

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: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S PARTS I II & III
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 05/15/2025	Time: 10:27:12 AM
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report.		0
	3.0.1 ☐ No Medicare Utilization Enter "Y" for yes or leave blank for no		0
Contractor use only:	4. ☐ Cost Report Status [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 TOWER LODGE CARE CTR #31-5069 for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR ENCRYPTION:

05/15/2025 10:27:12 AM

I7bzFRHMowgPUKP7Xdbn.flkRMr9h0

nJRQA0pGOMvtcCRqu.FgRknGjaAmHd

Czac0bVxlc0H0IHw

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Avi Maierovits	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Avi Maierovits		2
3	Signatory Title	Controllor		3
4	Signature date	05/15/2025		4

PART III - SETTLEMENT SUMMARY

		TITLE V		TITLE XVIII		TITLE XIX	
		1	2	A	B		
1	SKILLED NURSING FACILITY	////////	////////	(45,568)	(4,587)		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			(45,568)	(4,587)	0	100

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

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

**SKILLED NURSING FACILITY AND SKILLED NURSING
FACILITY HEALTH CARE COMPLEX**

PROVIDER CCN:

PERIOD:

FROM: 01/01/2024

WORKSHEET S-2

PART I

IDENTIFICATION DATA

31-5069

TO: 12/31/2024

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	1506 GULLY ROAD	P.O. Box:				1
2	City:	WALL	State:	NJ	Zip Code:	07719	2
3	County:	MONMOUTH	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	TOWER LODGE CARE CTR	31-5069	01/01/1968		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	101,256	////////////////////	20
21	Declining Balance		////////////////////	21
22	Sum of the Year's Digits		////////////////////	22
23	Sum of line 20 through 22	101,256	////////////////////	23
24	If depreciation is funded, enter the balance as of the end of the period.			24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)	Y		25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	N		26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies	N		27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports	N		28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: 31-5069	PERIOD FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S-2 PART I (Cont.)
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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	ICF/IID	//////////	//////////		31	
32	SNF-Based HHA			//////////	32	
33	SNF-Based RHC	//////////		//////////	33	
34	SNF-Based FQHC	//////////		//////////	34	
35	SNF-Based CMHC	//////////	N	//////////	35	
36	SNF-Based OLTC	//////////	//////////	//////////	36	
				Y / N		
37	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients.				N	37
38	Are you legally-required to carry malpractice insurance?				Y	38
39	Is the malpractice a "claims-made:", or "occurrence" policy? If the policy is "claims-made" enter 1. If policy is "occurrence", enter 2.				1	39
	//////////	Premiums	Paid Losses	Self insurance		
41	List malpractice premiums and paid losses:	160,623			41	
	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center?				Y / N	
42	Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.				N	42
43	Are there home office costs as defined in CMS Pub. 15-1, chapter 10?				N	43
44	If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1.					44
	If this facility is part of a chain organization, enter the name and address of the home office on the lines below					
45	Name:	Contractor name	Contractor Number		45	
46	Street:	PO Box			46	
47	City:	State:	Zip Code:		47	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S-2 Part II
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General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No

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

Completed by All Skilled Nursing Facilities

Provider Organization and Operation		1 Y/N	2 Date		
1	Has the Provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N		////	1
		1 Y/N	2 Date	3 V / I	
2	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y	////	////	3
Financial Data and Reports		1 Y/N	2 Type	3 Date	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N	////	////	5
Approved Educational Activities			1 Y/N	2 Legal Oper.	
6	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)		N	N	6
7	Were costs claimed for Allied Health Programs? (Y/N) see instructions.		N	////	7
8	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.		N	////	8
Bad Debts				1 Y/N	
9	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9
10	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10
11	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11
Bed Complement					
12	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12
PS&R Data		1 Y/N	2 Date	3 Y/N	4 Date
		Part A	Part A	Part B	Part B
13	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	04/21/2025	Y	#####
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	
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	////
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	////
17	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: _____	N	////	N	////
18	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N	////	N	////
COST REPORT PREPARER CONTACT INFORMATION					
19	First name	Abi	Last name	Goldenberg	Title
20	Employer	Martin Friedman CPA, PC			Partner
21	Phone number	718-338-6900	Email address	agoldenberg@mfandco.com	

SKILLED NURSING FACILITY AND		PROVIDER CCN:	PERIOD:	WORKSHEET S-3
SKILLED NURSING FACILITY HEALTH CARE COMPLEX			FROM: 01/01/2024	PART I
STATISTICAL DATA		31-5069	TO: 12/31/2024	

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		60	21,960	////////////////	////////////////	993	12,443	6,084	19,520
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)		60	21,960	////////////////	////////////////	993	12,443	6,084	19,520

Component		Discharges					Average Length of Stay			
		Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Total
		8	9	10	11	12	13	14	15	16
1	Skilled Nursing Facility	////////////////	16	27	15	58	////////////////	62.06	460.85	336.55
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)	////////////////	16	27	15	58	////////////////	62.06	460.85	336.55

Component			Admissions					Full Time Equivalent		
			Title V	Title XVIII	Title XIX	Other	Total		Employees on Payroll	Nonpaid Workers
			17	18	19	20	21		22	23
1	Skilled Nursing Facility		////////////////	25	10	20	55		44.76	
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)		////////////////	25	10	20	55		44.76	0.00

SNF WAGE INDEX INFORMATION

PROVIDER CCN:
31-5069PERIOD:
FROM: 01/01/2024
TO: 12/31/2024WORKSHEET S-3
PARTS II & III

PART II DIRECT SALARIES		Amount Reported	Reclass.of Salaries from Wkst A-6	Adjusted Salaries	Paid Hrs Related to col.3	Average Hrly Wage	
		1	2	3	4	5	
1	Total salary (See Instructions)	2,647,940	0	2,647,940	93,093.65	28.44	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)	2,647,940	0	2,647,940	93,093.65	28.44	6
7	Other Long Term Care	0	0	0		0.00	7
8	HHA	0	0	0		0.00	8
9	CMHC	0	0	0		0.00	9
10	Hospice	0	0	0		0.00	10
11	Other excluded areas	0	0	0		0.00	11
12	Subtotal Excluded salary (Sum of lines 7-11)	0	0	0	0.00	0.00	12
13	Total Adjusted Salaries (line 6 minus line 12)	2,647,940	0	2,647,940	93,093.65	28.44	13
OTHER WAGES AND RELATED COSTS							
14	Contract Labor: Patient Related & Mgmt	681,897		681,897	15,515.00	43.95	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)	660,116		660,116			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 12)	660,116	0	660,116			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	467,741	0	467,741	8,123.75	57.58	2
3	Plant Operation, Maintenance & Repairs	59,966	0	59,966	2,113.75	28.37	3
4	Laundry & Linen Service	0	0	0		0.00	4
5	Housekeeping	150,546	0	150,546	8,340.75	18.05	5
6	Dietary	277,977	0	277,977	14,261.00	19.49	6
7	Nursing Administration	178,953	0	178,953	3,597.30	49.75	7
8	Central Services and Supply	0	0	0		0.00	8
9	Pharmacy	0	0	0		0.00	9
10	Medical Records & Medical Records Library	0	0	0		0.00	10
11	Social Service	43,665	0	43,665	1,480.20	29.50	11
12	Nursing and Allied Health Education Activities						12
13	Other General Service Cost	111,987	0	111,987	6,076.50	18.43	13
14	Total (sum lines 1 thru 13)	1,290,835	0	1,290,835	43,993.25	29.34	14

MED-CALC SYSTEMS

In Lieu of CMS Form 2540-10

SNF WAGE RELATED COSTS	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET S-3 PART IV
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PART IV - Wage Related Cost
Part A - Core List

		Amount Reported	
RETIREMENT COST			
1	401K Employer Contributions	5,802	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)	316,071	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	104,550	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	196,523	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	451	19
20	State or Federal Unemployment Taxes	36,719	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)	660,116	24

Part B Other than Core Related Cost

		Amount Reported	
25			25

SNF REPORTING OF DIRECT CARE EXPENDITURES		PROVIDER CCN: 31-5069		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)	29,776	7,423	37,199	592.00	62.84	1
2	Licensed Practical Nurses (LPNs)	511,351	127,477	638,828	14,034.75	45.52	2
3	Certified Nursing Assistants/Nursing Assistants/Aides	815,979	203,419	1,019,398	34,473.65	29.57	3
4	Total Nursing (sum of lines 1 through 3)	1,357,106	338,319	1,695,425	49,100.40	34.53	4
5	Physical Therapists			-		0.00	5
6	Physical Therapy Assistants			-		0.00	6
7	Physical Therapy Aides			-		0.00	7
8	Occupational Therapists			-		0.00	8
9	Occupational Therapy Assistants			-		0.00	9
10	Occupational Therapy Aides			-		0.00	10
11	Speech Therapists			-		0.00	11
12	Respiratory Therapists			-		0.00	12
13	Other Medical Staff			-		0.00	13
	Contract Labor	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	/
	Nursing Occupations	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	/
14	Registered Nurses (RNs)	23,913	////////////////////////////////////	23,913	339.00	70.54	14
15	Licensed Practical Nurses (LPNs)	154,202	////////////////////////////////////	154,202	2,808.00	54.92	15
16	Certified Nursing Assistants/Nursing Assistants/Aides	322,312	////////////////////////////////////	322,312	9,413.00	34.24	16
17	Total Nursing (sum of lines 14 through 16)	500,427	////////////////////////////////////	500,427	12,560.00	39.84	17
18	Physical Therapists	80,528	////////////////////////////////////	80,528	1,706.00	47.20	18
19	Physical Therapy Assistants		////////////////////////////////////	-		0.00	19
20	Physical Therapy Aides		////////////////////////////////////	-		0.00	20
21	Occupational Therapists	67,428	////////////////////////////////////	67,428	879.00	76.71	21
22	Occupational Therapy Assistants		////////////////////////////////////	-		0.00	22
23	Occupational Therapy Aides		////////////////////////////////////	-		0.00	23
24	Speech Therapists	33,514	////////////////////////////////////	33,514	370.00	90.58	24
25	Respiratory Therapists		////////////////////////////////////	-		0.00	25
26	Other Medical Staff		////////////////////////////////////	-		0.00	26

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				PROVIDER CCN: 31-5069		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	////////////////////	370,068	370,068	0	370,068	0	370,068
2	0200	Capital-Related Costs - Movable Equipment	////////////////////	0	0	0	0	0	0
3	0300	Employee Benefits	0	660,116	660,116	0	660,116	0	660,116
4	0400	Administrative and General	467,741	1,478,864	1,946,605	0	1,946,605	(364,019)	1,582,586
5	0500	Plant Operation, Maintenance and Repairs	59,966	155,691	215,657	0	215,657	0	215,657
6	0600	Laundry and Linen Service	0	32,307	32,307	0	32,307	0	32,307
7	0700	Housekeeping	150,546	99,433	249,979	0	249,979	0	249,979
8	0800	Dietary	277,977	181,328	459,305	0	459,305	0	459,305
9	0900	Nursing Administration	178,953	661	179,614	0	179,614	0	179,614
10	1000	Central Services and Supply	0	100,113	100,113	0	100,113	0	100,113
11	1100	Pharmacy	0	0	0	0	0	0	0
12	1200	Medical Records and Library	0	0	0	0	0	0	0
13	1300	Social Service	43,665	0	43,665	0	43,665	0	43,665
14	1400	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0
15	1500	Other General Service Cost	111,987	17,548	129,535	0	129,535	0	129,535
INPATIENT ROUTINE SERVICE COST CENTERS			////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////	////////////////////
30	3000	Skilled Nursing Facility	1,357,105	504,474	1,861,579	0	1,861,579	(310)	1,861,269
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	1,075	1,075	0	1,075	0	1,075
41	4100	Laboratory	0	8,622	8,622	0	8,622	0	8,622
42	4200	Intravenous Therapy	0	975	975	0	975	0	975
43	4300	Oxygen (Inhalation) Therapy	0	3,231	3,231	0	3,231	0	3,231
44	4400	Physical Therapy	0	181,469	181,469	(100,942)	80,527	0	80,527
45	4500	Occupational Therapy	0	0	0	67,428	67,428	0	67,428
46	4600	Speech Pathology	0	0	0	33,514	33,514	0	33,514
47	4700	Electrocardiology	0	0	0	0	0	0	0
48	4800	Medical Supplies Charged to Patients	0	0	0	0	0	0	0
49	4900	Drugs Charged to Patients	0	16,767	16,767	0	16,767	0	16,767
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: 31-5069			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)	2,647,940	3,812,742	6,460,682	0	6,460,682	(364,329)	6,096,353
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	0	0	0	0	0	0
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	2,647,940	3,812,742	6,460,682	0	6,460,682	(364,329)	6,096,353

EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1) 1	INCREASE				DECREASE			
		COST CENTER 2	LINE NO. 3	SALARY 4	NON- SALARY 5	COST CENTER 6	LINE NO. 7	SALARY 8	NON- SALARY 9
1 RECLASS OT	A	Occupational Therapy	45		67,428	Physical Therapy	44		67,428
2 RECLASS ST	B	Speech Pathology	46		33,514	Physical Therapy	44		33,514
3									
4									
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72									
### TOTAL RECLASSIFICATIONS		////////////////////	////	0	100,942	////////////////////	////	0	100,942

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

	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET A-7
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ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

ASSET BALANCES

Description		Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets
			Purchases	Donation	Total			
		1	2	3	4	5	6	7
1	Land				0		0	
2	Land Improvements				0		0	
3	Buildings and Fixtures				0		0	
4	Building Improvements	1,053,816			0	7,779	1,046,037	
5	Fixed Equipment				0		0	
6	Movable Equipment	11,166			0		11,166	
7	Subtotal (sum of lines 1-6)	1,064,982	0	0	0	7,779	1,057,203	0
8	Reconciling Items				0		0	
9	Total (line 7 minus line 8)	1,064,982	0	0	0	7,779	1,057,203	0

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024
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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	(152)	Administrative and General	4
2 Trade, quantity and time discounts on purchases (Chapter 8)				
3 Refunds and rebates of expenses (Chapter 8)				
4 Rental of provider space by suppliers (Chapter 8)				
5 Telephone services (pay stations excluded) (Chapter 21)				
6 Television and radio service (Chapter 21)				
7 Parking lot (Chapter 21)				
8 Remuneration applicable to provider-	//////////	//////////	//////////	//////////
based physician adjustment	A-8-2	0	//////////	//////////
9 Home office costs (Chapter 21)				
10 Sale of scrap, waste, etc. (Chapter 23)				
11 Nonallowable costs related to certain	//////////	//////////	//////////	//////////
Capital expenditures (Chapter 24)				
12 Adjustment resulting from transactions	//////////	//////////	//////////	//////////
with related organizations (Chapter 10)	A-8-1	(92,156)	//////////	//////////
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	(272,021)	Administrative and General	4
25.01				
25.02				
25.03				
25.04				
A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW)	//////////	0	//////////	//////////
100 TOTAL	//////////	(364,329)	//////////	//////////

(1)		(2)	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
DESCRIPTION		BASIS* FOR ADJ	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: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET A-8-1
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PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

		Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A. , col. 5	Adjustments (Col 4 minus Col 5)
		1	2	3	4	5	6
1		3	Employee Benefits	Self Insurance	394,012	394,012	0
2		10	Central Services and Supply	Med Supplies	65,822	65,822	0
3		43	Oxygen (Inhalation) Therapy	Oxygen	1,827	1,827	0
4		10	Central Services and Supply	OTC Drugs	13,092	13,092	0
5		8	Dietary	Dietary	182,019	182,019	0
6		5	Plant Operation, Maintenance and	Maintenance	30,020	30,020	0
7		6	Laundry and Linen Service	Diapers	32,307	32,307	0
8		4	Administrative and General	Office Supplies	4,382	4,382	0
9		4	Administrative and General	Office Support	464,799	556,645	(91,846)
9.01		30	Skilled Nursing Facility	Nursing	3,983	4,293	(310)
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					1,192,263	1,284,419	(92,156)

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.

	Descri ption	(1) Symbol	Name	Percentage of Ownership	Related Organization(s)		
					Name	Percentage of Ownership	Type of Business
			2	3	4	5	6
1		A	M Feigenbaum	34.00	Dynamic Health	50.00	Office Support
2		A	C Feigenbaum	4.00	Dynamic Health	50.00	Office Support
3		A	M Feigenbaum	34.00	Ocean Dietary	50.00	Purchasing
4		A	C Feigenbaum	4.00	Ocean Dietary	50.00	Purchasing
5		A	M Feigenbaum	34.00	Ocean Healthcr	100.00	Self Insurance
6							
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: 31-5069		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: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B PART I								PROVIDER CCN: 31-5069
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	370,068	370,068										
2	Capital-Related Costs - Movable Equipment	0	////////////////////	0									
3	Employee Benefits	660,116	0	0	660,116								
4	Administrative and General	1,582,586	5,870	0	116,605	1,705,061	1,705,061						
5	Plant Operation, Maintenance and Repairs	215,657	37,339	0	14,949	267,945	104,038	371,983					
6	Laundry and Linen Service	32,307	21,512	0	0	53,819	20,897	24,482	99,198				
7	Housekeeping	249,979	1,844	0	37,530	289,353	112,351	2,098	0	403,802			
8	Dietary	459,305	36,878	0	69,298	565,481	219,566	41,969	0	49,065	876,081		
9	Nursing Administration	179,614	2,366	0	44,612	226,592	87,982	2,693	0	3,148	0	320,415	
10	Central Services and Supply	100,113	0	0	0	100,113	38,872	0	0	0	0	0	
11	Pharmacy	0	0	0	0	0	0	0	0	0	0	0	
12	Medical Records and Library	0	0	0	0	0	0	0	0	0	0	0	
13	Social Service	43,665	1,967	0	10,885	56,517	21,945	2,238	0	2,617	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	129,535	0	0	27,918	157,453	61,136	0	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS													
30	Skilled Nursing Facility	1,861,269	219,360	0	338,319	2,418,948	939,234	249,645	99,198	291,852	876,081	320,415	
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	1,075	0	0	0	1,075	417	0	0	0	0	0	
41	Laboratory	8,622	0	0	0	8,622	3,348	0	0	0	0	0	
42	Intravenous Therapy	975	0	0	0	975	379	0	0	0	0	0	
43	Oxygen (Inhalation) Therapy	3,231	0	0	0	3,231	1,255	0	0	0	0	0	
44	Physical Therapy	80,527	0	0	0	80,527	31,267	0	0	0	0	0	
45	Occupational Therapy	67,428	6,884	0	0	74,312	28,854	7,834	0	9,159	0	0	
46	Speech Pathology	33,514	0	0	0	33,514	13,013	0	0	0	0	0	
47	Electrocardiology	0	0	0	0	0	0	0	0	0	0	0	
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0	0	0	0	
49	Drugs Charged to Patients	16,767	0	0	0	16,767	6,510	0	0	0	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	

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10					In Lieu of CMS Form 2540-10					
COST ALLOCATION GENERAL SERVICE COSTS		PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B PART I							PROVIDER CCN: 31-5069	
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)	6,096,353	334,020	0	660,116	6,060,305	1,691,064	330,959	99,198	355,841	876,081	320,415
NON REIMBURSABLE COST CENTERS												
90	Gift, Flower, Coffee Shop & Canteen	0	36,048	0	0	36,048	13,997	41,024	0	47,961	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	0	0	0	0	0	0	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	6,096,353	370,068	0	660,116	6,096,353	1,705,061	371,983	99,198	403,802	876,081	320,415

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	138,985								
11	Pharmacy	0	0							
12	Medical Records and Library	0	0	0						
13	Social Service	0	0	0	83,317					
14	Nursing and Allied Health Education Activities	0	0	0	0	0				
15	Other General Service Cost	0	0	0	0	0	218,589			
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Skilled Nursing Facility	138,985	0	0	83,317	0	218,589	5,636,264	0	5,636,264
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	1,492	0	1,492
41	Laboratory	0	0	0	0	0	0	11,970	0	11,970
42	Intravenous Therapy	0	0	0	0	0	0	1,354	0	1,354
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	4,486	0	4,486
44	Physical Therapy	0	0	0	0	0	0	111,794	0	111,794
45	Occupational Therapy	0	0	0	0	0	0	120,159	0	120,159
46	Speech Pathology	0	0	0	0	0	0	46,527	0	46,527
47	Electrocardiology	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0	0
49	Drugs Charged to Patients	0	0	0	0	0	0	23,277	0	23,277
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)	138,985	0	0	83,317	0	218,589	5,957,323	0	5,957,323
NON REIMBURSABLE COST CENTERS										
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	139,030	0	139,030
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	0	0	0	0	0	0	0	0	0
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	138,985	0	0	83,317	0	218,589	6,096,353	0	6,096,353

ALLOCATION OF CAPITAL-RELATED COSTS		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		PROVIDER CCN: 31-5069		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		5,870	0	5,870	0	5,870					
5	Plant Operation, Maintenance and Repairs		37,339	0	37,339	0	358	37,697				
6	Laundry and Linen Service		21,512	0	21,512	0	72	2,481	24,065			
7	Housekeeping		1,844	0	1,844	0	387	213	0	2,444		
8	Dietary		36,878	0	36,878	0	756	4,253	0	297	42,184	
9	Nursing Administration		2,366	0	2,366	0	303	273	0	19	0	2,961
10	Central Services and Supply		0	0	0	0	134	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	0	0	0	0	0	0
13	Social Service		1,967	0	1,967	0	76	227	0	16	0	0
14	Nursing and Allied Health Education Activities		0	0	0	0	0	0	0	0	0	0
15	Other General Service Cost		0	0	0	0	211	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTER												
30	Skilled Nursing Facility		219,360	0	219,360	0	3,233	25,299	24,065	1,767	42,184	2,961
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	1	0	0	0	0	0
41	Laboratory		0	0	0	0	12	0	0	0	0	0
42	Intravenous Therapy		0	0	0	0	1	0	0	0	0	0
43	Oxygen (Inhalation) Therapy		0	0	0	0	4	0	0	0	0	0
44	Physical Therapy		0	0	0	0	108	0	0	0	0	0
45	Occupational Therapy		6,884	0	6,884	0	99	794	0	55	0	0
46	Speech Pathology		0	0	0	0	45	0	0	0	0	0
47	Electrocardiology		0	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients		0	0	0	0	0	0	0	0	0	0
49	Drugs Charged to Patients		0	0	0	0	22	0	0	0	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: 31-5069	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	334,020	0	334,020	0	5,822	33,540	24,065	2,154	42,184	2,961
NON REIMBURSABLE COST CENTERS												
90	Gift, Flower, Coffee Shop & Canteen		36,048	0	36,048	0	48	4,157	0	290	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	0	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	370,068	0	370,068	0	5,870	37,697	24,065	2,444	42,184	2,961

ALLOCATION OF CAPITAL-RELATED COSTS				PROVIDER CCN: 31-5069				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	134								
11	Pharmacy	0	0							
12	Medical Records and Library	0	0	0						
13	Social Service	0	0	0	2,286					
14	Nursing and Allied Health Education Activities	0	0	0	0	0				
15	Other General Service Cost	0	0	0	0	0	211			
INPATIENT ROUTINE SERVICE COST CENTER										
30	Skilled Nursing Facility	134	0	0	2,286	0	211	321,500	0	321,500
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	1	0	1
41	Laboratory	0	0	0	0	0	0	12	0	12
42	Intravenous Therapy	0	0	0	0	0	0	1	0	1
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	4	0	4
44	Physical Therapy	0	0	0	0	0	0	108	0	108
45	Occupational Therapy	0	0	0	0	0	0	7,832	0	7,832
46	Speech Pathology	0	0	0	0	0	0	45	0	45
47	Electrocardiology	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0	0
49	Drugs Charged to Patients	0	0	0	0	0	0	22	0	22
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: 31-5069				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)	134	0	0	2,286	0	211	329,525	0	329,525	
NON REIMBURSABLE COST CENTERS											
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	40,543	0	40,543	
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0	
92	Physicians' Private Offices	0	0	0	0	0	0	0	0	0	
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	134	0	0	2,286	0	211	370,068	0	370,068	

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10				TOWER LODGE CARE CTR		In Lieu of CMS Form 2540-10					
COST ALLOCATION STATISTICAL BASIS		PROVIDER CCN: 31-5069	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	//////////	12,042	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
2	Capital-Related Costs - Movable Equipment	//////////	//////////	0	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
3	Employee Benefits	//////////	//////////	0	2,647,940	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
4	Administrative and General	//////////	191	0	467,741	(1,705,061)	4,391,292	//////////	//////////	//////////	//////////	//////////	//////////
5	Plant Operation, Maintenance and Repairs	//////////	1,215	0	59,966	//////////	267,945	10,636	//////////	//////////	//////////	//////////	//////////
6	Laundry and Linen Service	//////////	700	0	0	//////////	53,819	700	19,520	//////////	//////////	//////////	//////////
7	Housekeeping	//////////	60	0	150,546	//////////	289,353	60	//////////	9,876	//////////	//////////	//////////
8	Dietary	//////////	1,200	0	277,977	//////////	565,481	1,200	//////////	1,200	58,560	//////////	//////////
9	Nursing Administration	//////////	77	0	178,953	//////////	226,592	77	//////////	77	//////////	19,520	//////////
10	Central Services and Supply	//////////	//////////	0	0	//////////	100,113	0	//////////	0	//////////	//////////	19,520
11	Pharmacy	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
12	Medical Records and Library	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
13	Social Service	//////////	64	0	43,665	//////////	56,517	64	//////////	64	//////////	//////////	//////////
14	Nursing and Allied Health Education Activities	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
15	Other General Service Cost	//////////	//////////	0	111,987	//////////	157,453	0	//////////	0	//////////	//////////	//////////
INPATIENT ROUTINE SERVICE COST CENTERS		//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
30	Skilled Nursing Facility	//////////	7,138	0	1,357,105	//////////	2,418,948	7,138	19,520	7,138	58,560	19,520	19,520
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	//////////	1,075	0	//////////	0	//////////	//////////	//////////
41	Laboratory	//////////	//////////	0	0	//////////	8,622	0	//////////	0	//////////	//////////	//////////
42	Intravenous Therapy	//////////	//////////	0	0	//////////	975	0	//////////	0	//////////	//////////	//////////
43	Oxygen (Inhalation) Therapy	//////////	//////////	0	0	//////////	3,231	0	//////////	0	//////////	//////////	//////////
44	Physical Therapy	//////////	//////////	0	0	//////////	80,527	0	//////////	0	//////////	//////////	//////////
45	Occupational Therapy	//////////	224	0	0	//////////	74,312	224	//////////	224	//////////	//////////	//////////
46	Speech Pathology	//////////	//////////	0	0	//////////	33,514	0	//////////	0	//////////	//////////	//////////
47	Electrocardiology	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
48	Medical Supplies Charged to Patients	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
49	Drugs Charged to Patients	//////////	//////////	0	0	//////////	16,767	0	//////////	0	//////////	//////////	//////////
50	Dental Care - Title XIX only	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
51	Support Surfaces	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
52	Other Ancillary Service Cost Center	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
52.01	Other Ancillary Service Cost Center II	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
52.02	Other Ancillary Service Cost Center III	//////////	//////////	0	0	//////////	0	0	//////////	0	//////////	//////////	//////////
OUTPATIENT SERVICE COST CENTERS		//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10				TOWER LODGE CARE CTR			In Lieu of CMS Form 2540-10					
COST ALLOCATION STATISTICAL BASIS			PROVIDER CCN: 31-5069	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)	////////	10,869	0	2,647,940	(1,705,061)	4,355,244	9,463	19,520	8,703	58,560	19,520	19,520	
NON REIMBURSABLE COST CENTERS		////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	
90	Gift, Flower, Coffee Shop & Canteen	////////	1,173	0	0		36,048	1,173		1,173				
91	Barber and Beauty Shop	////////		0	0		0	0		0				
92	Physicians' Private Offices	////////		0	0		0	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)	////////	370,068	0	660,116	////////	1,705,061	371,983	99,198	403,802	876,081	320,415	138,985	
103	Unit Cost Multiplier (Worksheet B, Part I)	////////	30.731440	0.000000	0.249294	////////	0.388282	34.973956	5.081865	40.887201	14.960400	16.414703	7.120133	
104	Cost to Be Allocated (Per Worksheet B, Part II)	////////	////////	////////	0	////////	5,870	37,697	24,065	2,444	42,184	2,961	134	
105	Unit Cost Multiplier (Worksheet B, Part II)	////////	////////	////////	0.000000	////////	0.001337	3.544284	1.232838	0.247469	0.720355	0.151691	0.006865	
* may zero out accum.cost stat at col.4 instead of using reconcil.														

COST ALLOCATION STATISTICAL BASIS		PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET B-1 (cont.)			
COST CENTER	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (TIME SPENT)	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		0					
13	Social Service		19,520					
14	Nursing and Allied Health Education Activities			0				
15	Other General Service Cost				19,520			
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility	0	0	19,520	19,520			
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: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B-1 (cont.)				
COST CENTER		PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (TIME SPENT)	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	0	19,520	0	19,520	////////////////////////////////	////////////////////////////////	////////////////////////////////
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	0	83,317	0	218,589	////////////////////////////////	////////////////////////////////	////////////////////////////////
103	Unit Cost Multiplier (Worksheet B, Part I)	0.000000	0.000000	4.268289	0.000000	11.198207	////////////////////////////////	////////////////////////////////	////////////////////////////////
104	Cost to Be Allocated (Per Worksheet B, Part II)	0	0	2,286	0	211	////////////////////////////////	////////////////////////////////	////////////////////////////////
105	Unit Cost Multiplier (Worksheet B, Part II)	0.000000	0.000000	0.117111	0.000000	0.010809	////////////////////////////////	////////////////////////////////	////////////////////////////////

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B-2
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DESCRIPTION		WORKSHEET B PART NO. LINE NO.		AMOUNT
-1-		(1 or 2)	-2-	-3-
			-2-	-3-
			-2-	-3-
			-2-	-3-

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0

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN: 31-5069	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	1,492	5,146	0.289934
41	Laboratory	11,970	8,622	1.388309
42	Intravenous Therapy	1,354	975	1.388718
43	Oxygen (Inhalation) Therapy	4,486	3,231	1.388425
44	Physical Therapy	111,794	153,517	0.728219
45	Occupational Therapy	120,159	128,543	0.934777
46	Speech Pathology	46,527	63,890	0.728236
47	Electrocardiology	0	0	0.000000
48	Medical Supplies Charged	0	0	0.000000
49	Drugs Charged to Patients	23,277	84,292	0.276147
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	000000000000000000	000000000000000000	000000000000000000
62	FQHC	000000000000000000	000000000000000000	000000000000000000
63	Other Outpatient Service Cost	0	0	0.000000
71	Ambulance	0	0	0.000000
100	TOTAL	321,059	448,216	////////////////////

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10	
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST		PROVIDER CCN 31-5069	PERIOD : FROM: 01/01/2024 TO: 12/31/2024
Check ☐ Title V (1) Check One: ☒ SNF ☐ NF ☐ ICF/IID ☐ Other One: ☒ Title XVIII ☐ PPS - Must also complete Part II ☐ Title XIX (1)			
PART II - APPORTIONMENT OF VACCINE COST			
1	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		0.276147
2	Program vaccine charges (From your records, or the P S & R.) --->		14,450
3	Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)		3,990

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH						
		Total Cost (From Worksheet B, Part I, Col 18)	Nursing & Allied Health (From Wkst. B, Part I, Column 14)	Ratio of Nursing & Allied Health Costs To Total Costs - Part A (Col. 2 / Col.. 1)	Program Part A Cost (From Wkst. D, Part I, Col. 4)	Part A Nursing & Allie Health Costs f Pass Through (Col. 3 X Col. .
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS		////////////////////	////////////////////	////////////////////	////////////////////	////////////////////
40	Radiology	1,492	0	0.000000	36	0
41	Laboratory	11,970	0	0.000000	8,273	0
42	Intravenous Therapy	1,354	0	0.000000	0	0
43	Oxygen (Inhalation) Therapy	4,486	0	0.000000	0	0
44	Physical Therapy	111,794	0	0.000000	34,044	0
45	Occupational Therapy	120,159	0	0.000000	38,753	0
46	Speech Pathology	46,527	0	0.000000	16,851	0
47	Electro cardiology	0	0	0.000000	0	0
48	Medical Supplies	0	0	0.000000	0	0
49	Drugs Charged to Patients	23,277	0	0.000000	14,228	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)	321,059	0	////////////////////	112,185	0

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST		PROVIDER CCN 31-5069	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST Check ☐ Title V (1) Check One: ☐ SNF ☒ NF ☐ ICF/IID ☐ Other One: ☐ Title XVIII ☐ PPS - Must also complete Part II ☒ Title XIX (1)					
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	
		1	2	3	4 5
ANCILLARY SERVICE COST CENTERS:		////////////////////////////////	////////////////////////////////	////////////////////////////////	////////////////////////////////
40	Radiology	0.289934		0	////////////////////////////////
41	Laboratory	1.388309		0	////////////////////////////////
42	Intravenous Therapy	1.388718		0	////////////////////////////////
43	Oxygen (Inhalation) Therapy	1.388425		0	////////////////////////////////
44	Physical Therapy	0.728219		0	////////////////////////////////
45	Occupational Therapy	0.934777		0	////////////////////////////////
46	Speech Pathology	0.728236		0	////////////////////////////////
47	Electro cardiology	0.000000		0	////////////////////////////////
48	Medical Supplies Charged	0.000000		0	////////////////////////////////
49	Drugs Charged to Patients	0.276147		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 :	PERIOD :	WORKSHEET D-1 PARTS I & II
	31-5069	FROM: 01/01/2024 TO: 12/31/2024	
Check One:	☐ Title V ☒ Title XVI ☐ Title XIX		
Check One:	☒ SNF ☐ NF ☐ ICF/IID		

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	19,520
2	Private room days	
3	Inpatient days including private room days applicable to the Program	993
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	5,636,264

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	6,250,591
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.901717
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)	5,636,264

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	288.74
17	Program routine service cost (Line 3 times line 16)	286,719
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)	286,719
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)	321,500
21	Per diem capital related costs (Line 20 divided by line 1)	16.47
22	Program capital related cost (Line 3 times line 21)	16,355
23	Inpatient routine service cost (Line 19 minus line 22)	270,364
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)	270,364
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	19,520
2	Program inpatient days. (see instructions)	993
3	Total Nursing & Allied Health costs. (see instructions)	0
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	0.050871
5	Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4)	0

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN :	PERIOD :	WORKSHEET D-1 PARTS I & II
	31-5069	FROM: 01/01/2024 TO: 12/31/2024	
	☐ Title XVIII	☒ Title XIX	
	Check One: ☒ NF	☐ ICF/IID	

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

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

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	0.00
17	Program routine service cost (Line 3 times line 16)	0
18	Medically necessary private room cost applicable to program (line 4 times line 13)	0
19	Total program general inpatient routine service cost (Line 17 plus line 18)	0
20	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, - line 30 for SNF; line 31 for NF, or line 32 for ICF/MR)	0
21	Per diem capital related costs (Line 20 divided by line 1)	0.00
22	Program capital related cost (Line 3 times line 21)	0
23	Inpatient routine service cost (Line 19 minus line 22)	0
24	Aggregate charges to beneficiaries for excess costs (From provider records)	
25	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	0
26	Enter the per diem limitation (1)	
27	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	0
28	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)	0
	(Transfer to Worksheet E, Part II, line 4) (See instructions)	
	(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	PROVIDER CCN : 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET E PART I
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PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

1	Inpatient PPS amount (See Instructions)	787,585
2	Nursing and Allied Health Education Activities (pass through payments)	0
3	Subtotal (Sum of lines 1 and 2)	787,585
4	Primary payor amounts (	0)
5	Coinsurance (	132,192)
6	Allowable bad debts (from your records)	97,975
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	97,975
8	Adjusted reimbursable bad debts. (See instructions)	63,684
9	Recovery of bad debts - for statistical records only	
10	Utilization review	0
11	Subtotal (See instructions)	719,077
12	Interim payments (See instructions)	750,263
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)	1,274
14.99	Sequestration amount (see instructions)	13,108
15	Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14)	(45,568)
	(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)	3,990
19	Total reasonable costs (Sum of lines 17 and 18)	3,990
20	Medicare Part B ancillary charges (See instructions)	14,450
21	Cost of covered services (Lesser of line 19 or line 20)	3,990
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)	3,990
26	Interim payments (See instructions)	8,497
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)	80
29	Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28)	(4,587)
	(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: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET E-1
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Description			Inpatient Part A		Part B		
			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
			1	2	3	4	
1 Total interim payments paid to provider			////////////////////	642,286	////////////////////	8,497	
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.			////////////////////	62,460	////////////////////		
3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE," or enter a zero (1)	Program to Provider	.01	06/07/24	45,517			
		.02					
		.03					
		.04					
		.05					
	Provider to Program *	.50					
		.51					
		.52					
		.53					
		.54					
SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99	////////////////////	45,517	////////////////////	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.)			////////////////////	750,263	////////////////////	8,497	
			////////////////////		////////////////////		
TO BE COMPLETED BY CONTRACTOR							
5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Program to Provider	.01					
		.02					
		.03					
	Provider to Program	.50					
		.51					
		.52					
SUBTOTAL (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99	////////////////////		////////////////////		
6 Determine net settlement amount (balance due) based on the cost report. (1)	Program to provider	.01					
	Provider to program	.50					
7 TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)			////////////////////		////////////////////		
8 Name of Contractor	Contractor Number						

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET E PART II TITLE XIX
Check one: ☐ Title V ☒ Title XIX			
Check one: ☐ SNF ☒ NF ☐ ICF/IID			

COMPUTATION OF NET COST OF COVERED PART A - INPATIENT SERVICES

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

REASONABLE CHARGES

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

CUSTOMARY CHARGES:

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT:

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

BALANCE SHEET	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND
	1	2	3
			PLANT FUND
			4

ASSETS

CURRENT ASSETS				
1	Cash on hand and in banks	381,837		
2	Temporary investments	0		
3	Notes receivable	0		
4	Accounts receivable	564,250		
5	Other receivables	0		
6	Less: allowances for uncollectible notes and A/R	0		
7	Inventory	0		
8	Prepaid expenses	182,948		
9	Other current assets	0		
10	Due from other funds	0		
11	TOTAL CURRENT ASSETS	1,129,035	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	1,046,037		
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	11,166		
24	Less: Accumulated depreciation	(782,424)		
25	Minor equipment - Depreciable	0		
26	Minor equipment nondepreciable	0		
27	Other fixed assets	0		
28	TOTAL FIXED ASSETS	274,779	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	3,840		
33	TOTAL OTHER ASSETS	3,840	0	0
	(Sum of lines 29 - 32)			
34	TOTAL ASSETS	1,407,654	0	0
	(Sum of lines 11, 28 and 33)			

BALANCE SHEET	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G (cont'd)
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LIABILITIES & FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4

CURRENT LIABILITIES

35	Accounts payable	563,794			
36	Salaries, wages & fees payable	131,625			
37	Payroll taxes payable	113,826			
38	Notes & loans payable (Short term)	0			
39	Deferred income	0			
40	Accelerated payments	0	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
41	Due to other funds	0			
42	Other current liabilities	598,993			
43	TOTAL CURRENT LIABILITIES	1,408,238	0	0	0
	(Sum of lines 35 - 42)				

LONG TERM LIABILITIES

44	Mortgage payable	0			
45	Notes payable	0			
46	Unsecured loans	116,475			
47	Loans from owners:	0			
48	Other long term liabilities	0			
49	Other (Specify)	0			
50	TOTAL LONG TERM LIABILITIES	116,475	0	0	0
	(Sum of lines 44 - 49)				
51	TOTAL LIABILITIES	1,524,713	0	0	0
	(Sum of lines 43 and 50)				

CAPITAL ACCOUNTS

52	General fund balance	(117,059)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
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	(117,059)	0	0	0
	(Sum of lines 52 thru 58)				
60	TOTAL LIABILITIES & FUND BALANCES	1,407,654	0	0	0
	(Sum of lines 51 and 59)				

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-1
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		General Fund		Specific Purpose Fund		Endowment Fund		Plant Fund	
		1	2	3	4	5	6	7	8
1	Fund balances at beginning of period	////////////////////////////////////	19,916	////////////////////////////////////		////////////////////////////////////		////////////////////////////////////	
2	Net income (loss) (From Wkst. G-3, line 31)	////////////////////////////////////	(136,975)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
3	Total (Sum of line 1 and line 2)	////////////////////////////////////	(117,059)	////////////////////////////////////	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)	////////////////////////////////////	(117,059)	////////////////////////////////////	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)	////////////////////////////////////	(117,059)	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-2 PARTS I/II
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PART I - PATIENT REVENUES

REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL
		1	2	3
GENERAL INPATIENT ROUTINE CARE SERVICES		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
1	Skilled Nursing Facility	6,250,591	////////////////////////////////////	6,250,591
2	Nursing facility	0	////////////////////////////////////	0
3	ICF-IID	0	////////////////////////////////////	0
4	Other long term care	0	////////////////////////////////////	0
5	Total general inpatient care services	6,250,591	////////////////////////////////////	6,250,591
	(Sum of lines 1 - 4)			

ALL OTHER CARE SERVICES				
6	Ancillary services	435,786	0	435,786
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)	6,686,377	0	6,686,377
	(Transfer column 3 to Worksheet G-3, Line 1)			

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 100)	////////////////////////////////////	6,460,682
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)	////////////////////////////////////	6,460,682

STATEMENT OF REVENUES & EXPENSES	PROVIDER CCN 31-5069	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G-3
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1	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	6,686,377
2	Less: contractual allowances and discounts on patients accounts (	391,165)
3	Net patient revenues (Line 1 minus line 2)	6,295,212
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	6,460,682
5	Net income from service to patients (Line 3 minus 4)	(165,470)
////////	OTHER INCOME:	////////////////////////////////////
6	Contributions, donations, bequests, etc	0
7	Income from investments	152
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	28,343
24.50	COVID-19 PHE Funding	0
25	Total other income (Sum of lines 6 - 24)	28,495
26	Total (Line 5 plus line 25)	(136,975)
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)	(136,975)