

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: 31-5209	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. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 05/29/2025	Time: 12:13:12 PM
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report.		0
	3.0.1 <input type="checkbox"/> No Medicare Utilization Enter "Y" for yes or leave blank for no		0
Contractor use only:	4. <input type="checkbox"/> 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. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. <input type="checkbox"/> NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code _____ 12. Medicare Utilization Enter "F" for full, "L" for low, or "N" for no utilization _____	

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

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMMONTON CENTER FOR REHAB & HC #31-5209 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:

05/29/2025 12:13:12 PM

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Uz5RH0fWy6QXOXtT.QDLO38IsKrqsa

BDOq0hPRp60dzwFx

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

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	SKILLED NURSING FACILITY	//////////	25,960	1,912		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		25,960	1,912	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

TO: 12/31/2024

**WORKSHEET S-2
PART I**

IDENTIFICATION DATA

31-5209

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	43 N. WHITE HORSE PIKE	P.O. Box:				1
2	City:	HAMMONTON	State:	NJ	Zip Code:	08034	2
3	County:	ATLANTIC	CBSA Code:	12100	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	HAMMONTON CENTER FOR R	31-5209	01/03/2006		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	259,596	////////////////////	20
21	Declining Balance		////////////////////	21
22	Sum of the Year's Digits		////////////////////	22
23	Sum of line 20 through 22	259,596	////////////////////	23
24	If depreciation is funded, enter the balance as of the end of the period.			24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)	N		25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	N		26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies	N		27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports	N		28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: 31-5209	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:	125,782			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: 31-5209	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	02/24/2025	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		31-5209	TO: 12/31/2024	

Component			Number of Beds	Bed Days Available		Inpatient Days / Visits				
						Title V	Title XVIII	Title XIX	Other	Total
						3	4	5	6	7
1	Skilled Nursing Facility		240	87,840	////////////////	////////////////	3,418	54,906	4,120	62,444
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)		240	87,840	////////////////	////////////////	3,418	54,906	4,120	62,444

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	////////	78	373	84	535	////////	43.82	147.20	116.72
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)	////////	78	373	84	535	////////	43.82	147.20	116.72

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	////////	122	339	108	569		106.13	
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)	////////	122	339	108	569		106.13	0.00

SNF WAGE INDEX INFORMATION

PROVIDER CCN:
31-5209PERIOD:
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)	5,434,338	0	5,434,338	220,750.37	24.62	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)	5,434,338	0	5,434,338	220,750.37	24.62	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)	5,434,338	0	5,434,338	220,750.37	24.62	13
OTHER WAGES AND RELATED COSTS							
14	Contract Labor: Patient Related & Mgmt	8,568,540		8,568,540	174,879.16	49.00	14
15	Contract Labor: Physician services-Part A			0		0.00	15
16	Home office salaries & wage related costs			0		0.00	16
WAGE RELATED COSTS							
17	Wage related costs core. (See Part IV)	1,458,603		1,458,603			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)	1,458,603	0	1,458,603			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	320,193	0	320,193	8,929.70	35.86	2
3	Plant Operation, Maintenance & Repairs	182,191	0	182,191	6,697.71	27.20	3
4	Laundry & Linen Service	7,244	0	7,244	411.82	17.59	4
5	Housekeeping	591,248	0	591,248	34,716.32	17.03	5
6	Dietary	825,088	0	825,088	42,435.15	19.44	6
7	Nursing Administration	1,490,430	0	1,490,430	35,719.17	41.73	7
8	Central Services and Supply	56,038	0	56,038	2,892.98	19.37	8
9	Pharmacy	0	0	0		0.00	9
10	Medical Records & Medical Records Library	16,090	0	16,090	855.52	18.81	10
11	Social Service	131,931	0	131,931	4,123.18	32.00	11
12	Nursing and Allied Health Education Activities						12
13	Other General Service Cost	307,676	0	307,676	16,695.12	18.43	13
14	Total (sum lines 1 thru 13)	3,928,129	0	3,928,129	153,476.67	25.59	14

MED-CALC SYSTEMS

In Lieu of CMS Form 2540-10

SNF WAGE RELATED COSTS	PROVIDER CCN:	PERIOD:	WORKSHEET
	31-5209	FROM: 01/01/2024 TO: 12/31/2024	S-3 PART IV

PART IV - Wage Related Cost
Part A - Core List

		Amount Reported	
RETIREMENT COST			
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost	45,427	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)	307,726	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	525,754	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	412,741	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	(216)	19
20	State or Federal Unemployment Taxes	88,432	20
OTHER			
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement	78,739	23
24	Total Wage Related cost (Sum of lines 1 -23)	1,458,603	24

Part B Other than Core Related Cost

		Amount Reported	
25			25

SNF REPORTING OF DIRECT CARE EXPENDITURES		PROVIDER CCN: 31-5209		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)	93,308	25,044	118,352	2,454.61	48.22	1
2	Licensed Practical Nurses (LPNs)	208,338	55,919	264,257	5,884.98	44.90	2
3	Certified Nursing Assistants/Nursing Assistants/Aides	1,032,351	277,088	1,309,439	53,239.43	24.60	3
4	Total Nursing (sum of lines 1 through 3)	1,333,997	358,051	1,692,048	61,579.02	27.48	4
5	Physical Therapists			-		0.00	5
6	Physical Therapy Assistants	44,887	12,048	56,935	2,173.96	26.19	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)	569,947	////////////////////////////////	569,947	2,676.79	212.92	14
15	Licensed Practical Nurses (LPNs)	2,899,448	////////////////////////////////	2,899,448	52,230.08	55.51	15
16	Certified Nursing Assistants/Nursing Assistants/Aides	4,272,071	////////////////////////////////	4,272,071	104,032.30	41.06	16
17	Total Nursing (sum of lines 14 through 16)	7,741,466	////////////////////////////////	7,741,466	158,939.17	48.71	17
18	Physical Therapists	430,464	////////////////////////////////	430,464	8,335.00	51.65	18
19	Physical Therapy Assistants		////////////////////////////////	-		0.00	19
20	Physical Therapy Aides		////////////////////////////////	-		0.00	20
21	Occupational Therapists	272,846	////////////////////////////////	272,846	5,875.00	46.44	21
22	Occupational Therapy Assistants		////////////////////////////////	-		0.00	22
23	Occupational Therapy Aides		////////////////////////////////	-		0.00	23
24	Speech Therapists	123,765	////////////////////////////////	123,765	1,730.00	71.54	24
25	Respiratory Therapists		////////////////////////////////	-		0.00	25
26	Other Medical Staff		////////////////////////////////	-		0.00	26

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER CCN: 31-5209			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	////	3,253,217	3,253,217	0	3,253,217	0	3,253,217
2	0200	Capital-Related Costs - Movable Equipment	////	0	0	0	0	0	0
3	0300	Employee Benefits	0	1,458,604	1,458,604	0	1,458,604	0	1,458,604
4	0400	Administrative and General	320,193	5,360,836	5,681,029	0	5,681,029	(1,829,330)	3,851,699
5	0500	Plant Operation, Maintenance and Repairs	182,191	542,701	724,892	0	724,892	0	724,892
6	0600	Laundry and Linen Service	7,244	99,417	106,661	0	106,661	0	106,661
7	0700	Housekeeping	591,248	149,445	740,693	0	740,693	0	740,693
8	0800	Dietary	825,088	646,994	1,472,082	0	1,472,082	0	1,472,082
9	0900	Nursing Administration	1,490,430	29,373	1,519,803	0	1,519,803	0	1,519,803
10	1000	Central Services and Supply	56,038	154,605	210,643	0	210,643	0	210,643
11	1100	Pharmacy	0	0	0	0	0	0	0
12	1200	Medical Records and Library	16,090	6,306	22,396	0	22,396	0	22,396
13	1300	Social Service	131,931	217	132,148	0	132,148	0	132,148
14	1400	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0
15	1500	Other General Service Cost	307,676	59,149	366,825	0	366,825	0	366,825
INPATIENT ROUTINE SERVICE COST CENTERS			////	////	////	////	////	////	////
30	3000	Skilled Nursing Facility	1,461,322	7,343,724	8,805,046	0	8,805,046	0	8,805,046
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	3,058	3,058	0	3,058	0	3,058
41	4100	Laboratory	0	38,105	38,105	0	38,105	0	38,105
42	4200	Intravenous Therapy	0	1,166	1,166	0	1,166	0	1,166
43	4300	Oxygen (Inhalation) Therapy	0	32,129	32,129	0	32,129	0	32,129
44	4400	Physical Therapy	44,887	430,464	475,351	0	475,351	0	475,351
45	4500	Occupational Therapy	0	272,846	272,846	0	272,846	0	272,846
46	4600	Speech Pathology	0	123,765	123,765	0	123,765	0	123,765
47	4700	Electrocardiology	0	0	0	0	0	0	0
48	4800	Medical Supplies Charged to Patients	0	28,169	28,169	33,000	61,169	0	61,169
49	4900	Drugs Charged to Patients	0	202,858	202,858	(33,000)	169,858	0	169,858
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: 31-5209			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)	5,434,338	20,237,148	25,671,486	0	25,671,486	(1,829,330)	23,842,156
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	2,295	2,295	0	2,295	0	2,295
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	5,434,338	20,239,443	25,673,781	0	25,673,781	(1,829,330)	23,844,451

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	INCREASE			DECREASE			
			COST CENTER	LINE NO.	SALARY	COST CENTER	LINE NO.	SALARY	NON-SALARY
			2	3	4	6	7	8	9
1									
2	RECLASS MED SUPP	B	Medical Supplies Charged to	48		Drugs Charged to Pat	49		33,000
3									
4									
5									
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71									
72									
### TOTAL RECLASSIFICATIONS			0		33,000	0		33,000	

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

		PROVIDER CCN:	PERIOD:	WORKSHEET A-7
		31-5209	FROM: 01/01/2024 TO: 12/31/2024	

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

ASSET BALANCES

Description		Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets
			Purchases	Donation	Total			
		1	2	3	4	5	6	7
1	Land				0		0	
2	Land Improvements				0		0	
3	Buildings and Fixtures				0		0	
4	Building Improvements	2,389,254	63,731		63,731		2,452,985	
5	Fixed Equipment				0		0	
6	Movable Equipment	2,180,330	179,051		179,051		2,359,381	
7	Subtotal (sum of lines 1-6)	4,569,584	242,782	0	242,782	0	4,812,366	0
8	Reconciling Items				0		0	
9	Total (line 7 minus line 8)	4,569,584	242,782	0	242,782	0	4,812,366	0

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5209	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	(53,515)	Administrative and General	4
2 Trade, quantity and time discounts on purchases (Chapter 8)				
3 Refunds and rebates of expenses (Chapter 8)				
4 Rental of provider space by suppliers (Chapter 8)				
5 Telephone services (pay stations excluded) (Chapter 21)				
6 Television and radio service (Chapter 21)				
7 Parking lot (Chapter 21)				
8 Remuneration applicable to provider-	//////////	//////////	//////////	//////////
based physician adjustment	A-8-2	0	//////////	//////////
9 Home office costs (Chapter 21)				
10 Sale of scrap, waste, etc. (Chapter 23)				
11 Nonallowable costs related to certain	//////////	//////////	//////////	//////////
Capital expenditures (Chapter 24)				
12 Adjustment resulting from transactions	//////////	//////////	//////////	//////////
with related organizations (Chapter 10)	A-8-1	(3,481)	//////////	//////////
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	(1,772,334)	Administrative and General	4
25.01				
25.02				
25.03				
25.04				
A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW)		0	//////////	//////////
100 TOTAL	//////////	(1,829,330)	//////////	//////////

ADJUSTMENTS TO EXPENSES	PROVIDER CCN	PERIOD:
	31-5209	FROM: 01/01/2024
		TO: 12/31/2024

WORKSHEET A-8

(1) DESCRIPTION	(2) BASIS* FOR ADJ	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
		AMOUNT	COST CENTER	LINE #

ADDITIONAL ADJUSTMENTS

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

SUBTOTAL OF ADDITIONAL ADJUSTMENTS 0

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN: 31-5209	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		4	Administrative and General	Software	170,589	174,070	(3,481)
2							0
3							0
4							0
5							0
6							0
7							0
8							0
9							0
9.01							0
9.02							0
9.03							0
9.04							0
9.05							0
9.06							0
9.07							0
9.08							0
9.09							0
9.10							0
10 TOTAL					170,589	174,070	(3,481)

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	Hammonton	100.00	BIS Funding Capital	100.00	Software
2							
3							
4							
5							
6							
7							
8							
9							
10							
10.01							
10.02							
10.03							
10.04							
10.05							

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 - B. Corporation, partnership or other organization has financial interest in provider.
 - C. Provider has financial interest in corporation, partnership, or other organization
 - D. Director, officer, administrator or key person of provider or organization.
 - E. Individual is director, officer, administrator or key person of provider and related organization.
 - F. Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider.
 - G. Other (financial or non-financial) specify

PROVIDER-BASED PHYSICIAN ADJUSTMENTS				PROVIDER CCN: 31-5209		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: 31-5209	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B PART I								PROVIDER CCN: 31-5209
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	3,253,217	3,253,217										
2	Capital-Related Costs - Movable Equipment	0	////////////////////	0									
3	Employee Benefits	1,458,604	0	0	1,458,604								
4	Administrative and General	3,851,699	0	0	85,941	3,937,640	3,937,640						
5	Plant Operation, Maintenance and Repairs	724,892	0	0	48,901	773,793	153,059	926,852					
6	Laundry and Linen Service	106,661	0	0	1,944	108,605	21,483	0	130,088				
7	Housekeeping	740,693	0	0	158,694	899,387	177,902	0	0	1,077,289			
8	Dietary	1,472,082	0	0	221,458	1,693,540	334,989	0	0	0	2,028,529		
9	Nursing Administration	1,519,803	0	0	400,039	1,919,842	379,752	0	0	0	0	2,299,594	
10	Central Services and Supply	210,643	0	0	15,041	225,684	44,641	0	0	0	0	0	
11	Pharmacy	0	0	0	0	0	0	0	0	0	0	0	
12	Medical Records and Library	22,396	0	0	4,319	26,715	5,284	0	0	0	0	0	
13	Social Service	132,148	0	0	35,411	167,559	33,144	0	0	0	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	366,825	0	0	82,582	449,407	88,895	0	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS													
30	Skilled Nursing Facility	8,805,046	3,253,217	0	392,226	12,450,489	2,462,751	926,852	130,088	1,077,289	2,028,529	2,299,594	
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	3,058	0	0	0	3,058	605	0	0	0	0	0	
41	Laboratory	38,105	0	0	0	38,105	7,537	0	0	0	0	0	
42	Intravenous Therapy	1,166	0	0	0	1,166	231	0	0	0	0	0	
43	Oxygen (Inhalation) Therapy	32,129	0	0	0	32,129	6,355	0	0	0	0	0	
44	Physical Therapy	475,351	0	0	12,048	487,399	96,409	0	0	0	0	0	
45	Occupational Therapy	272,846	0	0	0	272,846	53,970	0	0	0	0	0	
46	Speech Pathology	123,765	0	0	0	123,765	24,481	0	0	0	0	0	
47	Electrocardiology	0	0	0	0	0	0	0	0	0	0	0	
48	Medical Supplies Charged to Patients	61,169	0	0	0	61,169	12,099	0	0	0	0	0	
49	Drugs Charged to Patients	169,858	0	0	0	169,858	33,599	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: 31-5209	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B PART I						PROVIDER CCN: 31-5209	
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)	23,842,156	3,253,217	0	1,458,604	23,842,156	3,937,186	926,852	130,088	1,077,289	2,028,529	2,299,594
NON REIMBURSABLE COST CENTERS												
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	2,295	0	0	0	2,295	454	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	23,844,451	3,253,217	0	1,458,604	23,844,451	3,937,640	926,852	130,088	1,077,289	2,028,529	2,299,594

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	270,325								
11	Pharmacy	0	0							
12	Medical Records and Library	0	0	31,999						
13	Social Service	0	0	0	200,703					
14	Nursing and Allied Health Education Activities	0	0	0	0	0				
15	Other General Service Cost	0	0	0	0	0	538,302			
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Skilled Nursing Facility	270,325	0	31,999	200,703	0	538,302	22,416,921	0	22,416,921
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	3,663	0	3,663
41	Laboratory	0	0	0	0	0	0	45,642	0	45,642
42	Intravenous Therapy	0	0	0	0	0	0	1,397	0	1,397
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	38,484	0	38,484
44	Physical Therapy	0	0	0	0	0	0	583,808	0	583,808
45	Occupational Therapy	0	0	0	0	0	0	326,816	0	326,816
46	Speech Pathology	0	0	0	0	0	0	148,246	0	148,246
47	Electrocardiology	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	73,268	0	73,268
49	Drugs Charged to Patients	0	0	0	0	0	0	203,457	0	203,457
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)	270,325	0	31,999	200,703	0	538,302	23,841,702	0	23,841,702
NON REIMBURSABLE COST CENTERS										
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	0	0	0	0	0	0	2,749	0	2,749
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	270,325	0	31,999	200,703	0	538,302	23,844,451	0	23,844,451

ALLOCATION OF CAPITAL-RELATED COSTS		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		PROVIDER CCN: 31-5209	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		0	0	0	0	0				
5	Plant Operation, Maintenance and Repairs		0	0	0	0	0	0			
6	Laundry and Linen Service		0	0	0	0	0	0			
7	Housekeeping		0	0	0	0	0	0	0		
8	Dietary		0	0	0	0	0	0	0	0	
9	Nursing Administration		0	0	0	0	0	0	0	0	0
10	Central Services and Supply		0	0	0	0	0	0	0	0	0
11	Pharmacy		0	0	0	0	0	0	0	0	0
12	Medical Records and Library		0	0	0	0	0	0	0	0	0
13	Social Service		0	0	0	0	0	0	0	0	0
14	Nursing and Allied Health Education Activities		0	0	0	0	0	0	0	0	0
15	Other General Service Cost		0	0	0	0	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTER											
30	Skilled Nursing Facility		3,253,217	0	3,253,217	0	0	0	0	0	0
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	0	0	0
41	Laboratory		0	0	0	0	0	0	0	0	0
42	Intravenous Therapy		0	0	0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy		0	0	0	0	0	0	0	0	0
44	Physical Therapy		0	0	0	0	0	0	0	0	0
45	Occupational Therapy		0	0	0	0	0	0	0	0	0
46	Speech Pathology		0	0	0	0	0	0	0	0	0
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	0	0	0
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		PERIOD: FROM: 01/01/2024 TO: 12/31/2024		PROVIDER CCN: 31-5209	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	3,253,217	0	3,253,217	0	0	0	0	0	0	0
NON REIMBURSABLE COST CENTERS												
90	Gift, Flower, Coffee Shop & Canteen		0	0	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop		0	0	0	0	0	0	0	0	0	0
92	Physicians' Private Offices		0	0	0	0	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	3,253,217	0	3,253,217	0	0	0	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS			PROVIDER CCN: 31-5209		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	0							
11	Pharmacy	0	0						
12	Medical Records and Library	0	0	0					
13	Social Service	0	0	0	0				
14	Nursing and Allied Health Education Activities	0	0	0	0	0			
15	Other General Service Cost	0	0	0	0	0	0		
INPATIENT ROUTINE SERVICE COST CENTER									
30	Skilled Nursing Facility	0	0	0	0	0	3,253,217	0	3,253,217
31	Nursing Facility	0	0	0	0	0	0	0	0
32	ICF/IID	0	0	0	0	0	0	0	0
33	Other Long Term Care	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS									
40	Radiology	0	0	0	0	0	0	0	0
41	Laboratory	0	0	0	0	0	0	0	0
42	Intravenous Therapy	0	0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	0	0
44	Physical Therapy	0	0	0	0	0	0	0	0
45	Occupational Therapy	0	0	0	0	0	0	0	0
46	Speech Pathology	0	0	0	0	0	0	0	0
47	Electrocardiology	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0
49	Drugs Charged to Patients	0	0	0	0	0	0	0	0
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS				PROVIDER CCN: 31-5209				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)	0	0	0	0	0	0	3,253,217	0	3,253,217	
NON REIMBURSABLE COST CENTERS											
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0	
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0	0	
92	Physicians' Private Offices	0	0	0	0	0	0	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	0	0	0	0	0	0	3,253,217	0	3,253,217	

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10					HAMMONTON CENTER FOR REHAB & HC					In Lieu of CMS Form 2540-10				
COST ALLOCATION STATISTICAL BASIS			PROVIDER CCN: 31-5209	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	////////	1,000	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////		
2	Capital-Related Costs - Movable Equipment	////////		0	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////		
3	Employee Benefits	////////		0	5,434,338	////////	////////	////////	////////	////////	////////	////////	////////	////////		
4	Administrative and General	////////		0	320,193	(3,937,640)	19,906,811	////////	////////	////////	////////	////////	////////	////////		
5	Plant Operation, Maintenance and Repairs	////////		0	182,191		773,793	1,000	////////	////////	////////	////////	////////	////////		
6	Laundry and Linen Service	////////		0	7,244		108,605	0	62,444	////////	////////	////////	////////	////////		
7	Housekeeping	////////		0	591,248		899,387	0		1,000	////////	////////	////////	////////		
8	Dietary	////////		0	825,088		1,693,540	0		0	187,332	////////	////////	////////		
9	Nursing Administration	////////		0	1,490,430		1,919,842	0		0		62,444	////////	////////		
10	Central Services and Supply	////////		0	56,038		225,684	0		0				62,444		
11	Pharmacy	////////		0	0		0	0		0						
12	Medical Records and Library	////////		0	16,090		26,715	0		0						
13	Social Service	////////		0	131,931		167,559	0		0						
14	Nursing and Allied Health Education Activities	////////		0	0		0	0		0						
15	Other General Service Cost	////////		0	307,676		449,407	0		0						
INPATIENT ROUTINE SERVICE COST CENTERS			////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////		
30	Skilled Nursing Facility	////////	1,000	0	1,461,322		12,450,489	1,000	62,444	1,000	187,332	62,444		62,444		
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		3,058	0		0						
41	Laboratory	////////		0	0		38,105	0		0						
42	Intravenous Therapy	////////		0	0		1,166	0		0						
43	Oxygen (Inhalation) Therapy	////////		0	0		32,129	0		0						
44	Physical Therapy	////////		0	44,887		487,399	0		0						
45	Occupational Therapy	////////		0	0		272,846	0		0						
46	Speech Pathology	////////		0	0		123,765	0		0						
47	Electrocardiology	////////		0	0		0	0		0						
48	Medical Supplies Charged to Patients	////////		0	0		61,169	0		0						
49	Drugs Charged to Patients	////////		0	0		169,858	0		0						
50	Dental Care - Title XIX only	////////		0	0		0	0		0						
51	Support Surfaces	////////		0	0		0	0		0						
52	Other Ancillary Service Cost Center	////////		0	0		0	0		0						
52.01	Other Ancillary Service Cost Center II	////////		0	0		0	0		0						
52.02	Other Ancillary Service Cost Center III	////////		0	0		0	0		0						
OUTPATIENT SERVICE COST CENTERS			////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////		

COST ALLOCATION STATISTICAL BASIS			PROVIDER CCN: 31-5209	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)	////////	1,000	0	5,434,338	(3,937,640)	19,904,516	1,000	62,444	1,000	187,332	62,444	62,444	
NON REIMBURSABLE COST CENTERS		////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	////////	
90	Gift, Flower, Coffee Shop & Canteen	////////		0	0		0	0		0				
91	Barber and Beauty Shop	////////		0	0		0	0		0				
92	Physicians' Private Offices	////////		0	0		2,295	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)	////////	3,253,217	0	1,458,604	////////	3,937,640	926,852	130,088	1,077,289	2,028,529	2,299,594	270,325	
103	Unit Cost Multiplier (Worksheet B, Part I)	////////	3253.217000	0.000000	0.268405	////////	0.197804	926.852000	2.083275	1077.289000	10.828524	36.826501	4.329079	
104	Cost to Be Allocated (Per Worksheet B, Part II)	////////	////////	////////	0	////////	0	0	0	0	0	0	0	
105	Unit Cost Multiplier (Worksheet B, Part II)	////////	////////	////////	0.000000	////////	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	

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

COST ALLOCATION STATISTICAL BASIS			PROVIDER CCN: 31-5209	PERIOD: FROM: 01/01/2024 TO: 12/31/2024		WORKSHEET B-1 (cont.)				
COST CENTER			PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
			11	12	13	14	15	16	17	18
GENERAL SERVICE COST CENTERS										
1	Capital-Related Costs - Building & Fixture									
2	Capital-Related Costs - Movable Equipment									
3	Employee Benefits									
4	Administrative and General									
5	Plant Operation, Maintenance and Repairs									
6	Laundry and Linen Service									
7	Housekeeping									
8	Dietary									
9	Nursing Administration									
10	Central Services and Supply									
11	Pharmacy	0								
12	Medical Records and Library		62,444							
13	Social Service			62,444						
14	Nursing and Allied Health Education Activities				0					
15	Other General Service Cost					62,444				
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Skilled Nursing Facility	0	62,444	62,444		62,444				
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: 31-5209	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET B-1 (cont.)				
COST CENTER		PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		11	12	13	14	15	16	17	18
60	Clinic						////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
61	Rural Health Clinic								
62	FQHC								
63	Other Outpatient Service Cost						////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
OTHER REIMBURSABLE COST CENTERS		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
70	Home Health Agency Cost	0	0	0		0	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
71	Ambulance						////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
72	Outpatient Rehabilitation						////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
73	CMHC								
74	Other Reimbursable Cost						////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
SPECIAL PURPOSE COST CENTERS		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
83	Hospice								
84	Other Special Purpose Cost I						////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
84.01	Other Special Purpose Cost II								
89	SUBTOTALS (sum of lines 1 through 84)	0	62,444	62,444	0	62,444	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
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	31,999	200,703	0	538,302	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
103	Unit Cost Multiplier (Worksheet B, Part I)	0.000000	0.512443	3.214128	0.000000	8.620556	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
104	Cost to Be Allocated (Per Worksheet B, Part II)	0	0	0	0	0	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
105	Unit Cost Multiplier (Worksheet B, Part II)	0.000000	0.000000	0.000000	0.000000	0.000000	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN: 31-5209	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-
			-3-	-4-

1					
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50					

0

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN: 31-5209	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET C
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Cost Center	TOTAL (From Wkst B, Pt. I, Col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)
	1	2	3

ANCILLARY SERVICE COST CENTERS:

40	Radiology	3,663	3,058	1.197842
41	Laboratory	45,642	66,274	0.688686
42	Intravenous Therapy	1,397	1,166	1.198113
43	Oxygen (Inhalation) Therapy	38,484	32,129	1.197796
44	Physical Therapy	583,808	430,464	1.356230
45	Occupational Therapy	326,816	339,863	0.961611
46	Speech Pathology	148,246	288,158	0.514461
47	Electrocardiology	0	0	0.000000
48	Medical Supplies Charged	73,268	33,000	2.220242
49	Drugs Charged to Patients	203,457	174,737	1.164361
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	1,424,781	1,368,849	////////////////////

MED-CALC SYSTEMS			In Lieu of CMS Form 2540-10					
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST			PROVIDER CCN 31-5209	PERIOD : FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET D			
Check <input type="checkbox"/> Title V (1) Check One: <input checked="" type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> Other One: <input checked="" type="checkbox"/> Title XVIII <input type="checkbox"/> PPS - Must also complete Part II <input type="checkbox"/> Title XIX (1)								
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST			RATIO OF COST TO CHARGES		HEALTH CARE PROGRAM CHARGES		HEALTH CARE PROGRAM COST	
			(WS C, col 3)	PART A	PART B	PART A	PART B	
			1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS:								
40	Radiology	1.197842	0		0	0		
41	Laboratory	0.688686	0		0	0		
42	Intravenous Therapy	1.198113	0		0	0		
43	Oxygen (Inhalation) Therapy	1.197796	0		0	0		
44	Physical Therapy	1.356230	111,652		151,426	0		
45	Occupational Therapy	0.961611	117,064		112,570	0		
46	Speech Pathology	0.514461	80,095		41,206	0		
47	Electrocardiology	0.000000	0		0	0		
48	Medical Supplies Charged	2.220242	0		0	0		
49	Drugs Charged to Patients	1.164361	0		0	0		
50	Dental Care - Title XIX only	0.000000	////////////////	////////////////	0	////////////////		
51	Support Surfaces	0.000000	0		0	0		
52	Other Ancillary Service Cost Center	0.000000	0		0	0		
52.01	Other Ancillary Service Cost Center II	0.000000	0		0	0		
52.02	Other Ancillary Service Cost Center III	0.000000	0		0	0		
OUTPATIENT SERVICE COST CENTERS								
60	Clinic	0.000000	0		0	0		
61	Rural Health Clinic	0.000000			0	0		
62	FQHC	0.000000			0	0		
63	Other Outpatient Service Cost	0.000000	0		0	0		
71	Ambulance	0.000000	////////////////	////////////////				
	(2)							
100	Total (Sum of lines 40 - 71)		308,811	0	305,202	0		
(1) For titles V and XIX use columns 1, 2 and 4 only. (2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.								

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10	
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST		PROVIDER CCN 31-5209	PERIOD : FROM: 01/01/2024 TO: 12/31/2024
Check <input type="checkbox"/> Title V (1) Check One: <input checked="" type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> Other One: <input checked="" type="checkbox"/> Title XVIII <input type="checkbox"/> PPS - Must also complete Part II <input type="checkbox"/> Title XIX (1)			
PART II - APPORTIONMENT OF VACCINE COST			
1	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		1.164361
2	Program vaccine charges (From your records, or the P S & R.) --->		4,879
3	Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)		5,681

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 & Allied Health Costs f Pass Through (Col. 3 X Col.. 1)
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS		////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
40	Radiology	3,663	0	0.000000	0	0
41	Laboratory	45,642	0	0.000000	0	0
42	Intravenous Therapy	1,397	0	0.000000	0	0
43	Oxygen (Inhalation) Therapy	38,484	0	0.000000	0	0
44	Physical Therapy	583,808	0	0.000000	151,426	0
45	Occupational Therapy	326,816	0	0.000000	112,570	0
46	Speech Pathology	148,246	0	0.000000	41,206	0
47	Electro cardiology	0	0	0.000000	0	0
48	Medical Supplies	73,268	0	0.000000	0	0
49	Drugs Charged to Patients	203,457	0	0.000000	0	0
50	Dental Care - Title XIX only	0	0	0.000000	0	0
51	Support Surfaces	0	0	0.000000	0	0
52	Other Ancillary Service Cost Center	0	0	0.000000	0	0
52.01	Other Ancillary Service Cost Center II	0	0	0.000000	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0.000000	0	0
100	Total (Sum of lines 40 - 52)	1,424,781	0	////////////////////////////////////	305,202	0

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST		PROVIDER CCN 31-5209	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	PART A	PART B
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS:		////////////////////////////////	////////////////////////////////	////////////////////////////////	////////////////////////////////	////////////////////////////////
40	Radiology	1.197842		////////////////////////////////	0	////////////////////////////////
41	Laboratory	0.688686		////////////////////////////////	0	////////////////////////////////
42	Intravenous Therapy	1.198113		////////////////////////////////	0	////////////////////////////////
43	Oxygen (Inhalation) Therapy	1.197796		////////////////////////////////	0	////////////////////////////////
44	Physical Therapy	1.356230		////////////////////////////////	0	////////////////////////////////
45	Occupational Therapy	0.961611		////////////////////////////////	0	////////////////////////////////
46	Speech Pathology	0.514461		////////////////////////////////	0	////////////////////////////////
47	Electro cardiology	0.000000		////////////////////////////////	0	////////////////////////////////
48	Medical Supplies Charged	2.220242		////////////////////////////////	0	////////////////////////////////
49	Drugs Charged to Patients	1.164361		////////////////////////////////	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
	31-5209	FROM: 01/01/2024 TO: 12/31/2024	
Check One:	<input type="checkbox"/> Title V <input checked="" type="checkbox"/> Title XVI <input type="checkbox"/> Title XIX		
Check One:	<input checked="" type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF/IID		

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	62,444
2	Private room days	
3	Inpatient days including private room days applicable to the Program	3,418
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	22,416,921

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	20,379,297
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	1.099985
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)	22,416,921

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	358.99
17	Program routine service cost (Line 3 times line 16)	1,227,028
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)	1,227,028
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)	3,253,217
21	Per diem capital related costs (Line 20 divided by line 1)	52.10
22	Program capital related cost (Line 3 times line 21)	178,078
23	Inpatient routine service cost (Line 19 minus line 22)	1,048,950
24	Aggregate charges to beneficiaries for excess costs (From provider records)	
25	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	1,048,950
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	62,444
2	Program inpatient days. (see instructions)	3,418
3	Total Nursing & Allied Health costs. (see instructions)	0
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	0.054737
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
	31-5209	FROM: 01/01/2024 TO: 12/31/2024	
	Check One: <input type="checkbox"/> Title XVIII	<input checked="" type="checkbox"/> Title XIX	
	Check One: <input checked="" type="checkbox"/> NF	<input type="checkbox"/> ICF/IID	

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.000000
8	Enter private room charges from your records	
9	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00
10	Enter semi-private room charges from your records	
11	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private 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 : 31-5209	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)	2,513,333
2	Nursing and Allied Health Education Activities (pass through payments)	0
3	Subtotal (Sum of lines 1 and 2)	2,513,333
4	Primary payor amounts (0)
5	Coinsurance (468,180)
6	Allowable bad debts (from your records)	187,947
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	
8	Adjusted reimbursable bad debts. (See instructions)	122,166
9	Recovery of bad debts - for statistical records only	
10	Utilization review	0
11	Subtotal (See instructions)	2,167,319
12	Interim payments (See instructions)	2,098,013
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)	2,443
14.99	Sequestration amount (see instructions)	40,903
15	Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14)	25,960
	(Indicate overpayment in parentheses) (See Instructions)	
16	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	

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

17	Ancillary services Part B	0
18	Vaccine cost (From Wkst D, Part II, line 3)	5,681
19	Total reasonable costs (Sum of lines 17 and 18)	5,681
20	Medicare Part B ancillary charges (See instructions)	4,879
21	Cost of covered services (Lesser of line 19 or line 20)	4,879
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)	4,879
26	Interim payments (See instructions)	2,869
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)	98
29	Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28)	1,912
	(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: 31-5209	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	////////////////////	2,004,250	////////////////////	2,869
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.	////////////////////	148,783	////////////////////	
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			
		.02			
		.03			
		.04			
		.05			
	Provider to Program *	.50	06/13/24	55,020	
		.51			
		.52			
		.53			
		.54			
	SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)	.99	////////////////////	(55,020)	////////////////////
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.)	////////////////////	2,098,013	////////////////////	2,869
		////////////////////		////////////////////	
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: 31-5209	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET E PART II TITLE XIX
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Check one:	<input type="checkbox"/> Title V	<input checked="" type="checkbox"/> Title XIX	
Check one:	<input type="checkbox"/> SNF	<input checked="" type="checkbox"/> NF	<input type="checkbox"/> 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: 31-5209	PERIOD: FROM: 01/01/2024 TO: 12/31/2024	WORKSHEET G	
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4

ASSETS

CURRENT ASSETS				
1	Cash on hand and in banks	1,253,619		
2	Temporary investments	0		
3	Notes receivable	0		
4	Accounts receivable	9,100,553		
5	Other receivables	0		
6	Less: allowances for uncollectible notes and A/R	0		
7	Inventory	0		
8	Prepaid expenses	93,846		
9	Other current assets	0		
10	Due from other funds	95,533		
11	TOTAL CURRENT ASSETS	10,543,551	0	0
	(Sum of lines 1 - 10)			

FIXED ASSETS				
12	Land	0		
13	Land improvements	0		
14	Less: Accumulated depreciation	0		
15	Buildings	0		
16	Less Accumulated depreciation	0		
17	Leasehold improvements	2,452,985		
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	2,359,381		
24	Less: Accumulated depreciation	(3,810,033)		
25	Minor equipment - Depreciable	0		
26	Minor equipment nondepreciable	0		
27	Other fixed assets	0		
28	TOTAL FIXED ASSETS	1,002,333	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	15,335,083		
33	TOTAL OTHER ASSETS	15,335,083	0	0
	(Sum of lines 29 - 32)			
34	TOTAL ASSETS	26,880,967	0	0
	(Sum of lines 11, 28 and 33)			

BALANCE SHEET	PROVIDER CCN: 31-5209	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	7,995,087			
36	Salaries, wages & fees payable	440,536			
37	Payroll taxes payable	543,936			
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	8,856,739			
43	TOTAL CURRENT LIABILITIES	17,836,298	0	0	0
	(Sum of lines 35 - 42)				

LONG TERM LIABILITIES

44	Mortgage payable	15,042,397			
45	Notes payable	544,181			
46	Unsecured loans	(1,117,012)			
47	Loans from owners:	0			
48	Other long term liabilities	0			
49	Other (Specify)	0			
50	TOTAL LONG TERM LIABILITIES	14,469,566	0	0	0
	(Sum of lines 44 - 49)				
51	TOTAL LIABILITIES	32,305,864	0	0	0
	(Sum of lines 43 and 50)				

CAPITAL ACCOUNTS

52	General fund balance	(5,424,897)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
53	Specific purpose fund		0		
54	Donor created - EFB restricted			0	
55	Donor created - EFB unrestricted			0	
56	Governing body created - EFB			0	
57	PFB - invested in plant				0
58	PFB - reserve for plant improvement				0
59	TOTAL FUND BALANCES	(5,424,897)	0	0	0
	(Sum of lines 52 thru 58)				
60	TOTAL LIABILITIES & FUND BALANCES	26,880,967	0	0	0
	(Sum of lines 51 and 59)				

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: 31-5209	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	////////////////////////////////////	90,152	////////////////////////////////////		////////////////////////////////////		////////////////////////////////////	
2	Net income (loss) (From Wkst. G-3, line 31)	////////////////////////////////////	(5,515,049)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
3	Total (Sum of line 1 and line 2)	////////////////////////////////////	(5,424,897)	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0
4	Additions (Credit adjustments)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
5			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
6			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
7			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
8			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
9			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
10	Total additions (Sum of lines 5 - 9)	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0
11	Subtotal (Line 3 plus line 10)	////////////////////////////////////	(5,424,897)	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0
12	Deductions (Debit adjustments)	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////	////////////////////////////////////
13			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
14			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
15			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
16			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
17			////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////
18	Total deductions (Sum of lines 13 - 17)	////////////////////////////////////	0		0	////////////////////////////////////	0	////////////////////////////////////	0
19	Fund balance at end of period per	////////////////////////////////////		////////////////////////////////////		////////////////////////////////////		////////////////////////////////////	
	balance sheet (Line 11 - line 18)	////////////////////////////////////	(5,424,897)	////////////////////////////////////	0	////////////////////////////////////	0	////////////////////////////////////	0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: 31-5209	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	20,379,297	////////////////////////////////////	20,379,297
2	Nursing facility	0	////////////////////////////////////	0
3	ICF-IID	0	////////////////////////////////////	0
4	Other long term care	0	////////////////////////////////////	0
5	Total general inpatient care services	20,379,297	////////////////////////////////////	20,379,297
	(Sum of lines 1 - 4)			

ALL OTHER CARE SERVICES				
6	Ancillary services	1,363,970	0	1,363,970
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)	21,743,267	0	21,743,267
	(Transfer column 3 to Worksheet G-3, Line 1)			

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 100)	////////////////////////////////////	25,673,781
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)	////////////////////////////////////	25,673,781

STATEMENT OF REVENUES & EXPENSES	PROVIDER CCN: 31-5209	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)	21,743,267
2	Less: contractual allowances and discounts on patients accounts (1,678,878)
3	Net patient revenues (Line 1 minus line 2)	20,064,389
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	25,673,781
5	Net income from service to patients (Line 3 minus 4)	(5,609,392)
////////	OTHER INCOME:	////////
6	Contributions, donations, bequests, etc	0
7	Income from investments	53,515
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	52
21	Rental of vending machines	0
22	Rental of skilled nursing space	0
23	Governmental appropriations	0
24	Prior Year Income	40,776
24.50	COVID-19 PHE Funding	0
25	Total other income (Sum of lines 6 - 24)	94,343
26	Total (Line 5 plus line 25)	(5,515,049)
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)	(5,515,049)