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

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

OMB NO. 0938-0463

Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	**PROVIDER CCN:** **31-5429**	**PERIOD:** **FROM: 06/01/2023** **TO: 05/31/2024**	**WORKSHEET S** **PARTS I II & III**

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — **Date:** 10/29/2024 — **Time:** 09:07:26 AM
2. [ ] Manually prepared cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report. 0
3.0.1 [ ] No Medicare Utilization Enter "Y" for yes or leave blank for no 0

Contractor use only:

4. [ ] Cost Report Status
   - [1] As Submitted:
   - [2] Settled without audit
   - [3] Settled with audit
   - [4] Reopened
   - [5] Amended
5. Date Received

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

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

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLOVER REST HOME #31-5429 for the cost reporting period beginning 06/01/2023 and ending 05/31/2024 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:
10/29/2024 09:07:26 AM
lGIQPSMPQDEc9O.oPuceUtWh9MOd80
UWzRP0mg.DwGtUsGLGmNdL9vRB4AD1
sDWJ0xBnHQ0WxihO

PRINT FILE ENCRYPTION:

DO NOT SIGN UNTIL ENCRYPTION APPEARS HERE

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

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX	
		1	2	3	4	
1	**SKILLED NURSING FACILITY**		9,430	229		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**		9,430	229	0	100

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

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

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

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10		
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET S-2 PART I

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	28 WASHINGTON ST.	P.O. Box:					1
2	City:	COLUMBIA	State:	NJ	Zip Code:	00783		2
3	County:	WARREN	CBSA Code:	10900	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	CLOVER REST HOME	31-5429	08/29/1997		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: 06/01/2023		TO: 05/31/2024			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	18,272	//////////	20
21	Declining Balance		//////////	21
22	Sum of the Year's Digits		//////////	22
23	Sum of line 20 through 22	18,272	//////////	23
24	If depreciation is funded, enter the balance as of the end of the period.			24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)		Y	25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)		N	26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies		N	27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports		N	28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: 31-5429	PERIOD FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET S-2 PART I (Cont.)

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

		Part A	Part B	Other	
29	Skilled Nursing Facility	N	N	////////////////	29
30	Nursing Facility	////////////////	////////////////		30
31	I C F / I I D	////////////////	////////////////		31
32	SNF-Based HHA			////////////////	32
33	SNF-Based RHC	////////////////		////////////////	33
34	SNF-Based FQHC	////////////////		////////////////	34
35	SNF-Based CMHC	////////////////	N	////////////////	35
36	SNF-Based OLTC	////////////////	////////////////	////////////////	36
				Y / N	
37	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients.			N	37
38	Are you legally-required to carry malpractice insurance?			Y	38
39	Is the malpractice a "claims-made:", or "occurrence" policy? If the policy is "claims-made" enter 1. If policy is "occurence", enter 2.			1	39

	////////////////////////////////	Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:	79,605			41

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

If this facility is part of a chain organization, enter the name and address of the home office on the lines below

45	Name:		Contractor name		Contractor Number		45
46	Street:		PO Box				46
47	City:		State:		Zip Code:		47

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET S-2 Part II

General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No
For all the dates responses the format will be (mm/dd/yyyy)

Completed by All Skilled Nursing Facilities

	Provider Organization and Operation	1 Y/N	2 Date		
1	Has the Provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N		//////////// ////////////	1

		1 Y/N	2 Date	3 V / I	
2	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y	////////////	////////////	3

	Financial Data and Reports	1 Y/N	2 Type	3 Date	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N	////////////	////////////	5

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

	Bad Debts	1 Y/N	
9	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.	Y	9
10	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.	N	10
11	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.	N	11

Bed Complement

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

	PS&R Data	1 Y/N Part A	2 Date Part A	3 Y/N Part B	4 Date Part B	
13	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4 .(see Instructions.)	Y	09/27/2024	Y	09/27/2024	13
14	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N		14
15	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N	////////////	N	////////////	15
16	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R information? If "Y", see Instructions.	N	////////////	N	////////////	16
17	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:_____	N	////////////	N	////////////	17
18	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N	////////////	N	////////////	18

COST REPORT PREPARER CONTACT INFORMATION

19	First name	Abi	Last name	Goldenberg	Title	Owner	19
20	Employer	Taz Reporting LLC					20
21	Phone number	7183386900		Email address	agoldenberg@mfandco.com		21

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

PROVIDER CCN: 31-5429

PERIOD: FROM: 06/01/2023 TO: 05/31/2024

WORKSHEET S-3 PART I

	Component		Number of Beds	Bed Days Available		Inpatient Days / Visits: Title V	Title XVIII	Title XIX	Other	Total
			1	2		3	4	5	6	7
1	Skilled Nursing Facility		33	12,078			6,079	2,939	2,516	11,534
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)		33	12,078			6,079	2,939	2,516	11,534

	Component	Discharges: Title V	Title XVIII	Title XIX	Other	Total	Average Length of Stay: Title V	Title XVIII	Title XIX	Total
		8	9	10	11	12	13	14	15	16
1	Skilled Nursing Facility		184	39	47	270		33.04	75.36	42.72
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)		184	39	47	270		33.04	75.36	42.72

	Component		Admissions: Title V	Title XVIII	Title XIX	Other	Total		Full Time Equivalent: Employees on Payroll	Nonpaid Workers
			17	18	19	20	21		22	23
1	Skilled Nursing Facility			184	59	25	268		48.78	
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)			184	59	25	268		48.78	0.00

SNF WAGE INDEX INFORMATION | **PROVIDER CCN:** 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | **WORKSHEET S-3 PARTS II & III**

	PART II DIRECT SALARIES	Amount Reported	Reclass.of Salaries from Wkst A-6	Adjusted Salaries	Paid Hrs Related to col.3	Average Hrly Wage	
		1	2	3	4	5	
1	Total salary (See Instructions)	2,535,175	0	2,535,175	101,453.95	24.99	1
2	Physician salaries-Part A			0		0.00	2
3	Physician salaries-Part B			0		0.00	3
4	Home office personnel			0		0.00	4
5	Sum of lines 2 thru 4	0	0	0	0.00	0.00	5
6	Revised wages (line 1 minus line 5)	2,535,175	0	2,535,175	101,453.95	24.99	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	2,535,175	0	2,535,175	101,453.95	24.99	13
	OTHER WAGES AND RELATED COSTS	////////////	////////////	////////////	////////////	////////////	
14	Contract Labor: Patient Related & Mgmt	48,791		48,791	309.00	157.90	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)	375,751		375,751	////////////	////////////	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 instructior	375,751	0	375,751	////////////	////////////	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	67,506	0	67,506	2,367.23	28.52	2
3	Plant Operation, Maintenance & Repairs	85,545	0	85,545	2,851.19	30.00	3
4	Laundry & Linen Service	1,024	0	1,024	72.50	14.12	4
5	Housekeeping	150,588	0	150,588	10,157.48	14.83	5
6	Dietary	0	0	0		0.00	6
7	Nursing Administration	104,047	0	104,047	2,389.17	43.55	7
8	Central Services and Supply	0	0	0		0.00	8
9	Pharmacy	0	0	0		0.00	9
10	Medical Records & Medical Records Library	0	0	0		0.00	10
11	Social Service	68,396	0	68,396	66.01	1,036.15	11
12	Nursing and Allied Health Education Activities	////////////	////////////	////////////	////////////	////////////	12
13	Other General Service Cost	104,871	0	104,871	3,064.52	34.22	13
14	Total (sum lines 1 thru 13)	581,977	0	581,977	20,968.10	**27.76**	14

SNF WAGE RELATED COSTS	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET S-3 PART IV

PART IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost	3,182	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)	49,720	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	70,411	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	201,230	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	51,208	20
	OTHER		
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 -23)	375,751	24

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

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

SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET S-3 PART V

	Occupational Category	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)	
		1	2	3	4	5	
	Direct Salaries	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	//////
	Nursing Occupations	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	//////
1	Registered Nurses (RNs)	199,418	29,557	228,975	4,450.09	51.45	1
2	Licensed Practical Nurses (LPNs)	605,516	89,747	695,263	15,233.22	45.64	2
3	Certified Nursing Assistants/Nursing Assistants/Aides	740,008	109,680	849,688	53,174.09	15.98	3
4	Total Nursing (sum of lines 1 through 3)	1,544,942	228,984	1,773,926	72,857.40	24.35	4
5	Physical Therapists	134,659	19,958	154,617	2,791.87	55.38	5
6	Physical Therapy Assistants			-		0.00	6
7	Physical Therapy Aides			-		0.00	7
8	Occupational Therapists	159,780	23,682	183,462	4,660.58	39.36	8
9	Occupational Therapy Assistants			-		0.00	9
10	Occupational Therapy Aides			-		0.00	10
11	Speech Therapists	113,818	16,870	130,688	176.00	742.55	11
12	Respiratory Therapists			-		0.00	12
13	Other Medical Staff			-		0.00	13
	Contract Labor	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	/
	Nursing Occupations	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	/
14	Registered Nurses (RNs)		////////////////////////	-		0.00	14
15	Licensed Practical Nurses (LPNs)		////////////////////////	-		0.00	15
16	Certified Nursing Assistants/Nursing Assistants/Aides	8,980	////////////////////////	8,980	309.00	29.06	16
17	Total Nursing (sum of lines 14 through 16)	8,980	////////////////////////	8,980	309.00	29.06	17
18	Physical Therapists		////////////////////////	-		0.00	18
19	Physical Therapy Assistants		////////////////////////	-		0.00	19
20	Physical Therapy Aides		////////////////////////	-		0.00	20
21	Occupational Therapists		////////////////////////	-		0.00	21
22	Occupational Therapy Assistants		////////////////////////	-		0.00	22
23	Occupational Therapy Aides		////////////////////////	-		0.00	23
24	Speech Therapists		////////////////////////	-		0.00	24
25	Respiratory Therapists		////////////////////////	-		0.00	25
26	Other Medical Staff		////////////////////////	-		0.00	26

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | 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		454,637	**454,637**	0	**454,637**	(348,089)	**106,548**
2	0200	Capital-Related Costs - Movable Equipment		0	**0**	0	**0**	0	**0**
3	0300	Employee Benefits	0	375,752	**375,752**	0	**375,752**	0	**375,752**
4	0400	Administrative and General	67,506	915,704	**983,210**	0	**983,210**	(172,325)	**810,885**
5	0500	Plant Operation, Maintenance and Repairs	85,545	124,615	**210,160**	0	**210,160**	0	**210,160**
6	0600	Laundry and Linen Service	1,024	36,373	**37,397**	0	**37,397**	0	**37,397**
7	0700	Housekeeping	150,588	19,006	**169,594**	0	**169,594**	0	**169,594**
8	0800	Dietary	0	445,130	**445,130**	0	**445,130**	0	**445,130**
9	0900	Nursing Administration	104,047	0	**104,047**	0	**104,047**	0	**104,047**
10	1000	Central Services and Supply	0	67,983	**67,983**	0	**67,983**	0	**67,983**
11	1100	Pharmacy	0	0	**0**	0	**0**	0	**0**
12	1200	Medical Records and Library	0	0	**0**	0	**0**	0	**0**
13	1300	Social Service	68,396	21,070	**89,466**	0	**89,466**	0	**89,466**
14	1400	Nursing and Allied Health Education Activities	0	0	**0**	0	**0**	0	**0**
15	1500	Other General Service Cost	104,871	26,345	**131,216**	0	**131,216**	0	**131,216**
INPATIENT ROUTINE SERVICE COST CENTERS									
30	3000	Skilled Nursing Facility	1,544,941	9,830	**1,554,771**	0	**1,554,771**	0	**1,554,771**
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	30,347	**30,347**	0	**30,347**	0	**30,347**
41	4100	Laboratory	0	39,833	**39,833**	0	**39,833**	0	**39,833**
42	4200	Intravenous Therapy	0	0	**0**	0	**0**	0	**0**
43	4300	Oxygen (Inhalation) Therapy	0	0	**0**	0	**0**	0	**0**
44	4400	Physical Therapy	134,659	39,811	**174,470**	0	**174,470**	0	**174,470**
45	4500	Occupational Therapy	159,780	0	**159,780**	0	**159,780**	0	**159,780**
46	4600	Speech Pathology	113,818	0	**113,818**	0	**113,818**	0	**113,818**
47	4700	Electrocardiology	0	0	**0**	0	**0**	0	**0**
48	4800	Medical Supplies Charged to Patients	0	0	**0**	300	**300**	0	**300**
49	4900	Drugs Charged to Patients	0	286,406	**286,406**	(300)	**286,106**	0	**286,106**
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: 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | WORKSHEET A

		COST CENTER (Omit Cents)	SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASSI-FICATIONS Increase/Decrease (Fr Wkst A-6)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (Fr Wkst A-8)	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6)
A	B	C	1	2	3	4	5	6	7
52.01	5201	Other Ancillary Service Cost Center II	0	0	**0**	0	**0**	0	**0**
52.02	5202	Other Ancillary Service Cost Center III	0	0	**0**	0	**0**	0	**0**
OUTPATIENT SERVICE COST CENTERS			////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
60	6000	Clinic	0	0	**0**	0	**0**	0	**0**
61	6100	Rural Health Clinic	0	0	**0**	0	**0**	0	**0**
62	6200	FQHC	0	0	**0**	0	**0**	0	**0**
63	6300	Other Outpatient Service Cost	0	0	**0**	0	**0**	0	**0**
OTHER REIMBURSABLE COST CENTERS			////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
70	7000	Home Health Agency Cost	0	0	**0**	0	**0**	0	**0**
71	7100	Ambulance	0	0	**0**	0	**0**	0	**0**
72	7200	Outpatient Rehabilitation	0	0	**0**	0	**0**	0	**0**
73	7300	CMHC	0	0	**0**	0	**0**	0	**0**
74	7400	Other Reimbursable Cost	0	0	**0**	0	**0**	0	**0**
SPECIAL PURPOSE COST CENTERS			////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
80	8000	Malpractice Premiums & Paid Losses	////////////////////////	0	**0**	0	**0**	0	**-0-**
81	8100	Interest Expense	////////////////////////	0	**0**	0	**0**	0	**-0-**
82	8200	Utilization Review -- SNF	0	0	**0**	0	**0**	0	**-0-**
83	8300	Hospice	0	0	**0**	0	**0**	0	**0**
84	8400	Other Special Purpose Cost I	0	0	**0**	0	**0**	0	**0**
84.01	8401	Other Special Purpose Cost II	0	0	**0**	0	**0**	0	**0**
89		SUBTOTALS (sum of lines 1 through 84)	2,535,175	2,892,842	**5,428,017**	0	**5,428,017**	(520,414)	**4,907,603**
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	46,976	**46,976**	0	**46,976**	0	**46,976**
93	9300	Nonpaid Workers	0	0	**0**	0	**0**	0	**0**
94	9400	Patients Laundry	0	0	**0**	0	**0**	0	**0**
95	9500	Other Nonreimbursable Cost	0	0	**0**	0	**0**	0	**0**
100		TOTAL	**2,535,175**	**2,939,818**	**5,474,993**	**0**	**5,474,993**	**(520,414)**	**4,954,579**

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

RECLASSIFICATIONS | PROVIDER CCN: 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | WORKSHEET A-6

		INCREASE				DECREASE			
	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	COST CENTER	LINE NO.	SALARY	NON-SALARY	COST CENTER	LINE NO.	SALARY	NON-SALARY
		1	2	3	4	5	6	7	8	9
1										
2	Reclass Med Supp	B	Medical Supplies Charged to	48		300	Drugs Charged to Pati	49		300
3										
4										
5										
6										
7										
8										
9										
10										
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68										
69										
70										
71										
72										
100	**TOTAL RECLASSIFICATIONS**	//////////	//////////////////////////////////////	//////////	0	300	//////////////////////////////	//////////	0	300

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

	PROVIDER CCN:	PERIOD:	
		FROM: 06/01/2023	WORKSHEET A-7
	31-5429	TO: 05/31/2024	

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		115,000		**115,000**		**115,000**	
5	Fixed Equipment				**0**		**0**	
6	Movable Equipment	48,750	26,250		**26,250**		**75,000**	
7	Subtotal (sum of lines 1-6)	**48,750**	**141,250**	**0**	**141,250**	**0**	**190,000**	0
8	Reconciling Items				**0**		**0**	
9	Total (line 7 minus line 8)	48,750	141,250	0	141,250	0	190,000	0

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024

WORKSHEET A-8

	(1) DESCRIPTION	(2) BASIS* FOR ADJ	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
			AMOUNT	COST CENTER	LINE #
1	Investment income on restricted funds (Chapter 2)	B	(203)	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)	B	(11,814)	Capital-Related Costs - Building & Fixture	1
5	Telephone services (pay stations excluded) (Chapter 21)				
6	Television and radio service (Chapter 21)				
7	Parking lot (Chapter 21)				
8	Remuneration applicable to provider-	////////////	////////////	////////////	////////////
	based physician adjustment	A-8-2	0	////////////	////////////
9	Home office costs (Chapter 21)				
10	Sale of scrap, waste, etc. (Chapter23)				
11	Nonallowable costs related to certain	////////////	////////////	////////////	////////////
	Capital expenditures (Chapter 24)				
12	Adjustment resulting from transactions	////////////	////////////	////////////	////////////
	with related organizations (Chapter 10)	A-8-1	(336,275)	////////////	////////////
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	(172,122)	Administrative and General	4
25.01					
25.02					
25.03					
25.04					
	A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW)	////////////	0	////////////	////////////
100	TOTAL	////////////	(520,414)	////////////	////////////

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024

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: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	**WORKSHEET A-8-1**

PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

		Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A. , col. 5	Adjustments (Col 4 minus Col 5)
		1	2	3	4	5	6
1		1	Capital-Related Costs - Building	Rent	0	418,071	(418,071)
2		1	Capital-Related Costs - Building	Interest	56,299		56,299
3		1	Capital-Related Costs - Building	Depreciation	25,497		25,497
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					81,796	418,071	(336,275)

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

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

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

	Description	(1) Symbol	Name	Percentage of Ownership	Related Organization(s) Name	Related Organization(s) Percentage of Ownership	Related Organization(s) Type of Business
		1	2	3	4	5	6
1		A	Clover Rest Hm	100.00	Columbia Care	100.00	Realty
2							
3							
4							
5							
6							
7							
8							
9							
10							
10.01							
10.02							
10.03							
10.04							
10.05							

(1) Use the following symbols to indicate interrelationship to related organizations:

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS | PROVIDER CCN: 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | **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: 31-5429

PERIOD:
FROM: 06/01/2023
TO: 05/31/2024

WORKSHEET B
PART I

	COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	OTHER ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY
		0	1	2	3	3a	4.00	5	6	7	8
GENERAL SERVICE COST CENTERS											
1	Capital-Related Costs - Building & Fixture	106,548	106,548								
2	Capital-Related Costs - Movable Equipment	0	//////////////////////	0							
3	Employee Benefits	375,752	0	0	375,752						
4	Administrative and General	810,885	0	0	10,005	820,890	820,890				
5	Plant Operation, Maintenance and Repairs	210,160	0	0	12,679	222,839	44,252	267,091			
6	Laundry and Linen Service	37,397	0	0	152	37,549	7,457	0	45,006		
7	Housekeeping	169,594	0	0	22,319	191,913	38,111	0	0	230,024	
8	Dietary	445,130	0	0	0	445,130	88,396	0	0	0	533,526
9	Nursing Administration	104,047	0	0	15,421	119,468	23,725	0	0	0	0
10	Central Services and Supply	67,983	0	0	0	67,983	13,500	0	0	0	0
11	Pharmacy	0	0	0	0	0	0	0	0	0	0
12	Medical Records and Library	0	0	0	0	0	0	0	0	0	0
13	Social Service	89,466	0	0	10,137	99,603	19,780	0	0	0	0
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0	0	0
15	Other General Service Cost	131,216	0	0	15,543	146,759	29,144	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Skilled Nursing Facility	1,554,771	106,548	0	228,986	1,890,305	375,388	267,091	45,006	230,024	533,526
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	30,347	0	0	0	30,347	6,026	0	0	0	0
41	Laboratory	39,833	0	0	0	39,833	7,910	0	0	0	0
42	Intravenous Therapy	0	0	0	0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	0	0	0	0
44	Physical Therapy	174,470	0	0	19,958	194,428	38,610	0	0	0	0
45	Occupational Therapy	159,780	0	0	23,682	183,462	36,433	0	0	0	0
46	Speech Pathology	113,818	0	0	16,870	130,688	25,953	0	0	0	0
47	Electrocardiology	0	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	300	0	0	0	300	60	0	0	0	0
49	Drugs Charged to Patients	286,106	0	0	0	286,106	56,816	0	0	0	0
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0	0	0

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5429

PERIOD:
FROM: 06/01/2023
TO: 05/31/2024

WORKSHEET B
PART I

	COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	OTHER ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY
		0	1	2	3	3a	4.00	5	6	7	8
52.01	Other Ancillary Service Cost Center II	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
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)	4,907,603	106,548	0	375,752	4,907,603	811,561	267,091	45,006	230,024	533,526
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	46,976	0	0	0	46,976	9,329	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
100	TOTAL	4,954,579	106,548	0	375,752	4,954,579	820,890	267,091	45,006	230,024	533,526

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5429

PERIOD:
FROM: 06/01/2023
TO: 05/31/2024

WORKSHEET B
PART I
(cont.)

	COST CENTER	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	OTHER GEN. SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		9	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	143,193									
10	Central Services and Supply	0	81,483								
11	Pharmacy	0	0	0							
12	Medical Records and Library	0	0	0	0						
13	Social Service	0	0	0	0	119,383					
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0				
15	Other General Service Cost	0	0	0	0	0	0	175,903			
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Skilled Nursing Facility	143,193	81,483	0	0	119,383	0	175,903	3,861,302	0	3,861,302
31	Nursing Facility	0	0	0	0	0	0	0	0	0	0
32	ICF/IID	0	0	0	0	0	0	0	0	0	0
33	Other Long Term Care	0	0	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS											
40	Radiology	0	0	0	0	0	0	0	36,373	0	36,373
41	Laboratory	0	0	0	0	0	0	0	47,743	0	47,743
42	Intravenous Therapy	0	0	0	0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	0	0	0	0
44	Physical Therapy	0	0	0	0	0	0	0	233,038	0	233,038
45	Occupational Therapy	0	0	0	0	0	0	0	219,895	0	219,895
46	Speech Pathology	0	0	0	0	0	0	0	156,641	0	156,641
47	Electrocardiology	0	0	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	360	0	360
49	Drugs Charged to Patients	0	0	0	0	0	0	0	342,922	0	342,922
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0	0	0

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5429

PERIOD:
FROM: 06/01/2023
TO: 05/31/2024

WORKSHEET B
PART I
(cont.)

	COST CENTER	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	OTHER GEN. SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		9	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	0
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									0		
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)	143,193	81,483	0	0	119,383	0	175,903	4,898,274	0	4,898,274
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	56,305	0	56,305
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
100	TOTAL	143,193	81,483	0	0	119,383	0	175,903	4,954,579	0	4,954,579

ALLOCATION OF CAPITAL-RELATED COSTS | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | PROVIDER CCN: 31-5429 | **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	DIE
		0	1	2	2a	3	4	5	6	7	
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	0		
7	Housekeeping		0	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	
10	Central Services and Supply		0	0	0	0	0	0	0	0	
11	Pharmacy		0	0	0	0	0	0	0	0	
12	Medical Records and Library		0	0	0	0	0	0	0	0	
13	Social Service		0	0	0	0	0	0	0	0	
14	Nursing and Allied Health Education Activities		0	0	0	0	0	0	0	0	
15	Other General Service Cost		0	0	0	0	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Skilled Nursing Facility		106,548	0	106,548	0	0	0	0	0	
31	Nursing Facility		0	0	0	0	0	0	0	0	
32	ICF/IID		0	0	0	0	0	0	0	0	
33	Other Long Term Care		0	0	0	0	0	0	0	0	
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 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | PROVIDER CCN: 31-5429 | **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	DIE
		0	1	2	2a	3	4	5	6	7	
52.02	Other Ancillary Service Cost Center III		0	0	0	0	0	0	0	0	
OUTPATIENT SERVICE COST CENTERS											
60	Clinic		0	0	0	0	0	0	0	0	
61	Rural Health Clinic		0	0	0	0	0	0	0	0	
62	FQHC		0	0	0	0	0	0	0	0	
63	Other Outpatient Service Cost		0	0	0	0	0	0	0	0	
OTHER REIMBURSABLE COST CENTERS											
70	Home Health Agency Cost		0	0	0	0	0	0	0	0	
71	Ambulance		0	0	0	0	0	0	0	0	
72	Outpatient Rehabilitation		0	0	0	0	0	0	0	0	
73	CMHC		0	0	0	0	0	0	0	0	
74	Other Reimbursable Cost		0	0	0	0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS											
83	Hospice		0	0	0	0	0	0	0	0	
84	Other Special Purpose Cost I		0	0	0	0	0	0	0	0	
84.01	Other Special Purpose Cost II		0	0	0	0	0	0	0	0	
89	SUBTOTALS (sum of lines 1 through 84)	0	106,548	0	106,548	0	0	0	0	0	
NON REIMBURSABLE COST CENTERS											
90	Gift, Flower, Coffee Shop & Canteen		0	0	0	0	0	0	0	0	
91	Barber and Beauty Shop		0	0	0	0	0	0	0	0	
92	Physicians' Private Offices		0	0	0	0	0	0	0	0	
93	Nonpaid Workers		0	0	0	0	0	0	0	0	
94	Patients Laundry		0	0	0	0	0	0	0	0	
95	Other Nonreimbursable Cost		0	0	0	0	0	0	0	0	
98	Cross Foot Adjustments		////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	//////////
99	Negative Cost Center		0	0	0	0	0	0	0	0	
100	TOTAL	0	106,548	0	106,548	0	0	0	0	0	

ALLOCATION OF CAPITAL-RELATED COSTS | PROVIDER CCN: 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | WORKSH PAF (cont.)

	COST CENTER	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	OTHER GEN. SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOT
		9	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	0									
10	Central Services and Supply	0	0								
11	Pharmacy	0	0	0							
12	Medical Records and Library	0	0	0	0						
13	Social Service	0	0	0	0	0					
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0				
15	Other General Service Cost	0	0	0	0	0	0	0			
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Skilled Nursing Facility	0	0	0	0	0	0	0	106,548	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 | PROVIDER CCN: 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | WORKSH PAF (cont.)

	COST CENTER	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH	OTHER GEN. SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOT
		9	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	0	106,548	0	
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	0	106,548	0	

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | 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)
	0	1	2	3	4.00a	4.00	5	6	7	8
GENERAL SERVICE COST CENTERS										
1	Capital-Related Costs - Building & Fixture		14,690							
2	Capital-Related Costs - Movable Equipment			0						
3	Employee Benefits			0	2,535,175					
4	Administrative and General			0	67,506	(820,890)	4,133,689			
5	Plant Operation, Maintenance and Repairs			0	85,545		222,839	14,690		
6	Laundry and Linen Service			0	1,024		37,549	0	11,534	
7	Housekeeping			0	150,588		191,913	0		14,690
8	Dietary			0	0		445,130	0		0
9	Nursing Administration			0	104,047		119,468	0		0
10	Central Services and Supply			0	0		67,983	0		0
11	Pharmacy			0	0		0	0		0
12	Medical Records and Library			0	0		0	0		0
13	Social Service			0	68,396		99,603	0		0
14	Nursing and Allied Health Education Activities			0	0		0	0		0
15	Other General Service Cost			0	104,871		146,759	0		0
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Skilled Nursing Facility		14,690	0	1,544,941		1,890,305	14,690	11,534	14,690	34,602
31	Nursing Facility			0	0		0	0	0	0	0
32	ICF/IID			0	0		0	0	0	0	0
33	Other Long Term Care			0	0		0	0	0	0	0
ANCILLARY SERVICE COST CENTERS										
40	Radiology			0	0		30,347	0		0	
41	Laboratory			0	0		39,833	0		0	
42	Intravenous Therapy			0	0		0	0		0	
43	Oxygen (Inhalation) Therapy			0	0		0	0		0	
44	Physical Therapy			0	134,659		194,428	0		0	
45	Occupational Therapy			0	159,780		183,462	0		0	
46	Speech Pathology			0	113,818		130,688	0		0	
47	Electrocardiology			0	0		0	0		0	
48	Medical Supplies Charged to Patients			0	0		300	0		0	
49	Drugs Charged to Patients			0	0		286,106	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: 31-5429 | PERIOD: FROM: 06/01/2023 TO: 05/31/2024 | 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)
		0	1	2	3	4.00a	4.00	5	6	7	8
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
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)	////////////	14,690	0	2,535,175	(820,890)	4,086,713	14,690	11,534	14,690	34,602
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		46,976	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)	////////////	106,548	0	375,752	////////////	820,890	267,091	45,006	230,024	533,526
103	Unit Cost Multiplier (Worksheet B, Part I)	////////////	7.253097	0.000000	0.148215	////////////	0.198585	18.181824	3.902029	15.658543	15.418935
104	Cost to Be Allocated (Per Worksheet B, Part II)	////////////	////////////	////////////	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

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

COST ALLOCATION
STATISTICAL BASIS

PROVIDER CCN: 31-5429

PERIOD: FROM: 06/01/2023 TO: 05/31/2024

WORKSHEET B-1 (cont.)

	COST CENTER	NURSING ADMIN. (PATIENT DAYS)	CENTRAL SVC & SUPP (PATIENT DAYS)	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		9	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	11,534									
10	Central Services and Supply		11,534								
11	Pharmacy			0							
12	Medical Records and Library				0						
13	Social Service					11,534					
14	Nursing and Allied Health Education Activities						0				
15	Other General Service Cost							11,534			
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Skilled Nursing Facility	11,534	11,534	0	0	11,534		11,534			
31	Nursing Facility	0	0	0	0	0		0			
32	ICF/IID	0	0	0	0	0		0			
33	Other Long Term Care	0	0	0	0	0		0			
ANCILLARY SERVICE COST CENTERS											
40	Radiology										
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: 31-5429

PERIOD: FROM: 06/01/2023 TO: 05/31/2024

WORKSHEET B-1 (cont.)

	COST CENTER	NURSING ADMIN. (PATIENT DAYS)	CENTRAL SVC & SUPP (PATIENT DAYS)	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL
		9	10	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	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)	11,534	11,534	0	0	11,534	0	11,534			
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)	143,193	81,483	0	0	119,383	0	175,903			
103	Unit Cost Multiplier (Worksheet B, Part I)	12.414860	7.064592	0.000000	0.000000	10.350529	0.000000	15.250824			
104	Cost to Be Allocated (Per Worksheet B, Part II)	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			

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN: 31-5429	PERIOD: **FROM: 06/01/2023 TO: 05/31/2024**	**WORKSHEET B-2**

	DESCRIPTION	WORKSHEET B PART NO. (1 or 2)	LINE NO.		AMOUNT
	-1-	-2-		-3-	-4-
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
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37					
38					
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
					0

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN: 31-5429	PERIOD : FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET C

	Cost Center	TOTAL (From Wkst B, Pt. I, Col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)
		1	2	3
ANCILLARY SERVICE COST CENTERS:				
40	Radiology	36,373	30,347	1.198570
41	Laboratory	47,743	40,819	1.169627
42	Intravenous Therapy	0	0	0.000000
43	Oxygen (Inhalation) Therapy	0	0	0.000000
44	Physical Therapy	233,038	394,884	0.590143
45	Occupational Therapy	219,895	538,269	0.408523
46	Speech Pathology	156,641	55,251	2.835080
47	Electrocardiology	0	0	0.000000
48	Medical Supplies Charged	360	607	0.593081
49	Drugs Charged to Patients	342,922	287,906	1.191090
50	Dental Care - Title XIX only	0	0	0.000000
51	Support Surfaces	0	0	0.000000
52	Other Ancillary Service Cost Center	0	0	0.000000
52.01	Other Ancillary Service Cost Center II	0	0	0.000000
52.02	Other Ancillary Service Cost Center III	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS				
60	Clinic	0	0	0.000000
61	Rural Health Clinic	00000000000000000	0000000000000000	0000000000000000
62	FQHC	00000000000000000	0000000000000000	0000000000000000
63	Other Outpatient Service Cost	0	0	0.000000
71	Ambulance	0	0	0.000000
100	TOTAL	1,036,972	1,348,083	////////////////////////////////

MED-CALC SYSTEMS			In Lieu of CMS Form 2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST			PROVIDER CCN 31-5429	PERIOD : FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET D	
Check One: [ ] Title V (1) [X] Title XVIII [ ] Title XIX (1)		Check One:	[X] SNF [ ] NF [ ] ICF/IID [ ] Other [ ] PPS - Must also complete Part II			
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST		RATIO OF COST TO CHARGES	HEALTH CARE PROGRAM CHARGES		HEALTH CARE PROGRAM COST	
		(WS C, col 3)	PART A	PART B	PART A	PART B
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS:						
40	Radiology	1.198570	24,151		28,947	0
41	Laboratory	1.169627	40,819		47,743	0
42	Intravenous Therapy	0.000000	0		0	0
43	Oxygen (Inhalation) Therapy	0.000000	0		0	0
44	Physical Therapy	0.590143	335,925		198,244	0
45	Occupational Therapy	0.408523	496,305		202,752	0
46	Speech Pathology	2.835080	46,080		130,640	0
47	Electrocardiology	0.000000	0		0	0
48	Medical Supplies Charged	0.593081	0		0	0
49	Drugs Charged to Patients	1.191090	217,558		259,131	0
50	Dental Care - Title XIX only	0.000000	////////////////////////	////////////////////////	0	////////////////
51	Support Surfaces	0.000000	0		0	0
52	Other Ancillary Service Cost Center	0.000000	0		0	0
52.01	Other Ancillary Service Cost Center II	0.000000	0		0	0
52.02	Other Ancillary Service Cost Center III	0.000000	0		0	0
OUTPATIENT SERVICE COST CENTERS						
60	Clinic	0.000000	0		0	0
61	Rural Health Clinic	0.000000			0	0
62	FQHC	0.000000			0	0
63	Other Outpatient Service Cost	0.000000	0		0	0
71	Ambulance	0.000000	////////////////////////	////////////////////////		
	(2)					
100	Total (Sum of lines 40 - 71)		1,160,838	0	867,457	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 31-5429	PERIOD : FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET D

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

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

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.191090
2	Program vaccine charges (From your records, or the P S & R.) --->	1,800
3	Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	2,144

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

		Total Cost (From Worksheet B, Part I, Col 18)	Nursing & Allied Health (From Wkst. B, Part I, Column 14)	Ratio of Nursing & Allied Health Costs To Total Costs - Part A (Col. 2 / Col.. 1)	Program Part A Cost (From Wkst. D. Part I, Col. 4)	Part A ursing & Allie ealth Costs f Pass Througl (Col. 3 X Col.
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	//////////////////
40	Radiology	36,373	0	0.000000	28,947	0
41	Laboratory	47,743	0	0.000000	47,743	0
42	Intravenous Therapy	0	0	0.000000	0	0
43	Oxygen (Inhalation) Therapy	0	0	0.000000	0	0
44	Physical Therapy	233,038	0	0.000000	198,244	0
45	Occupational Therapy	219,895	0	0.000000	202,752	0
46	Speech Pathology	156,641	0	0.000000	130,640	0
47	Electro cardiology	0	0	0.000000	0	0
48	Medical Supplies	360	0	0.000000	0	0
49	Drugs Charged to Patients	342,922	0	0.000000	259,131	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)	1,036,972	0	////////////////////////////	867,457	0

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10		
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN 31-5429	PERIOD : FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET D

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

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

[ ] SNF **[X] NF** [ ] ICF/IID [ ] Other

[ ] PPS - Must also complete Part II

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST		RATIO OF COST TO CHARGES	HEALTH CARE PROGRAM INPATIENT CHARGES		HEALTH CARE PROGRAM INPATIENT COST	
			PART A	PART B	PART A	PART B
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS:		////////////////////	////////////////////	////////////////////	////////////////////	////////////////////
40	Radiology	1.198570		////////////////////	0	////////////////////
41	Laboratory	1.169627		////////////////////	0	////////////////////
42	Intravenous Therapy	0.000000		////////////////////	0	////////////////////
43	Oxygen (Inhalation) Therapy	0.000000		////////////////////	0	////////////////////
44	Physical Therapy	0.590143		////////////////////	0	////////////////////
45	Occupational Therapy	0.408523		////////////////////	0	////////////////////
46	Speech Pathology	2.835080		////////////////////	0	////////////////////
47	Electro cardiology	0.000000		////////////////////	0	////////////////////
48	Medical Supplies Charged	0.593081		////////////////////	0	////////////////////
49	Drugs Charged to Patients	1.191090		////////////////////	0	////////////////////
50	Dental Care - Title XIX only	0.000000		////////////////////	0	////////////////////
51	Support Surfaces	0.000000		////////////////////	0	////////////////////
52	Other Ancillary Service Cost Center	0.000000		////////////////////	0	////////////////////
52.01	Other Ancillary Service Cost Center II	0.000000		////////////////////	0	////////////////////
52.02	Other Ancillary Service Cost Center III	0.000000		////////////////////	0	////////////////////
OUTPATIENT SERVICE COST CENTERS		////////////////////	////////////////////	////////////////////	////////////////////	////////////////////
60	Clinic	0.000000		////////////////////	0	////////////////////
61	Rural Health Clinic	0.000000		////////////////////	0	////////////////////
62	FQHC	0.000000		////////////////////	0	////////////////////
63	Other Outpatient Service Cost	0.000000		////////////////////	0	////////////////////
71	Ambulance	0.000000		////////////////////	0	////////////////////
				////////////////////		////////////////////
100	Total (Sum of lines 40 - 71)		**0**	////////////////////	**0**	////////////////////

(1) For titles V and XIX use columns 1, 2 and 4 only.
(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10		
COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN : 31-5429	PERIOD : FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET D-1 PARTS I & II
Check One:	[ ] Title V	[X] Title XVI	[ ] Title XIX
Check One:	[X] SNF	[ ] NF	[ ] ICF/IID

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	11,534
2	Private room days	
3	Inpatient days including private room days applicable to the Program	6,079
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	3,861,302

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	4,848,304
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.796423
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)	3,861,302

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	334.78
17	Program routine service cost (Line 3 times line 16)	2,035,128
18	Medically necessary private room cost applicable to program (line 4 times line 13)	0
19	Total program general inpatient routine service cost (Line 17 plus line 18)	2,035,128
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)	106,548
21	Per diem capital related costs (Line 20 divided by line 1)	9.24
22	Program capital related cost (Line 3 times line 21)	56,170
23	Inpatient routine service cost (Line 19 minus line 22)	1,978,958
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)	1,978,958
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	11,534
2	Program inpatient days. (see instructions)	6,079
3	'Total Nursing & Allied Health costs. (see instructions)	0
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	0.527050
5	Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4)	0

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN : 31-5429	PERIOD : FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET D-1 PARTS I & II
Check One:	[ ] Title XVIII	**[X] Title XIX**	
Check One:	**[X] NF**	[ ] ICF/IID	

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.000000
8	Enter private room charges from your records	
9	Average private room per diem charge (Private room charges line 8 divided by private room days, lir	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-pr	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 : 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	**WORKSHEET E PART I**

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

1	Inpatient PPS amount (See Instructions)	3,959,664
2	Nursing and Allied Health Education Activities (pass through payments)	0
3	Subtotal (Sum of lines 1 and 2)	3,959,664
4	Primary payor amounts	(0)
5	Coinsurance	(788,828)
6	Allowable bad debts (from your records)	144,011
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	25,000
8	Adjusted reimbursable bad debts. (See instructions)	93,607
9	Recovery of bad debts - for statistical records only	
10	Utilization review	0
11	Subtotal (See instructions)	3,264,443
12	Interim payments (See instructions)	3,189,724
13	Tentative adjustment	
14	Other Adjustments (See Instructions)	
14.50	Demonstration payment adjustment amount before sequestration	0
14.55	Demonstration payment adjustment amount after sequestration	0
14.75	Sequestration for non-claims based amounts (see instructions)	1,872
14.99	Sequestration amount (see instructions)	63,417
15	Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14)	**9,430**
	(Indicate overpayment in parentheses) (See Instructions)	
16	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	

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

17	Ancillary services Part B	0
18	Vaccine cost (From Wkst D, Part II, line 3)	2,144
19	Total reasonable costs (Sum of lines 17 and 18)	2,144
20	Medicare Part B ancillary charges (See instructions)	1,800
21	Cost of covered services (Lesser of line 19 or line 20)	1,800
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)	1,800
26	Interim payments (See instructions)	1,535
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)	36
29	Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28)	**229**
	(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: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	**WORKSHEET E-1**

	Description			Inpatient Part A		Part B	
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
				1	2	3	4
1	Total interim payments paid to provider			//////////	3,107,419	//////////	1,535
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.			//////////	46,995	//////////	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero (1)		.01	11/14/23	35,310		
			.02				
		Program to	.03				
		Provider	.04				
			.05				
			.50				
		Provider to	.51				
		Program	.52				
		*	.53				
			.54				
	SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99	//////////	35,310	//////////	0
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) Transfer to Wkst E, Part I line 12 for Part A, and line 26 for Part B.)			//////////	3,189,724	//////////	1,535
				//////////		//////////	

TO BE COMPLETED BY CONTRACTOR

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	**WORKSHEET E PART II TITLE XIX**

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

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

COMPUTATION OF NET COST OF COVERED PART A - INPATIENT SERVICES

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

REASONABLE CHARGES

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

CUSTOMARY CHARGES:

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT:

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

BALANCE SHEET	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	**WORKSHEET G**

ASSETS

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	Cash on hand and in banks	493,474			
2	Temporary investments	0			
3	Notes receivable	0			
4	Accounts receivable	1,014,510			
5	Other receivables	0			
6	Less: allowances for uncollectible notes and A/R	0			
7	Inventory	0			
8	Prepaid expenses	11,620			
9	Other current assets	0			
10	Due from other funds	(257,991)			
11	TOTAL CURRENT ASSETS	1,261,613	0	0	0
	(Sum of lines 1 - 10)				
	FIXED ASSETS				
12	Land	0			
13	Land improvements	0			
14	Less: Accumulated depreciation	0			
15	Buildings	0			
16	Less Accumulated depreciation	0			
17	Leasehold improvements	115,000			
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	75,000			
24	Less: Accumulated depreciation	(48,750)			
25	Minor equipment - Depreciable	0			
26	Minor equipment nondepreciable	0			
27	Other fixed assets	0			
28	TOTAL FIXED ASSETS	141,250	0	0	0
	(Sum of lines 12 - 27)				
	OTHER ASSETS				
29	Investments	0			
30	Deposits on leases	0			
31	Due from owners/officers	0			
32	Other assets	3,262,563			
33	TOTAL OTHER ASSETS	3,262,563	0	0	0
	(Sum of lines 29 - 32)				
34	TOTAL ASSETS	4,665,426	0	0	0
	(Sum of lines 11, 28 and 33)				

BALANCE SHEET	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET G (cont'd)

	LIABILITIES & FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
35	Accounts payable	80,123			
36	Salaries, wages & fees payable	62,040			
37	Payroll taxes payable	22,000			
38	Notes & loans payable (Short term)	114,610			
39	Deferred income	2,847,094			
40	Accelerated payments	0	////////////////////	////////////////////	////////////////////
41	Due to other funds	0			
42	Other current liabilities	0			
43	TOTAL CURRENT LIABILITIES	3,125,867	0	0	0
	(Sum of lines 35 - 42)				
	LONG TERM LIABILITIES				
44	Mortgage payable	0			
45	Notes payable	0			
46	Unsecured loans	91,676			
47	Loans from owners:	0			
48	Other long term liabilities	0			
49	Other (Specify)	0			
50	TOTAL LONG TERM LIABILITIES	91,676	0	0	0
	(Sum of lines 44 - 49)				
51	TOTAL LIABILITIES	3,217,543	0	0	0
	(Sum of lines 43 and 50)				
	CAPITAL ACCOUNTS				
52	General fund balance	1,447,883	////////////////////	////////////////////	////////////////////
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	1,447,883	0	0	0
	(Sum of lines 52 thru 58)				
60	TOTAL LIABILITIES & FUND BALANCES	4,665,426	0	0	0
	(Sum of lines 51 and 59)				

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET G-1

		General Fund		Specific Purpose Fund		Endowment Fund		Plant Fund	
		1	2	3	4	5	6	7	8
1	Fund balances at beginning of period	////////////	4,278,206	////////////		////////////		////////////	
2	Net income (loss) (From Wkst. G-3, line 31)	////////////	286,249	////////////	////////////	////////////	////////////	////////////	////////////
3	Total (Sum of line 1 and line 2)	////////////	4,564,455	////////////	0	////////////	0	////////////	0
4	Additions (Credit adjustments)	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
5			////////////		////////////		////////////		////////////
6			////////////		////////////		////////////		////////////
7			////////////		////////////		////////////		////////////
8			////////////		////////////		////////////		////////////
9			////////////		////////////		////////////		////////////
10	Total additions (Sum of lines 5 - 9)	////////////	0	////////////	0	////////////	0	////////////	0
11	Subtotal (Line 3 plus line 10)	////////////	4,564,455	////////////	0	////////////	0	////////////	0
12	Deductions (Debit adjustments)	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
13	Members Drawings	3,116,572	////////////		////////////		////////////		////////////
14			////////////		////////////		////////////		////////////
15			////////////		////////////		////////////		////////////
16			////////////		////////////		////////////		////////////
17			////////////		////////////		////////////		////////////
18	Total deductions (Sum of lines 13 - 17)	////////////	3,116,572		0	////////////	0	////////////	0
19	Fund balance at end of period per	////////////		////////////		////////////		////////////	
	balance sheet (Line 11 - line 18)	////////////	1,447,883	////////////	0	////////////	0	////////////	0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET G-2 PARTS I/II

PART I - PATIENT REVENUES

	REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL
			1	2	3
GENERAL INPATIENT ROUTINE CARE SERVICES			////////////////////////	////////////////////////	////////////////////////
1	Skilled Nursing Facility		4,848,304	////////////////////////	4,848,304
2	Nursing facility		0	////////////////////////	0
3	ICF-IID		0	////////////////////////	0
4	Other long term care		0	////////////////////////	0
5	Total general inpatient care services		4,848,304	////////////////////////	4,848,304
	(Sum of lines 1 - 4)				
ALL OTHER CARE SERVICES					
6	Ancillary services		1,347,134	0	1,347,134
7	Clinic		////////////////////////	0	0
8	Home Health Agency		////////////////////////	0	0
9	Ambulance		////////////////////////	0	0
10	RHC/FQHC		////////////////////////	0	0
11	CMHC		////////////////////////	0	0
12	Hospice		0	0	0
13	Other Svc Revenues		0	0	0
14	Total Patient Revenues (Sum of lines 5 - 13)		6,195,438	0	6,195,438
	(Transfer column 3 to Worksheet G-3, Line 1)				

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 100)	////////////////////////	5,474,993
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)	////////////////////////	5,474,993

STATEMENT OF REVENUES & EXPENSES	PROVIDER CCN: 31-5429	PERIOD: FROM: 06/01/2023 TO: 05/31/2024	WORKSHEET G-3

1	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	6,195,438
2	Less: contractual allowances and discounts on patients accounts	(446,997)
3	Net patient revenues (Line 1 minus line 2)	5,748,441
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	5,474,993
5	Net income from service to patients (Line 3 minus 4)	273,448
//////////	OTHER INCOME:	////////////////////////////
6	Contributions, donations, bequests, etc	0
7	Income from investments	203
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	11,814
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	132
21	Rental of vending machines	652
22	Rental of skilled nursing space	0
23	Governmental appropriations	0
24		0
24.50	COVID-19 PHE Funding	0
25	Total other income (Sum of lines 6 - 24)	12,801
26	Total (Line 5 plus line 25)	286,249
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)	286,249