drugs Charged to Patients	0	0	0	0	0	0	416,919	0	416,919
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0	0

COST ALLOCATION
GENERAL SERVICE COSTS

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

WORKSHEET B
PART I
(cont.)

	COST CENTER	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	OTHER GEN. SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		10	11	12	13	14	15	16	17	18
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS										
60	Clinic	0	0	0	0	0	0	0	0	0
61	Rural Health Clinic	0	0	0	0	0	0	0	0	0
62	FQHC	0	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost	0	0	0	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS								0		
70	Home Health Agency Cost	0	0	0	0	0	0	0	0	0
71	Ambulance	0	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0	0
73	CMHC	0	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS										
83	Hospice	0	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	1,830,480	0	9,235	780,100	0	855,512	39,333,879	0	39,333,879
NON REIMBURSABLE COST CENTERS										
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	0	0	0	0	0	0	184,408	0	184,408
93	Nonpaid Workers	0	0	0	0	0	0	0	0	0
94	Patients Laundry	0	0	0	0	0	0	0	0	0
95	Other Nonreimbursable Cost	0	0	0	0	0	0	0	0	0
98	Cross Foot Adjustments	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////
99	Negative Cost Center	0	0	0	0	0	0	0		0
100	TOTAL	1,830,480	0	9,235	780,100	0	855,512	39,518,287	0	39,518,287

ALLOCATION OF CAPITAL-RELATED COSTS | PERIOD: FROM: 01/01/2024 TO: 12/31/2024 | PROVIDER CCN: 31-5229 | **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	HOUSE-KEEPING	DIETARY	NURSING ADMIN.
		0	1	2	2a	3	4	5	6	7	8	9
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		800,290	0	800,290	0	800,290					
5	Plant Operation, Maintenance and Repairs		141,023	0	141,023	0	31,833	172,856				
6	Laundry and Linen Service		155,905	0	155,905	0	9,414	5,899	171,218			
7	Housekeeping		121,700	0	121,700	0	32,446	4,605	0	158,751		
8	Dietary		439,872	0	439,872	0	53,117	16,643	0	16,274	525,906	
9	Nursing Administration		0	0	0	0	26,544	0	0	0	0	26,544
10	Central Services and Supply		0	0	0	0	37,070	0	0	0	0	0
11	Pharmacy		0	0	0	0	0	0	0	0	0	0
12	Medical Records and Library		0	0	0	0	187	0	0	0	0	0
13	Social Service		64,210	0	64,210	0	14,852	2,430	0	2,376	0	0
14	Nursing and Allied Health Education Activities		0	0	0	0	0	0	0	0	0	0
15	Other General Service Cost		114,979	0	114,979	0	15,632	4,350	0	4,254	0	0
INPATIENT ROUTINE SERVICE COST CENTER												
30	Skilled Nursing Facility		3,314,219	0	3,314,219	0	438,792	125,400	171,218	122,619	525,906	26,544
31	Nursing Facility		0	0	0	0	0	0	0	0	0	0
32	ICF/IID		0	0	0	0	0	0	0	0	0	0
33	Other Long Term Care		0	0	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS												
40	Radiology		0	0	0	0	348	0	0	0	0	0
41	Laboratory		0	0	0	0	790	0	0	0	0	0
42	Intravenous Therapy		3,000	0	3,000	0	190	114	0	111	0	0
43	Oxygen (Inhalation) Therapy		0	0	0	0	90,308	0	0	0	0	0
44	Physical Therapy		198,152	0	198,152	0	23,053	7,498	0	7,331	0	0
45	Occupational Therapy		96,016	0	96,016	0	9,818	3,633	0	3,552	0	0
46	Speech Pathology		12,002	0	12,002	0	3,724	454	0	444	0	0
47	Electrocardiology		0	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients		0	0	0	0	706	0	0	0	0	0
49	Drugs Charged to Patients		48,368	0	48,368	0	7,731	1,830	0	1,790	0	0
50	Dental Care - Title XIX only		0	0	0	0	0	0	0	0	0	0
51	Support Surfaces		0	0	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center		0	0	0	0	0	0	0	0	0	0
52.01	Other Ancillary Service Cost Center II		0	0	0	0	0	0	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS | PERIOD: FROM: 01/01/2024 TO: 12/31/2024 | PROVIDER CCN: 31-5229 | **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	HOUSE-KEEPING	DIETARY	NURSING ADMIN.
		0	1	2	2a	3	4	5	6	7	8	9
52.02	Other Ancillary Service Cost Center III		0	0	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS												
60	Clinic		0	0	0	0	0	0	0	0	**0**	0
61	Rural Health Clinic		0	0	0	0	0	0	0	0	0	0
62	FQHC		0	0	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost		0	0	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	0	0
71	Ambulance		0	0	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation		0	0	0	0	0	0	0	0	0	0
73	CMHC		0	0	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost		0	0	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS												
83	Hospice		0	0	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I		0	0	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II		0	0	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	0	5,509,736	0	5,509,736	0	796,555	172,856	171,218	158,751	525,906	26,544
NON REIMBURSABLE COST CENTERS												
90	Gift, Flower, Coffee Shop & Canteen		0	0	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop		0	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices		0	0	0	0	3,735	0	0	0	0	0
93	Nonpaid Workers		0	0	0	0	0	0	0	0	0	0
94	Patients Laundry		0	0	0	0	0	0	0	0	0	0
95	Other Nonreimbursable Cost		0	0	0	0	0	0	0	0	0	0
98	Cross Foot Adjustments		////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
99	Negative Cost Center		0	0	0	0	0	0	0	0	0	0
100	TOTAL	0	5,509,736	0	5,509,736	0	800,290	172,856	171,218	158,751	525,906	26,544

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: 31-5229

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

WORKSHEET B PART II (cont.)

	COST CENTER	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	OTHER GEN. SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		10	11	12	13	14	15	16	17	18
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									
9	Nursing Administration									
10	Central Services and Supply	37,070								
11	Pharmacy	0	0							
12	Medical Records and Library	0	0	187						
13	Social Service	0	0	0	83,868					
14	Nursing and Allied Health Education Activities	0	0	0	0	0				
15	Other General Service Cost	0	0	0	0	0	139,215			
INPATIENT ROUTINE SERVICE COST CENTER										
30	Skilled Nursing Facility	37,070	0	187	83,868	0	139,215	4,985,038	0	4,985,038
31	Nursing Facility	0	0	0	0	0	0	0	0	0
32	ICF/IID	0	0	0	0	0	0	0	0	0
33	Other Long Term Care	0	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS										
40	Radiology	0	0	0	0	0	0	348	0	348
41	Laboratory	0	0	0	0	0	0	790	0	790
42	Intravenous Therapy	0	0	0	0	0	0	3,415	0	3,415
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	90,308	0	90,308
44	Physical Therapy	0	0	0	0	0	0	236,034	0	236,034
45	Occupational Therapy	0	0	0	0	0	0	113,019	0	113,019
46	Speech Pathology	0	0	0	0	0	0	16,624	0	16,624
47	Electrocardiology	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	706	0	706
49	Drugs Charged to Patients	0	0	0	0	0	0	59,719	0	59,719
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0	0
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: 31-5229

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

WORKSHEET B PART II (cont.)

	COST CENTER	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	OTHER GEN. SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		10	11	12	13	14	15	16	17	18
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS										
60	Clinic	0	0	0	0	0	0	0	0	0
61	Rural Health Clinic	0	0	0	0	0	0	0	0	0
62	FQHC	0	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost	0	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	0
71	Ambulance	0	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0	0
73	CMHC	0	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS										
83	Hospice	0	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	37,070	0	187	83,868	0	139,215	5,506,001	0	5,506,001
NON REIMBURSABLE COST CENTERS										
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	0	0	0	0	0	0	3,735	0	3,735
93	Nonpaid Workers	0	0	0	0	0	0	0	0	0
94	Patients Laundry	0	0	0	0	0	0	0	0	0
95	Other Nonreimbursable Cost	0	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	37,070	0	187	83,868	0	139,215	5,509,736	0	5,509,736

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5229 | 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)	DIETARY (MEALS SERVED)	NURSING ADMIN. (PATIENT DAYS)	CENTRAL SVC & SUPP (PATIENT DAYS)
		0	1	2	3	4.00a	4.00	5	6	7	8	9	10
GENERAL SERVICE COST CENTERS													
1	Capital-Related Costs - Building & Fixture		45,907										
2	Capital-Related Costs - Movable Equipment			0									
3	Employee Benefits			0	19,085,925								
4	Administrative and General		6,668	0	446,482	(5,805,743)	33,712,544						
5	Plant Operation, Maintenance and Repairs		1,175	0	277,033		1,340,969	38,064					
6	Laundry and Linen Service		1,299	0	62,841		396,548	1,299	74,919				
7	Housekeeping		1,014	0	970,451		1,366,762	1,014		35,751			
8	Dietary		3,665	0	770,134		2,237,527	3,665		3,665	224,757		
9	Nursing Administration			0	809,913		1,118,179	0		0		74,919	
10	Central Services and Supply			0	65,176		1,561,559	0		0			74,919
11	Pharmacy			0	0		0	0		0			
12	Medical Records and Library			0	6,775		7,878	0		0			
13	Social Service		535	0	482,864		625,658	535		535			
14	Nursing and Allied Health Education Activities			0	0		0	0		0			
15	Other General Service Cost		958	0	391,274		658,495	958		958			
INPATIENT ROUTINE SERVICE COST CENTERS													
30	Skilled Nursing Facility		27,614	0	11,875,199		18,484,537	27,614	74,919	27,614	224,757	74,919	74,919
31	Nursing Facility			0	0		0	0	0	0	0	0	0
32	ICF/IID			0	0		0	0	0	0	0	0	0
33	Other Long Term Care			0	0		0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS													
40	Radiology			0	0		14,657	0		0			
41	Laboratory			0	0		33,258	0		0			
42	Intravenous Therapy		25	0	0		8,000	25		25			
43	Oxygen (Inhalation) Therapy			0	1,865,979		3,804,212	0		0			
44	Physical Therapy		1,651	0	664,201		971,110	1,651		1,651			
45	Occupational Therapy		800	0	273,121		413,586	800		800			
46	Speech Pathology		100	0	124,482		156,878	100		100			
47	Electrocardiology			0	0		0	0		0			
48	Medical Supplies Charged to Patients			0	0		29,753	0		0			
49	Drugs Charged to Patients		403	0	0		325,662	403		403			
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: 31-5229 | 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)	DIETARY (MEALS SERVED)	NURSING ADMIN. (PATIENT DAYS)	CENTRAL SVC & SUPP (PATIENT DAYS)
		0	1	2	3	4.00a	4.00	5	6	7	8	9	10
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	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)	////////////	45,907	0	19,085,925	(5,805,743)	33,555,228	38,064	74,919	35,751	224,757	74,919	74,919
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		157,316	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)	////////////	5,509,736	0	3,106,162	////////////////////////	5,805,743	1,571,901	518,483	1,644,010	2,942,744	1,310,744	1,830,480
103	Unit Cost Multiplier (Worksheet B, Part I)	////////////	120.019518	0.000000	0.162746	////////////////////////	0.172213	41.296264	6.920581	45.985007	13.093003	17.495482	24.432787
104	Cost to Be Allocated (Per Worksheet B, Part II)	////////////	////////////////////////	////////////////////////	0	////////////////////////	800,290	172,856	171,218	158,751	525,906	26,544	37,070
105	Unit Cost Multiplier (Worksheet B, Part II)	////////////	////////////////////////	////////////////////////	0.000000	////////////////////////	0.023739	4.541194	2.285375	4.440463	2.339887	0.354303	0.494801

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

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5229 | PERIOD: FROM: 01/01/2024 TO: 12/31/2024 | WORKSHEET B-1 (cont.)

	COST CENTER	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		11	12	13	14	15	16	17	18
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								
9	Nursing Administration								
10	Central Services and Supply								
11	Pharmacy	0							
12	Medical Records and Library		74,919						
13	Social Service			74,919					
14	Nursing and Allied Health Education Activities				0				
15	Other General Service Cost					74,919			
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	0	74,919	74,919		74,919			
31	Nursing Facility	0	0	0		0			
32	ICF/IID	0	0	0		0			
33	Other Long Term Care	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: 31-5229 | PERIOD: FROM: 01/01/2024 TO: 12/31/2024 | WORKSHEET B-1 (cont.)

	COST CENTER	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		11	12	13	14	15	16	17	18
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	////////////	////////////	////////////
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)	0	74,919	74,919	0	74,919	////////////	////////////	////////////
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)	0	9,235	780,100	0	855,512	////////////	////////////	////////////
103	Unit Cost Multiplier (Worksheet B, Part I)	0.000000	0.123266	10.412579	0.000000	11.419159	////////////	////////////	////////////
104	Cost to Be Allocated (Per Worksheet B, Part II)	0	187	83,868	0	139,215	////////////	////////////	////////////
105	Unit Cost Multiplier (Worksheet B, Part II)	0.000000	0.002496	1.119449	0.000000	1.858207	////////////	////////////	////////////

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN: 31-5229	PERIOD: **FROM: 01/01/2024 TO: 12/31/2024**	**WORKSHEET B-2**

	DESCRIPTION	WORKSHEET B PART NO. (1 or 2)	LINE NO.	AMOUNT
	-1-	-2-	-3-	-4-
1				
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				0

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN: 31-5229	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET C

	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	17,181	42,674	0.402610
41	Laboratory	38,985	33,258	1.172199
42	Intravenous Therapy	11,560	5,000	2.312000
43	Oxygen (Inhalation) Therapy	4,459,347	1,634,552	2.728177
44	Physical Therapy	1,282,449	330,241	3.883373
45	Occupational Therapy	554,636	359,332	1.543520
46	Speech Pathology	192,623	60,663	3.175296
47	Electrocardiology	0	0	0.000000
48	Medical Supplies Charged	34,877	16,000	2.179813
49	Drugs Charged to Patients	416,919	277,294	1.503527
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	00000000000000000	00000000000000000	00000000000000000
62	FQHC	00000000000000000	00000000000000000	00000000000000000
63	Other Outpatient Service Cost	0	0	0.000000
71	Ambulance	0	0	0.000000
100	TOTAL	7,008,577	2,759,014	////////////////////////////////

MED-CALC SYSTEMS			In Lieu of CMS Form 2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST			PROVIDER CCN 31-5229	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D	
Check One: [ ] Title V (1) [X] Title XVIII [ ] Title XIX (1)		Check One:	[X] SNF [ ] NF [ ] ICF/IID [ ] Other [ ] 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	PART A	PART B
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS:						
40	Radiology	0.402610	42,674		17,181	0
41	Laboratory	1.172199	9,388		11,005	0
42	Intravenous Therapy	2.312000	0		0	0
43	Oxygen (Inhalation) Therapy	2.728177	0		0	0
44	Physical Therapy	3.883373	330,241		1,282,449	0
45	Occupational Therapy	1.543520	359,332		554,636	0
46	Speech Pathology	3.175296	60,663		192,623	0
47	Electrocardiology	0.000000	0		0	0
48	Medical Supplies Charged	2.179813	0		0	0
49	Drugs Charged to Patients	1.503527	141,688		213,032	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)		943,986	0	2,270,926	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 31-5229	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D

Check One: [ ] Title V (1) [ ] Title XIX (1) [X] Title XVIII

Check One: [X] SNF [ ] NF [ ] ICF/IID [ ] Other [ ] PPS - Must also complete Part II

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.503527
2	Program vaccine charges (From your records, or the P S & R.) --->	0
3	Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	0

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 ursing & Allie ealth Costs f Pass Through (Col. 3 X Col.
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////
40	Radiology	17,181	0	0.000000	17,181	0
41	Laboratory	38,985	0	0.000000	11,005	0
42	Intravenous Therapy	11,560	0	0.000000	0	0
43	Oxygen (Inhalation) Therapy	4,459,347	0	0.000000	0	0
44	Physical Therapy	1,282,449	0	0.000000	1,282,449	0
45	Occupational Therapy	554,636	0	0.000000	554,636	0
46	Speech Pathology	192,623	0	0.000000	192,623	0
47	Electro cardiology	0	0	0.000000	0	0
48	Medical Supplies	34,877	0	0.000000	0	0
49	Drugs Charged to Patients	416,919	0	0.000000	213,032	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)	7,008,577	0	////////////////////////////	2,270,926	0

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10		
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN 31-5229	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

Check One: [ ] Title V (1) [ ] Title XVIII **[X] Title XIX (1)**

Check One: [ ] SNF **[X] NF** [ ] ICF/IID [ ] Other [ ] 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	0.402610		////////////	0	////////////
41	Laboratory	1.172199		////////////	0	////////////
42	Intravenous Therapy	2.312000		////////////	0	////////////
43	Oxygen (Inhalation) Therapy	2.728177		////////////	0	////////////
44	Physical Therapy	3.883373		////////////	0	////////////
45	Occupational Therapy	1.543520		////////////	0	////////////
46	Speech Pathology	3.175296		////////////	0	////////////
47	Electro cardiology	0.000000		////////////	0	////////////
48	Medical Supplies Charged	2.179813		////////////	0	////////////
49	Drugs Charged to Patients	1.503527		////////////	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 : 31-5229	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D-1 PARTS I & II
Check One:	[ ] Title V	[X] Title XVI	[ ] Title XIX
Check One:	[X] SNF	[ ] NF	[ ] ICF/IID

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	74,919
2	Private room days	
3	Inpatient days including private room days applicable to the Program	6,167
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	32,325,302

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	37,470,349
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.862690
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)	32,325,302

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	431.47
17	Program routine service cost (Line 3 times line 16)	2,660,875
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)	2,660,875
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)	4,985,038
21	Per diem capital related costs (Line 20 divided by line 1)	66.54
22	Program capital related cost (Line 3 times line 21)	410,352
23	Inpatient routine service cost (Line 19 minus line 22)	2,250,523
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)	2,250,523
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	74,919
2	Program inpatient days. (see instructions)	6,167
3	'Total Nursing & Allied Health costs. (see instructions)	0
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	0.082316
5	Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4)	0

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN : 31-5229	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D-1 PARTS I & II
Check One:	[ ] Title XVIII	**[X] Title XIX**	
Check One:	**[X] 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, li	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-p	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 : 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	**WORKSHEET E PART I**

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

1	Inpatient PPS amount (See Instructions)	5,325,396
2	Nursing and Allied Health Education Activities (pass through payments)	0
3	Subtotal (Sum of lines 1 and 2)	5,325,396
4	Primary payor amounts	(0)
5	Coinsurance	(977,160)
6	Allowable bad debts (from your records)	312,199
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	159,335
8	Adjusted reimbursable bad debts. (See instructions)	202,929
9	Recovery of bad debts - for statistical records only	
10	Utilization review	0
11	Subtotal (See instructions)	4,551,165
12	Interim payments (See instructions)	4,448,790
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)	4,059
14.99	Sequestration amount (see instructions)	86,965
15	Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14)	**11,351**
	(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)	0
19	Total reasonable costs (Sum of lines 17 and 18)	0
20	Medicare Part B ancillary charges (See instructions)	0
21	Cost of covered services (Lesser of line 19 or line 20)	0
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)	0
26	Interim payments (See instructions)	0
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)	0
29	Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28)	**0**
	(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: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	**WORKSHEET E-1**

	Description			Inpatient Part A		Part B	
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
				1	2	3	4
1	Total interim payments paid to provider			//////////	4,261,272	//////////	0
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.			//////////	131,380	//////////	
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)		.01	07/17/24	56,138		
			.02				
		Program to	.03				
		Provider	.04				
			.05				
			.50				
		Provider to	.51				
		Program	.52				
		*	.53				
			.54				
	SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99	//////////	56,138	//////////	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.)			//////////	4,448,790	//////////	0
				//////////		//////////	

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)		.01				
		Program to	.02				
		Provider	.03				
			.50				
		Provider to	.51				
		Program	.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: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	**WORKSHEET E PART II TITLE XIX**

Check one: [ ] Title V **[X] Title XIX**

Check one: [ ] SNF **[X] NF** [ ] ICF/IID

COMPUTATION OF NET COST OF COVERED 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 serviceson 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: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	**WORKSHEET G**

ASSETS

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	Cash on hand and in banks	806,910			
2	Temporary investments	0			
3	Notes receivable	0			
4	Accounts receivable	8,796,184			
5	Other receivables	0			
6	Less: allowances for uncollectible notes and A/R	0			
7	Inventory	0			
8	Prepaid expenses	44,834			
9	Other current assets	0			
10	Due from other funds	0			
11	TOTAL CURRENT ASSETS	9,647,928	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	5,146,014			
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	179,126			
24	Less: Accumulated depreciation	(2,798,687)			
25	Minor equipment - Depreciable	0			
26	Minor equipment nondepreciable	0			
27	Other fixed assets	0			
28	TOTAL FIXED ASSETS	2,526,453	0	0	0
	(Sum of lines 12 - 27)				
	OTHER ASSETS				
29	Investments	0			
30	Deposits on leases	0			
31	Due from owners/officers	0			
32	Other assets	0			
33	TOTAL OTHER ASSETS	0	0	0	0
	(Sum of lines 29 - 32)				
34	TOTAL ASSETS	12,174,381	0	0	0
	(Sum of lines 11, 28 and 33)				

BALANCE SHEET	PROVIDER CCN: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET G (cont'd)
LIABILITIES & FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
	CURRENT LIABILITIES			
35	Accounts payable	6,951,353			
36	Salaries, wages & fees payable	1,384,536			
37	Payroll taxes payable	292,646			
38	Notes & loans payable (Short term)	11,861			
39	Deferred income	123,462			
40	Accelerated payments	0	////////////////////////	////////////////////////////////	////////////////////////////////
41	Due to other funds	0			
42	Other current liabilities	6,357,763			
43	TOTAL CURRENT LIABILITIES	15,121,621	0	0	0
	(Sum of lines 35 - 42)				
	LONG TERM LIABILITIES				
44	Mortgage payable	0			
45	Notes payable	20,954			
46	Unsecured loans	2,525,000			
47	Loans from owners:	0			
48	Other long term liabilities	0			
49	Other (Specify)	0			
50	TOTAL LONG TERM LIABILITIES	2,545,954	0	0	0
	(Sum of lines 44 - 49)				
51	TOTAL LIABILITIES	17,667,575	0	0	0
	(Sum of lines 43 and 50)				
	CAPITAL ACCOUNTS				
52	General fund balance	(5,493,194)	////////////////////////	////////////////////////////////	////////////////////////////////
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	(5,493,194)	0	0	0
	(Sum of lines 52 thru 58)				
60	TOTAL LIABILITIES & FUND BALANCES	12,174,381	0	0	0
	(Sum of lines 51 and 59)				

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-1

		General Fund		Specific Purpose Fund		Endowment Fund		Plant Fund	
		1	2	3	4	5	6	7	8
1	Fund balances at beginning of period	////////////////////////	(4,466,569)	////////////////////		////////////////////		////////////////////	
2	Net income (loss) (From Wkst. G-3, line 31)	////////////////////////	(1,026,625)	////////////////////	////////////////	////////////////////	////////////////////	////////////////////	////////////////////
3	Total (Sum of line 1 and line 2)	////////////////////////	(5,493,194)	////////////////////	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)	////////////////////////	(5,493,194)	////////////////////	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)	////////////////////////	(5,493,194)	////////////////////	0	////////////////////	0	////////////////////	0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-2 PARTS I/II

PART I - PATIENT REVENUES

	REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL
			1	2	3
GENERAL INPATIENT ROUTINE CARE SERVICES			////////////////////////////	////////////////////////////	////////////////////////////
1	Skilled Nursing Facility		37,470,349	////////////////////////////	37,470,349
2	Nursing facility		0	////////////////////////////	0
3	ICF-IID		0	////////////////////////////	0
4	Other long term care		0	////////////////////////////	0
5	Total general inpatient care services		37,470,349	////////////////////////////	37,470,349
	(Sum of lines 1 - 4)				
ALL OTHER CARE SERVICES					
6	Ancillary services		2,759,014	0	2,759,014
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)		40,229,363	0	40,229,363
	(Transfer column 3 to Worksheet G-3, Line 1)				

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 100)	////////////////////////////	40,797,004
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)	////////////////////////////	40,797,004

STATEMENT OF REVENUES & EXPENSES	PROVIDER CCN 31-5229	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-3

1	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	40,229,363
2	Less: contractual allowances and discounts on patients accounts	(1,028,694)
3	Net patient revenues (Line 1 minus line 2)	39,200,669
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	40,797,004
5	Net income from service to patients (Line 3 minus 4)	(1,596,335)
//////////	OTHER INCOME:	////////////////////////////
6	Contributions, donations, bequests, etc	0
7	Income from investments	17,989
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	0
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	551,721
24.50	COVID-19 PHE Funding	0
25	Total other income (Sum of lines 6 - 24)	569,710
26	Total (Line 5 plus line 25)	(1,026,625)
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)	(1,026,625)