Health Financia	I Systems LITTLE BR	OOK NURSING &	CONV. HOME	In Lie	u of Form CMS-2540-10
	required by law (42 USC 1395g; 42 CFR 413.2 since the beginning of the cost reporting pe		•		OMB NO. 0938-0463
					Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEAN PORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315467	Period: From 01/01/2023 To 12/31/2023	
PART I - COST F	REPORT STATUS				
Provi der	1. [X] Electronically prepared cost rep	port		Date: 8/23/20	24 Time: 11:45 pm
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report ent			r resubmitted thi	s cost report
	3.01 [] No Medicare Utilization. Enter "	'Y" for yes o	r leave blank for no.		
Contractor	4.[1]Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN	
	Settled without audit	8.[N] Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened	10.[0] f	ine 4, column 1 is "4"	Enter number of	times reopened
	(5) Amended		r Vendor Code		
	5. Date Received:		care Utilization. Ente no utilization.	er "F" for full, '	'L" for low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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 OR PROCURED 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 certification 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 LITTLE BROOK NURSING & CONV. HOME (315467) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	John Hampilos		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	John Hampilos			2
3	Signatory Title	MANAGI NG DI RECTOR			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
P	PART III - SETTLEMENT SUMMARY	_				
1.00 5	SKILLED NURSING FACILITY	0	0	0	0	1.00
2.00 N	NURSING FACILITY	0			0	2.00
3.00 I	ICF/IID				0	3.00
4.00 5	SNF – BASED HHA I	0	0	0		4.00
5.00 5	SNF – BASED RHC I	0		0		5.00
6.00 5	SNF - BASED FQHC I	0		0		6.00
7.00 5	SNF - BASED CMHC I	0		0		7.00
100.001	TOTAL	0	0	0	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. 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 and review the 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 the 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.

WPLE	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALT X INDENTIFICATION DATA	<u>OK NURSING &</u> TH CARE	Provider No.	: 315467	Period: From 01/01/ To 12/31/	/2023	u of For Workshe Part I Date/Ti 8/23/20	et S-2 me Pre	pared:
	1.00	2.00		3.00					
	Skilled Nursing Facility and Skilled Nursing Facilit	y Complex Ad	ldress:						4
00	Street: 78 SLIKER ROAD PO Box:								1.0
	City: CALIFON State:		Zip Code: 078						2.0
0C	County: HUNTERDON CBSA Co	de: 35084	Urban/Rural:	U					3.0
01	CBSA Co	de:							3.0
		Compor	nent Name	Provi der	Date	Payme	ent Syst	em (P,	
				CCN	Certified		0, or N)	4
						V	XVIII	XIX	<u> </u>
			1.00	2.00	3.00	4.00	5.00	6.00	
	SNF and SNF-Based Component Identification:	1			1				4
00	SNF		OK NURSING &	315467	02/01/2001	N	P	0	4.0
		CONV. HOME							
00	Nursing Facility								5. C
	ICF/IID								6.0
00	SNF-Based HHA								7.0
00	SNF-Based RHC								8.0
00	SNF-Based FQHC								9.0
	SNF-Based CMHC								10.0
	SNF-Based OLTC								11.0
	SNF-Based HOSPICE								12.0
00	SNF-Based CORF			I		L			13. (
					From:		To		4
00					1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy)				01/01/2		12/31/	2023	14. (
00	Type of Control (See Enstructions)					4			15. (
						-	Y/		4
	Turne of Europeandian Childred Number Facility						1.0	00	-
~~	Type of Freestanding Skilled Nursing Facility				: 40.0FP	T			1
00	Is this a distinct part skilled nursing facility that	t meets the	requi rements	set forth	IN 42 CFR		N		16. (
~ ~	section 483.5?					.			
00	Is this a composite distinct part skilled nursing fac	cility that	meets the rec	quirements	set forth	in	N		17.0
~ ~	42 CFR section 483.5?								
. 00	Are there any costs included in Worksheet A that resu						Y		18.0
	organizations as defined in CMS Pub. 15-1, chapter 10	0? IT yes,	complete work	ksneet A-8	-1.				-
~~	Miscellaneous Cost Reporting Information		11)/II C			r			100
	If this is a low Medicare utilization cost report, in						N		19.0
01	If line 19 is yes, does this cost report meet your co			TIIIng a	I ow Medicar	e	N		19.0
	utilization cost report, indicate with a "Y", for yes Depreciation - Enter the amount of depreciation repo			mothod in	dicated on	Linoc	20 20)	1
00	Straight Line					Lines	20 - 22	17, 599	2 20 0
	Declining Balance								20.0
	-								
	Sum of the Year's Digits								1 ~~
								17, 599	
00	Sum of line 20 through 22								
00 00	If depreciation is funded, enter the balance as of						N	(23.0
00 00 00	If depreciation is funded, enter the balance as of Were there any disposal of capital assets during the	cost report	ing period? (• •	posti se e		N	(24. 25.
00 00 00	If depreciation is funded, enter the balance as of Were there any disposal of capital assets during the Was accelerated depreciation claimed on any assets in	cost report	ing period? (• •	porting per	i od?	N N	(24. 25.
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	If depreciation is funded, enter the balance as of " Were there any disposal of capital assets during the Was accelerated depreciation claimed on any assets in (Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state th regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insuran Is the malpractice a "claims-made" or "occurrence" po	cost report n the currer at end of t proportion wider that c ach componer hat certifie XIX patient nce? (Y/N) olicy? If th	ing period? (it or any priod the period to of allowable qualifies for it and type of sthe provide s? (Y/N)	or cost re which thi cost from an exempt f service	s cost repo prior cost ion from th that qualif <u>Y/N</u> 1.00 F Y	Part . 1.00 ne appl i es fo N N	N N N 2.00 i cati or or the N N N N N	Other 3.00	2 24. (25. (26. (27. (28. (28. (30. (31. (33. (33. (33. (33. (34. (35. (33. ()))))))))))))))))))))))))))))))))))
	If depreciation is funded, enter the balance as of " Were there any disposal of capital assets during the Was accelerated depreciation claimed on any assets in (Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state th regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insura	cost report n the currer at end of t proportion wider that c ach componer hat certifie XIX patient nce? (Y/N) olicy? If th	ing period? (it or any pric the period to of allowable qualifies for it and type of the provide s? (Y/N) the policy is	or cost re which thi cost from an exempt f service er as a SN	s cost repo prior cost ion from th that qualif	Part 1.00 ne appl i es fo	N N APart B 2.00 i cati or or the N N N N N 2.0	0ther 3.00 N	2 24. (25. (26. (27. (28. (28. (30. (31. (33. (33. (33. (33. (35. (33. (35. (33. (35. (33. (35. (37. (38.
	If depreciation is funded, enter the balance as of " Were there any disposal of capital assets during the Was accelerated depreciation claimed on any assets in (Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state th regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insuran Is the malpractice a "claims-made" or "occurrence" po	cost report n the currer at end of t proportion wider that c ach componer hat certifie XIX patient nce? (Y/N) olicy? If th	ing period? (it or any pric the period to of allowable qualifies for it and type of the provide s? (Y/N) the policy is	or cost re which thi cost from an exempt f service	s cost repo prior cost ion from th that qualif <u>Y/N</u> 1.00 F Y	Part 1.00 ne appl i es fo	N N N 2.00 i cati or or the N N N N N	Other 3.00 N N DO	2 24. (25. (26. (27. (28. (28. (30. (31. (33. (33. (33. (33. (35. (33. (35. (33. (35. (33. (35. (37. (38.

Heal th	Financial Systems	LITTLE BROOK NURSING &	CONV. HOME		In Lieu	u of Form Cl	MS-2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 31		Period:	Worksheet	S-2
COMPLE	X INDENTIFICATION DATA				From 01/01/2023 To 12/31/2023	Part I Date/Time	Droparad
				'	10 12/31/2023	8/23/2024	
						Y/N	
						1.00	
42.00						N	42.00
	center? Enter Y or N. If yes, check box	c, and submit supporting s	schedule listing	cost ce	nters and		
	amounts.						
	Are there any home office costs as defi					N	43.00
	If line 43 is yes, enter the home offic	ce chain number and enter	the name and add	dress of	the home		44.00
	office on lines 45, 46 and 47.						
	1.00	2.00			3.00		
	If this facility is part of a chain or	ganization, enter the name	e and address of	the hom	ne office on the	lines	
	bel ow.						
45.00	Name:	Contractor's Name:	Ca	ontracto	r's Number:		45.00
46.00	Street:	PO Box:					46.00
47.00	Ci ty:	State:	Zi	ip Code:			47.00
				-			

	ED NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE P	rovider No	o.: 315467	Peri od:	Worksheet S	-2
MPL	EX REIMBURSEMENT QUESTIONNAIRE				From 01/01/2023 To 12/31/2023	Date/Time P	
					Y/N	8/23/2024 1 Date	<u>1:45 pr</u>
					1,00	2.00	_
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy)	ses enter in column 1,	"Y" for	Yes or "N"			
	Completed by All Skilled Nursing Facilites						
00	Provider Organization and Operation Has the provider changed ownership immediate	ly prior to the bogin	aing of th	o cost	N	1	1.
00	reporting period? If column 1 is "Y", enter instructions)				i v		1.
			_	Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Program?	? f	1.00 N	2.00	3.00	2.
	column 1 is yes, enter in column 2 the date of a straight of the date of a straight of the date of the	of termination and in	col umn				
00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or a relationships? (see instructions)	., chain home offices, d to the provider or i l, or members of the b	drug ts poard	Y			3.
	Terationships? (see thistructions)			Y/N	Туре	Date	
				1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepa	ared by a Cortified D	iblic	Y	С		4.
50	Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	" for Audited, "C" for te copy or enter date	r I	I	C		4.
00	Are the cost report total expenses and total those on the filed financial statements? If o reconciliation.	revenues different fr	rom	Ν			5.
			ľ		Y/N	Legal Oper.	
	Approved Educational Activities				1.00	2.00	_
00	Column 1: Were costs claimed for Nursing Scho	ool2 (V/N) Colump 2:		ouidor the	N	N	6.
00			Is the pr	ovider the	N	IN IN	0.
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin	s? (Y/N) see instructi ng the cost reporting	ons.		N N N		7.
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s? (Y/N) see instructi ng the cost reporting	ons.		N	Y/N 1.00	7.
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts	s? (Y/N) see instructi ng the cost reporting ee instructions.	ons. period fo	or Nursing	N	Y/N 1.00	7. 8.
00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt	s? (Y/N) see instructing the cost reporting ee instructions.	ons. period fo	or Nursing	NN	Y/N	7. 8. 9.
00 00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see inst t collection policy ch	structions	or Nursing S. ng this cos	N N t reporting	Y/N 1.00 N	7. 8. 9. 10.
00 00 00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy.	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive	ons. period fo structions nange duri ed? If "Y"	or Nursing s. ng this cos ', see instr	N N N t reporting ructions.	Y/N 1.00 N N	9. 10. 11. 12.
)0)0)0 00 00	<pre>legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement</pre>	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see inst t collection policy ch d/or coinsurance waive cost reporting period	ons. period fo structions nange duri ed? If "Y"	or Nursing s. ng this cos ', see instru see instru Pa	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 N N N Part B	7. 8. 9. 10. 11.
)0)0)0 00 00	<pre>legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement</pre>	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive	ons. period fo structions nange duri ed? If "Y"	or Nursing s. ng this cos ', see instr see instru Pa Y/N	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 N N N Part B Y/N	7. 8. 9. 10. 11.
)0)0)0 00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting period Description	ons. period fo structions nange duri ed? If "Y"	or Nursing S. ng this cos ', see instru See instru Pa Y/N 1.00	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 N N N Part B Y/N 3.00	7. 8. 9. 10. 11.
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data 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	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting period Description	ons. period fo structions nange duri ed? If "Y"	or Nursing s. ng this cos ', see instr see instru Pa Y/N	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 N N N Part B Y/N	7. 8. 9. 10. 11. 12.
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data 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 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 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	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see instruction policy ch d/or coinsurance waive cost reporting period Description 0	ons. period fo structions nange duri ed? If "Y"	or Nursing S. ng this cos ', see instru See instru Pa Y/N 1.00	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 N N N Part B Y/N 3.00	7 8 9 10 11 12 12 13
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data 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 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 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. 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	s? (Y/N) see instructing the cost reporting ee instructions.	ons. period fo structions nange duri ed? If "Y"	or Nursing S. ng this cos d, see instru see instru Pa Y/N 1.00 Y	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 N N N Part B Y/N 3.00 Y	7. 8. 9. 10. 11.
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data 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.) 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. 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. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	s? (Y/N) see instructing the cost reporting ee instructions.	ons. period fo structions nange duri ed? If "Y"	or Nursing S. ng this cos 7, see instru See instru Pa Y/N 1.00 Y	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 N N N Part B Y/N 3.00 Y N	7. 8. 9. 10. 11. 12. 13. 14.
00 00 00 . 00 . 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data 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 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. (see Instructions.) 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. If line 13 or 14 is "Y", were adjustments made to	s? (Y/N) see instructing the cost reporting ee instructions.	ons. period fo structions nange duri ed? If "Y"	or Nursing S. ng this cos C, see instru See instru Pa Y/N 1.00 Y N	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 N N N Part B Y/N 3.00 Y N N	7. 8. 9. 10. 11. 12. 13. 14. 15.

Health Financial Systems	LI TTLE BROOK NURS	SING &	CONV. HOME		In Lie	u of Form CMS-	2540-10
	ND SKILLED NURSING FACILITY HEALTH CAR	-	Provider No.: 31		eri od:	Worksheet S-2	
COMPLEX REIMBURSEMENT QUES	TI ONNAI RE				rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre	pared:
		_				8/23/2024 11:	45 pm
			1.00		2. (00	
Cost Report Preparer	Contact Information						
19.00 Enter the first name	e, last name and the title/position	VARI	OUS		VARI OUS		19.00
held by the cost rep	port preparer in columns 1, 2, and 3,						
respecti vel y.							
20.00 Enter the employer/o	company name of the cost report	HUBCO) HEALTH CARE GRO	UP, LLC			20.00
preparer.							
21.00 Enter the telephone	number and email address of the cost	60973	301980		COSTREPORTS@HUE	3CO. NET	21.00
report preparer in o	columns 1 and 2, respectively.						

	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provi der No.: 315467	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 8/23/2024 11:	epared
		Part B Date 4.00				
	PS&R Data	4.00				
3. 00	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.)	08/22/2024				13.0
4.00	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.					14.0
5. 00	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.					15. C
6. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16.0
7. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.0
8. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.0
		_	3.00			
	Cost Report Preparer Contact Information		0.00			
9. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		ARI OUS			19. (
0. 00	Enter the employer/company name of the cost r	report				20.
1. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.0

OMPLE	Financial Systems ED NURSING FACILITY AND SKILLED NURSING EX STATISTICAL DATA	FACILITY HEALTH CARE	Provi der	F	eriod: rom 01/01/2023 o 12/31/2023	Date/Time Prep 8/23/2024 11:4	bared:
				l np	atient Days/Vis	sits	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
	1	1.00	2.00	3.00	4.00	5.00	
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	36	13, 140	0		7, 875 0	1.00 2.00
. 00	ICF/IID	0	0	0		0	3.00
00	HOME HEALTH AGENCY COST			0	0	0	4.00
00	Other Long Term Care	0	0				5.00
. 00 . 00	SNF-Based CMHC HOSPI CE						6.00 7.00
. 00	Total (Sum of lines 1-7)	36	13, 140	0	209	7, 875	8.00
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
00		6.00	7.00	8.00	9.00	10.00	1 00
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	2, 293 0	10, 377 0	0	/	8	1.00 2.00
. 00	ICF/IID		-			_	3.00
. 00	HOME HEALTH AGENCY COST	0	0				4.00
. 00 . 00	Other Long Term Care SNF-Based CMHC	0	0				5.0 6.0
. 00	HOSPI CE						7.0
. 00	Total (Sum of lines 1-7)	2, 293	10, 377	0		8	8.0
		Di scha	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
00	SKILLED NURSING FACILITY	11.00	12.00 23	<u>13.00</u> 0.00	14.00 29.86	15.00 984.38	1.00
. 00 . 00	NURSING FACILITY	8	23	0.00		984.38 0.00	2.00
. 00	ICF/IID						3.00
. 00	HOME HEALTH AGENCY COST	0	0				4.0 5.0
. 00 . 00	Other Long Term Care SNF-Based CMHC	0	0				6.0
. 00	HOSPI CE						7.0
. 00	Total (Sum of lines 1-7)	8	23	0.00		984.38	8.0
		Average Length of Stay		Adiiii S	si ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
. 00	SKILLED NURSING FACILITY	<u> </u>	17.00	18.00	19.00	20.00	1.00
. 00	NURSING FACILITY	0.00	0	I	0	0	2.00
. 00	ICF/IID						3.0
. 00			1				4.0
. 00 . 00	HOME HEALTH AGENCY COST	0.00				0	
. 00 . 00 . 00	Other Long Term Care	0.00				0	5.0
. 00 . 00 . 00 . 00		0.00					5.0 6.0 7.0
. 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC	451. 17	0 Full Time		2		5.0 6.0 7.0
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE		O Full Time I		2		5. 00 6. 00 7. 00 8. 00
. 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE	451. 17	Full Time Employees on	Equi val ent Nonpai d	2		5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	451.17 Admi ssi ons Total	Full Time Employees on Payroll	Equi val ent Nonpai d Workers	2		5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	451.17 Admissions	Full Time Employees on	Equi val ent Nonpai d	-		5.0 6.0 7.0
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY	451.17 Admi ssi ons Total 21.00	Full Time Employees on Payroll 22.00	Equi val ent Nonpai d Workers 23.00			5.0 6.0 7.0 8.0 1.0 2.0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID	451.17 Admi ssi ons Total 21.00 17	Full Time Employees on Payrol I 22.00 26.45 0.00	Equi val ent Nonpai d Workers 23.00 0.00 0.00			5.0 6.0 7.0 8.0 1.0 2.0 3.0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY	451.17 Admi ssi ons Total 21.00 17	Full Time Employees on Payroll 22.00 26.45	Equi val ent Nonpai d Workers 23.00 0.00			5.0 6.0 7.0 8.0
. 00 . 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	451.17 Admi ssi ons Total 21.00 17 0	Full Time Employees on Payroll 22.00 26.45 0.00 0.00	Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00			5. 0 6. 0 7. 0 8. 0 1. 0 2. 0 3. 0 4. 0

Heal	th	Fi	nanci a	1 3	Systems	5
CNIE	14/ 0	<u> </u>		LAI		

LITTLE BROOK NURSING & CONV. HOME

In Lieu of Form CMS-2540-10

Heal th	Financial Systems LIT	TLE BROOK NURS	ING & CONV. HOM	/E	In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION			F	Period: rom 01/01/2023 o 12/31/2023	Date/Time Pre 8/23/2024 11:	pared: 45 pm
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
		1.00	0.00	0.00	3	5.00	
	PART I I - DI RECT SALARI ES	1.00	2.00	3.00	4.00	5.00	
	SALARI ES						
1.00	Total salaries (See Instructions)	1, 855, 362	0	1, 855, 362	55, 027. 00	33.72	1.00
2.00	Physician salaries-Part A	0	0	.,	0,00		
3.00	Physician salaries-Part B	0	0	0	0.00		
4.00	Home office personnel	0	0	0	0.00		
5.00	Sum of lines 2 through 4	0	0	0	0.00		
6.00	Revised wages (line 1 minus line 5)	1, 855, 362	0	1, 855, 362			
7.00	Other Long Term Care	0	0	0			
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		
9.00	СМНС	0	0	0	0.00		
10.00	HOSPICE						10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00		
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	1, 855, 362	0	1, 855, 362	55, 027. 00	33.72	13.00
	12)						
	OTHER WAGES & RELATED COSTS				1		
	Contract Labor: Patient Related & Mgmt	34, 554					
	Contract Labor: Physician services-Part A	0	0				
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
17 00	WAGE-RELATED COSTS	055 744	1	055 744	1		1 1 7 00
		355, 741	0	355, 741			17.00
	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00		0	0	0			19.00
20.00		0	0	0			20.00
21.00	Physician Part B - WRC						21.00
22.00	Total Adjusted Wage Related cost (see	355, 741	0	355, 741			22.00
	instructions)	I	I	I	1	I	I

Heal th	Financial Systems LIT	TLE BROOK NURS	ING & CONV. HOM	NE .	In Lie	u of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Peri od:	Worksheet S-3	
					From 01/01/2023		norod.
					To 12/31/2023	Date/Time Pre 8/23/2024 11:4	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0		0.00	0.00	1.00
2.00	Administrative & General	254, 403	0	254, 40	3 6, 145. 00	41.40	2.00
3.00	Plant Operation, Maintenance & Repairs	52, 921	0	52, 92	1 1, 900. 00	27.85	3.00
4.00	Laundry & Linen Service	18, 795	0	18, 79	5 1, 314. 00	14.30	4.00
5.00	Housekeepi ng	69, 711		69, 71	1 3, 423. 00	20.37	5.00
6.00	Dietary	157, 507	0	157, 50	7 6, 652. 00	23.68	6.00
7.00	Nursing Administration	123, 114	0	123, 11	4 1, 893.00	65.04	7.00
8.00	Central Services and Supply	0	0		0.00	0.00	8.00
9.00	Pharmacy	0	0	(0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	(0.00	0.00	10.00
11.00	Social Service	52, 868	0	52, 86	B 1, 541. 00	34.31	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	66, 194	0	66, 19	4 2, 325.00	28.47	13.00
14.00	Total (sum lines 1 thru 13)	795, 513	0	795, 51	3 25, 193. 00	31.58	14.00

	GE RELATED COSTS	Provi der No. : 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Pre 8/23/2024 11:	epare
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETIREMENT COST				
00	401K Employer Contributions			0	
00	Tax Sheltered Annuity (TSA) Employer Contribution			0	-
00	Qualified and Non-Qualified Pension Plan Cost			0	-
00	Prior Year Pension Service Cost			0	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				1
00	401K/TSA Plan Administration fees			0	
00	Legal /Accounting/Management Fees-Pension Plan			0	
00	Employee Managed Care Program Administration Fees			0	7
	HEALTH AND INSURANCE COST				1
	Health Insurance (Purchased or Self Funded)			77, 436	
	Prescription Drug Plan			0	
	Dental, Hearing and Vision Plan			0	
	Life Insurance (If employee is owner or beneficiary)			7, 840	
	Accident Insurance (If employee is owner or beneficiary)			0	
	Disability Insurance (If employee is owner or beneficiary)			0	
	Long-Term Care Insurance (If employee is owner or beneficiary)			0	
	Workers' Compensation Insurance			113, 896	
5.00	Retirement Health Care Cost (Only current year, not the extrao	rdinary accrual require	d by FASB 106.	0	16
	Non cumulative portion) TAXES				1
	FICA-Employers Portion Only			156, 569	1 17
	Medicare Taxes - Employers Portion Only			150, 509	
	Unemployment Insurance			0	
	State or Federal Unemployment Taxes			0	
	OTHER			0	20
	Executive Deferred Compensation			0	21
	Day Care Cost and Allowances			0	1
	Tuition Reimbursement			0	
	Total Wage Related cost (Sum of lines 1 - 23)			355, 741	1 - 0
				Amount	
				Reported	
				1.00	

Heal th Financial Systems

LITTLE BROOK NURSING & CONV. HOM	Е
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In Lieu of Form CMS-2540-10

	PORTING OF DIRECT CARE EXPENDITURES			No.: 315467 P F T	eriod: rom 01/01/2023 o 12/31/2023	Date/Time Pre 8/23/2024 11:	pared: 45 pm
	Occupational Category	Amount	Fringe	Adjusted		Average Hourly	
		Reported	Benefits	Salaries (col.	Related to Salary in col.	Wage (col. 3 ÷ col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations				1		
1.00	Registered Nurses (RNs)	91, 060	17, 460				1.00
2.00	Licensed Practical Nurses (LPNs)	482, 197	92, 455				2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	424, 836	81, 457	506, 293	15, 340. 00	33.00	3.00
4.00	Total Nursing (sum of lines 1 through 3)	998, 093	191, 372	1, 189, 465	28, 813. 00	41.28	4.00
5.00	Physical Therapists	39, 551	7, 583	47, 134	644.00	73.19	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00		6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	15, 791	3, 028	18, 819	271.00	69.44	
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	6, 414	1, 230	7, 644	106.00	72.11	11.00
12.00	Respiratory Therapists	0	0	0	0.00		
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations	· · · · · ·			1	1	
	Registered Nurses (RNs)	0		0	0.00		14.00
	Licensed Practical Nurses (LPNs)	15, 584		15, 584	311.00		
16.00	Certified Nursing Assistant/Nursing	18, 970		18, 970	568.00	33.40	16.00
47 00	Assi stants/Ai des	04 554					17 00
	Total Nursing (sum of lines 14 through 16)	34, 554		34, 554	879.00		
	Physical Therapists	0		0	0.00		
19.00	Physical Therapy Assistants	0		0	0.00		1
	Physical Therapy Aides	0		0	0.00		1
	Occupational Therapists	0		0	0.00		1
	Occupational Therapy Assistants	0		0	0.00		
	Occupational Therapy Aides Speech Therapists	0			0. 00 0. 00		23.00 24.00
24.00 25.00	Respi ratory Therapi sts	0			0.00		1
	Other Medical Staff	0			0.00		25.00
20.00	Uther medical Stall	l U		1 0	0.00	J 0.00	20.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	LITTLE BROOK NURSING	Provider No.: 315467	Period:	u of Form CMS Worksheet S-	
			From 01/01/2023 To 12/31/2023		epared:
			Group	Days	. 45 pm
1.00			1.00 RUX	2.00	1.00
2.00			RUL		2.00
3.00			RVX		3.00
4.00			RVL		4.00
5. 00 6. 00			RHX RHL		5.00 6.00
7.00			RMX		7.00
8.00			RML		8.00
9. 00 10. 00			RLX RUC		9.00 10.00
11.00			RUB		11.00
12.00			RUA		12.00
13.00			RVC		13.00
14. 00 15. 00			RVB RVA		14.00 15.00
16.00			RHC		16.00
17.00			RHB		17.00
18.00			RHA		18.00
19. 00 20. 00			RMC RMB		19.00 20.00
21.00			RMA		20.00
22.00			RLB		22.00
23.00			RLA		23.00
24. 00 25. 00			ES3 ES2		24.00 25.00
26.00			ES1		26.00
27.00			HE2		27.00
28.00			HE1		28.00
29. 00 30. 00			HD2 HD1		29.00 30.00
31.00			HC2		31.00
32.00			HC1		32.00
33.00			HB2		33.00
34. 00 35. 00			HB1 LE2		34.00 35.00
36.00			LE2 LE1		36.00
37.00			LD2		37.00
38.00			LD1		38.00
39. 00 40. 00			LC2 LC1		39.00 40.00
40.00			LB2		40.00
42.00			LB1		42.00
43.00			CE2		43.00
44. 00 45. 00			CE1 CD2		44.00 45.00
46.00			CD1		45.00
47.00			CC2		47.00
48.00			CC1		48.00
49. 00 50. 00			CB2 CB1		49.00 50.00
51.00			CA2		51.00
52.00			CA1		52.00
53.00			SE3		53.00
54. 00 55. 00			SE2 SE1		54.00 55.00
56.00			SSC		56.00
57.00			SSB		57.00
58.00			SSA		58.00 59.00
59. 00 60. 00			I B2 I B1		59.00 60.00
61.00			I A2		61.00
62.00			I A1		62.00
63.00			BB2		63.00
64. 00 65. 00			BB1 BA2		64.00 65.00
66.00			BA1		66.00
67.00			PE2		67.00
68. 00 69. 00			PE1		68.00
69. 00 70. 00			PD2 PD1		69.00 70.00
71.00			PC2		71.00
72.00			PC1		72.00
73. 00 74. 00			PB2 PB1		73.00 74.00

Health Financial Systems LITTLE BROOK NURSING & CON	NV. HOME	In Lie	u of Form CMS	6-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Pro	ovider No.: 315467	Peri od:	Worksheet S	-7
		From 01/01/2023 To 12/31/2023		
		Group	Days	
		1.00	2.00	
76.00		PA1		76.00
99.00		AAA		99.00
_100. 00 TOTAL				100.00
	Expenses	Percentage	Y/N	
	1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 Augus payments beginning 10/01/2003. Congress expected this increase to b expenses. For lines 101 through 106: Enter in column 1 the amount o column 2 the percentage of total expenses for each category to tota line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if with direct patient care and related expenses for each category. (I (See instructions)	e used for direct if the expense for I SNF revenue from the spending refl	patient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)				101.00 102.00 103.00 104.00 105.00 106.00

	Financial Systems LI SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	TTLE BROOK NURSING F EXPENSES		No.: 315467	Peri od:	u of Form CMS-2 Worksheet A	2010 10
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre 8/23/2024 11:	pared: 45 pm
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi ficati	Recl assi fi ed	
	•			+ col. 2)	ons	Trial Balance	
					Increase/Decre	(col. 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)		
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		286, 357	286, 3	57 0	286, 357	1.00
3.00	00300 EMPLOYEE BENEFITS	0	355, 741	355, 7		355, 741	3.00
3.00 4.00	00400 ADMI NI STRATI VE & GENERAL	254, 403	526, 731	781, 1		781, 134	4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	52, 921	104, 363			157, 284	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	18, 795	6, 962	25, 7		25, 757	6.00
7.00	00700 HOUSEKEEPING	69, 711	18, 991	88, 70		88, 702	
8.00	00800 DI ETARY	157, 507	115, 959	273, 40		273, 466	
9.00	00900 NURSI NG ADMI NI STRATI ON	123, 114	113, 939	123, 1		123, 114	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	70, 752	70, 7		70, 752	•
11.00	01100 PHARMACY	0	11, 234	11, 2		11, 234	
12.00	01200 MEDICAL RECORDS & LI BRARY	0	11, 234	11, 2.	0 0	0	12.00
13.00	01300 SOCIAL SERVICE	52, 868	0	52, 8	-	52,868	
	01500 PATIENT ACTIVITIES	66, 194	16, 562	82, 7		82, 756	•
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	00,174	10, 302	02,75	0	02,730	15.00
30, 00	03000 SKILLED NURSING FACILITY	998, 093	149, 407	1, 147, 50	0 00	1, 147, 500	30.00
31.00	03100 NURSING FACILITY	0	0	1, 147, 50	0 0	1, 147, 500	31.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	•
00.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>			0 0	0	00.00
40.00	04000 RADI OLOGY	0	3, 472	3, 4	72 0	3, 472	40.00
41.00	04100 LABORATORY	0	114		14 0	114	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	5, 402	5, 40	02 0	5, 402	43.00
44.00	04400 PHYSI CAL THERAPY	39, 551	0	39, 5	51 0	39, 551	44.00
45.00	04500 OCCUPATIONAL THERAPY	15, 791	0	15, 79	91 0	15, 791	45.00
46.00	04600 SPEECH PATHOLOGY	6, 414	0	6, 4	14 0	6, 414	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	10, 859	10, 8	59 0	10, 859	49.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS			L			
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	0		0 0	0	
73.00	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS				-		
89.00	SUBTOTALS (sum of lines 1-84)	1, 855, 362	1, 682, 906	3, 538, 2	68 0	3, 538, 268	89.00
~~ ~~	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
91.00	09100 BARBER & BEAUTY SHOP	0	1, 283	1, 2		1, 283	
92.00	09200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00	09300 NONPALD WORKERS	0	0		0 0	0	93.00
94.00	09400 PATI ENTS' LAUNDRY	0	0		0 0	0	94.00
	AAFAA ATUER NONDELMBURGARLE AAAT						
95.00 100.00	09500 OTHER NONREIMBURSABLE COST	0 1, 855, 362	0 1, 684, 189	3, 539, 5	0 0 51 0	0 3, 539, 551	95.00

RECLAS	Financial Systems LI SIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	TTLE BROOK NURSI		No.: 315467		Worksheet A	-2540-10
RECERS	STITICATION AND ADSUSTMENT OF TREAD DALANCE O	I EXIENSES	11001def	NO. : 515401	From 01/01/2023	3	
					To 12/31/2023	3 Date/Time Pre 8/23/2024 11:	
	Cost Center Description	Adjustments to	Net Expenses			0/23/2024 11.	. 45 pill
			For Allocation				
		Wkst A-8)	(col. 5 +-				
			col. 6)				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	444.045	105 110	1			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-161, 215	125, 142				1.00
3.00	00300 EMPLOYEE BENEFITS	0	355, 741				3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	-16, 432	764, 702				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	157, 284				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	25, 757				6.00
7.00	00700 HOUSEKEEPING	0	88, 702				7.00
8.00		0	273, 466				8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	123, 114				9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	70, 752				10.00
	01100 PHARMACY	0	11, 234				11.00
	01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
	01300 SOCIAL SERVICE	0	52, 868	1			13.00
15.00	01500 PATIENT ACTIVITIES	0	82, 756				15.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		4 4 4 7 500				
	03000 SKI LLED NURSI NG FACI LI TY	0	1, 147, 500	1			30.00
	03100 NURSI NG FACI LI TY	0	0				31.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0	1			33.00
40.00	04000 RADIOLOGY	0	3, 472	1			40.00
	04100 LABORATORY	0	3, 472	1			40.00
	04200 INTRAVENOUS THERAPY	0	0	1			41.00
	04300 OXYGEN (INHALATION) THERAPY	0	5, 402				42.00
	04400 PHYSICAL THERAPY	0	39, 551				43.00
	04400 PHISICAL THERAPT	0	15, 791				44.00
	04600 SPEECH PATHOLOGY	0	6, 414				45.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0,414				48.00
	04900 DRUGS CHARGED TO PATIENTS	0	10, 859				48.00
49.00 51.00	05100 SUPPORT SURFACES	0	10, 857	1			51.00
51.00	OUTPATIENT SERVICE COST CENTERS	<u>ч</u>	0	1			- 51.00
62.00	06200 FQHC			1			62.00
02.00	OTHER REIMBURSABLE COST CENTERS	11		I			- 02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0				70.00
	07100 AMBULANCE	0	0				71.00
73.00	07300 CMHC	0	0				73.00
75.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	1			- / 0.00
89.00	SUBTOTALS (sum of lines 1-84)	-177,647	3, 360, 621				89.00
57.00	NONREI MBURSABLE COST CENTERS	1,1,,,,,,,	3, 000, 021				1 27.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90.00
	09100 BARBER & BEAUTY SHOP	0	1, 283				91.00
	09200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 200	1			92.00
	09300 NONPAI D WORKERS	0	0				93.00
	09400 PATIENTS' LAUNDRY	0	0				94.00
		-	-				
	09500 OTHER NONREI MBURSABLE COST	0	0				95.00

Health Financial Systems LIT	TLE BROOK NURSING &	CONV. HOM	1E	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315467	Peri od:	Worksheet A-6)
				From 01/01/2023 To 12/31/2023	Date/Time Pre 8/23/2024 11:	
			Increases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
TOTALS						
	Total Reclassificat of columns 4 and 5 equal sum of columr 9)	must		0	С	100. 00

A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
 Transfer to Worksheet A, col. 5, line as appropriate.

Health Financial Systems LIT	TLE BROOK NURSING &	CONV. HON	ΛE	In Lie	u of Form CMS	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2023	Worksheet A-	6
					Date/Time Pro 8/23/2024 11	epared: 45 pm
			Decreases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
TOTALS						
100.00				0	(0 100. 00

A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
 Transfer to Worksheet A, col. 5, line as appropriate.

	· · · · · · · · · · · · · · · · · · ·	TLE BROOK NURSI	NG & CONV. HO	ME	In Lie	eu of Form CMS-2	2540-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315467	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		narod
					10 12/31/2023	8/23/2024 11:	45 pm
				Acqui si ti or	าร		
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	S		1		1	
1.00	Land	0	(D .	0 0	0	
2.00	Land Improvements	0	()	0 0	0	2.00
3.00	Buildings and Fixtures	0	()	0 0	0	3.00
4.00	Building Improvements	315, 307	()	0 0	0	4.00
5.00	Fixed Equipment	0	(2	0 0	0	5.00
6.00	Movable Equipment	424, 222	(2	0 0	0	6.00
7.00	Subtotal (sum of lines 1-6)	739, 529	(2	0 0	0	7.00
8.00	Reconciling Items	0	(2	0 0	0	8.00
9.00	Total (line 7 minus line 8)	739, 529	()	0 C	0 0	9.00
	Description	Endi ng Bal ance	Fully				
			Depreciated				
		6.00	Assets 7.00	-			
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE		7.00				
1.00	Land		(1.00
2.00	Land Improvements	0	(2.00
3.00	Buildings and Fixtures	0	(3.00
4.00	Building Improvements	315, 307	(4.00
5.00	Fixed Equipment	0,00,007	(5.00
6.00	Movable Equipment	424, 222	(6.00
7.00	Subtotal (sum of lines 1-6)	739, 529	(7.00
8.00	Reconciling Items	0	(8.00
9.00	Total (line 7 minus line 8)	739, 529	(9.00

Heal th	Fi nan	ci al	Systems
AD JUST	MENTS	TO	EXPENSES

In Lieu of Form CMS-2540-10

ADJUSTMENTS TO EXPENSES		Provi der	No.: 315467	Peri od:	Worksheet A-8	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
					8/23/2024 11:	45 pm
				lassification on		
			10/From Whice	ch the Amount is	to be Adjusted	
Decemination (1)		A	0	+ Cautau	Line Ne	
Description (1)	(2) Basis For	Amount	LOS	t Center	Line No.	
	Adjustment	0.00		0.00	4 00	
	1.00	2.00		3.00	4.00	1.00
1.00 Investment income on restricted funds	В	U	CAP REL COST	S - BLDGS &	1.00	1.00
(chapter 2)			FI XTURES		0.00	0.00
2.00 Trade, quantity, and time discounts (chapter		C			0.00	2.00
8)						
3.00 Refunds and rebates of expenses (chapter 8)		0			0.00	3.00
4.00 Rental of provider space by suppliers		C			0.00	4.00
(chapter 8)		_				
5.00 Tel ephone services (pay stations excluded)		C	1		0.00	5.00
(chapter 21)		_				
6.00 Television and radio service (chapter 21)		C			0.00	6.00
7.00 Parking lot (chapter 21)		C			0.00	7.00
8.00 Remuneration applicable to provider-based	A-8-2	C				8.00
physician adjustment						
9.00 Home office cost (chapter 21)		C			0.00	9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	
11.00 Nonallowable costs related to certain		C)		0.00	11.00
Capital expenditures (chapter 24)						
12.00 Adjustment resulting from transactions with	A-8-1	-161, 215				12.00
related organizations (chapter 10)						
13.00 Laundry and Linen service		0				13.00
14.00 Revenue - Employee meals		C			0.00	14.00
15.00 Cost of meals - Guests		C			0.00	15.00
16.00 Sale of medical supplies to other than		C)		0.00	16.00
patients						
17.00 Sale of drugs to other than patients		C			0.00	17.00
18.00 Sale of medical records and abstracts		C)		0.00	18.00
19.00 Vending machines		0			0.00	19.00
20.00 Income from imposition of interest, finance		C)		0.00	20.00
or penalty charges (chapter 21)						
21.00 Interest expense on Medicare overpayments		0			0.00	21.00
and borrowings to repay Medicare						
overpayments						
22.00 Utilization reviewphysicians' compensation		0	*** Cost Cen	iter Deleted ***	82.00	22.00
(chapter 21)						
23.00 Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23.00
			FI XTURES			
24.00 Depreciationmovable equipment		C		ter Deleted ***	2.00	24.00
25.00 TRANSPORTATI ON	A			VE & GENERAL	4.00	
25. 01 MISC INCOME	В			VE & GENERAL		25.01
25. 02		0			0.00	
25. 03		0			0.00	
25.04		0			0.00	
25. 05		0			0.00	
25.06		0				25.05
100.00 Total (sum of lines 1 through 99) (Transfer		-177, 647			0.00	100.00
to Worksheet A, col. 6, line 100)		-177,047				100.00
(1) Description - all chapter references in this co	ı lumn nertain to	CMS Pub 15-1	1 	I	1	I

(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.

Health Financial Systems LIT	TLE BROOK NURS	ING & CONV. HOM	ЛЕ	In Lie	u of Form CMS	-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOM	E Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet A- Parts I-II Date/Time Pr 8/23/2024 11	epared:
	Line No.	Cost (Center	Expense	e Items	
	1.00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	6 OR	
1.00		CAP REL COSTS FIXTURES	- BLDGS &	DEPR/AMORT/INTE	EREST/TAXES	1.00
2.00	4.00	ADMI NI STRATI VE	& GENERAL	GENERAL MANAGE	MENT CONSULT	2.00
3.00	4.00	ADMI NI STRATI VE	& GENERAL	ASSI STANT ADMIN	VI STRATOR	3.00
4.00	0, 00					4.00
5.00	0, 00					5.00
6.00	0.00					6.00
7.00	0.00					7.00
8.00	0.00					8.00
9.00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	0.00					10.00
6, line 100 to Worksheet A-8, column 3, line 12.						
12.	Amount	Amount	Adjustments			-
	Allowable In	Included in	(col. 4 minus			
	Cost	Wkst. A, col.	col. 5)	,		
	0031	5				
	4.00	5.00	6,00	_		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN				ED ORGANIZATIONS	OR	
CLAIMED HOME OFFICE COSTS:						
1.00	78, 785					1.00
2.00	115, 000			0		2.00
3.00	40, 385	40, 385		0		3.00
4.00	0	0		0		4.00
5.00	0	0		0		5.00
6.00	0	0		0		6.00
7.00	0	0		0		7.00
8.00	0	0		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	234, 170	395, 385	-161, 21	5		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						1

Health Financial Systems LIT	LITTLE BROOK NURSING & CONV. HOME				2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOME	Provider No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-II Date/Time Pre 8/23/2024 11:4	pared:
	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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 B 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

1.00	В		0.00	1.00
2.00	В		0.00	2.00
3.00	E	JP HAMPILOS	49.00	3.00
4.00	E	ROSE MARY FERNANDEZ	51.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

(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 relative of such person has financial interest in

related 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.

	Rel ated Organi	zation(s) and/	or Home Office					
	Name	Percentage of	Type of Business					
		Ownershi p						
	4.00	5.00	6.00]				
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 B 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

1.00	BETHANE PROPERTIES, INC.	0.00 REAL ESTATE	1.00
2.00	LAZARE GROUP, INC.	0. 00 CONSULTI NG	2.00
3.00		49.00	3.00
4.00		51.00	4.00
5.00		0.00	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

(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.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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.

LITTLE BROOK NURSING & CONV. HOME Provider No.: 315467 Period:

In Lieu of Form CMS-2540-10 Worksheet B

COST A	COST ALLOCATION - GENERAL SERVICE COSTS			No.: 315467	Period: From 01/01/2023	Worksheet B Part I	
					To 12/31/2023	Date/Time Pre	pared:
						8/23/2024 11:	45 pm
			CAPI TAL RELATED COSTS				
	Cost Center Description	Net Expenses	BLDGS &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	bost bontor boschiption	for Cost	FIXTURES	BENEFITS	Subtotal	& GENERAL	
		Allocation					
		(from Wkst A					
		col. 7)					
		0	1.00	3.00	3A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	125, 142	105 14				1.00
3.00	00300 EMPLOYEE BENEFITS	355, 741			11		3.00
3.00 4.00	00400 ADMINISTRATIVE & GENERAL	764, 702				815, 566	4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	157, 284					4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	25, 757					6.00
7.00	00700 HOUSEKEEPING	88, 702					7.00
8.00	00800 DI ETARY	273, 466					8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	123, 114					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	70, 752			0 71, 586		
11.00	01100 PHARMACY	11, 234			0 11, 234		
12.00	01200 MEDI CAL RECORDS & LI BRARY	0		1	0 834		12.00
13.00	01300 SOCIAL SERVICE	52, 868	(10, 13	63, 005	20, 180	13.00
15.00	01500 PATIENT ACTIVITIES	82, 756	(12, 64	92 95, 448	30, 571	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	P			- 1		
30.00	03000 SKILLED NURSING FACILITY	1, 147, 500				461, 693	30.00
31.00	03100 NURSING FACILITY	0			0 0		31.00
33.00	03300 OTHER LONG TERM CARE	0	(0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	3, 472		1	0 3, 472	1, 112	40.00
40.00	04000 RADIOLOGI 04100 LABORATORY	114			0 3, 472		40.00
41.00	04200 INTRAVENOUS THERAPY	0			0 0		41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	5, 402			0 5, 402	-	
44.00	04400 PHYSI CAL THERAPY	39, 551					
45.00	04500 OCCUPATI ONAL THERAPY	15, 791					
46.00	04600 SPEECH PATHOLOGY	6, 414	(1, 2	30 7,644	2, 448	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		D	0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	10, 859	(0 10, 859	3, 478	49.00
51.00	05100 SUPPORT SURFACES	0	(0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS		1				
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS	0					70.00
70.00 71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0			0 0 0 0		70.00 71.00
73.00	07300 CMHC						
73.00	SPECIAL PURPOSE COST CENTERS	0	1	<u>и</u>	0 0	0	73.00
89.00	SUBTOTALS (sum of lines 1-84)	3, 360, 621	125, 142	2 355, 74	41 3, 360, 621	815, 155	89.00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	(0 0	0	90.00
91.00	09100 BARBER & BEAUTY SHOP	1, 283			0 1, 283	411	91.00
92.00	09200 PHYSI CLANS' PRI VATE OFFI CES	0	(0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0			0 0	0	93.00
94.00	09400 PATI ENTS' LAUNDRY	0			0 0	0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST	0		1	0 0	0	95.00
98.00	Cross Foot Adjustments	0		1	0 0	0	98.00
99.00	Negative Cost Centers	0		1	0 0	015 577	99.00
100.00) TOTAL	3, 361, 904	125, 142	2 355, 74	3, 361, 904	815, 566	100.00

Heal th	Financial Systems LIT	TLE BROOK NURSI	NG & CONV. HO	ЛЕ	In Lie	u of Form CMS-2	2540-10
	LLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023		narod
					10 12/31/2023	8/23/2024 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATI ON,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS	(00	7.00	0.00	0.00	
		5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	222, 159					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	6,066	49, 237				6.00
7.00	00700 HOUSEKEEPING	1, 516	17,207	137, 37	6		7.00
8.00	00800 DI ETARY	9,099	C C				8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	3, 791	0	2, 42		202, 685	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	1, 516	0	97		0	10.00
11.00	01100 PHARMACY	0	0		0 0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	1, 516	C	97	1 0	0	12.00
13.00	01300 SOCIAL SERVICE	0	C		0 0	0	13.00
15.00	01500 PATIENT ACTIVITIES	0	C		0 0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	186, 523	49, 237	119, 41	5 422, 461	202, 685	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
33.00	03300 OTHER LONG TERM CARE	0	C		0 0	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	C		0 0	0	40.00
41.00	04100 LABORATORY	0	0		0 0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	12, 132	0	7,76	7 0	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0		0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	C		0 0	0	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	49.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS		-	1			
62.00							62.00
70.00	OTHER REIMBURSABLE COST CENTERS			1		0	70.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	0		0 0	0	71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
89, 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	222, 159	49, 237	137, 37	422, 461	202, 685	89.00
69.00	NONREIMBURSABLE COST CENTERS	222, 139	49,237	137,37	0 422, 401	202,000	09.00
90, 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	1	0 0	0	90.00
90.00 91.00	09100 BARBER & BEAUTY SHOP	0	0		0 0	0	90.00
92.00	09200 PHYSI CI ANS' PRI VATE OFFI CES	0				0	92.00
92.00 93.00	09300 NONPAID WORKERS	0				0	93.00
93.00 94.00	09400 PATIENTS' LAUNDRY					0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST				0 0	0	95.00
98.00	Cross Foot Adjustments		0		0 0	0	98.00
99.00	Negative Cost Centers	0	0		0 0	0	99.00
100.00	5	222, 159	49, 237	137, 37	422, 461	202, 685	
		,,	, _0,		,	,	

	Financial Systems LIT LOCATION - GENERAL SERVICE COSTS	TLE BROOK NURSIN		No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	CENTRAL	PHARMACY	MEDICAL	SOCI AL SERVI CE		45 pm
		SERVICES & SUPPLY		RECORDS & LI BRARY		ACTI VI TI ES	
		10.00	11.00	12.00	13.00	15.00	
-	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.0
	00300 EMPLOYEE BENEFITS						3.0
	00400 ADMINI STRATI VE & GENERAL						4.0
	00500 PLANT OPERATION, MAINT. & REPAIRS						5.0
	00600 LAUNDRY & LINEN SERVICE						6.0
	00700 HOUSEKEEPING						7.0
	00800 DI ETARY						8.0
	00900 NURSING ADMINISTRATION						9.0
0.00	01000 CENTRAL SERVICES & SUPPLY	97,001					10.0
	01100 PHARMACY	0	14, 832				11.0
2.00	01200 MEDI CAL RECORDS & LI BRARY	0	0	3, 58	8		12.0
3.00 0	01300 SOCIAL SERVICE	0	0		0 83, 185		13.0
5.00 0	01500 PATIENT ACTIVITIES	0	0		0 0	126, 019	15.0
I	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 SKILLED NURSING FACILITY	97,001	14, 832	3, 58	8 83, 185	126, 019	30.0
. 00 0	03100 NURSING FACILITY	0	0		0 0	0	31.0
	03300 OTHER LONG TERM CARE	0	0		0 0	0	33. C
	ANCI LLARY SERVI CE COST CENTERS						
	04000 RADI OLOGY	0	0		0 0		
	04100 LABORATORY	0	0		0 0		
	04200 I NTRAVENOUS THERAPY	0	0		0 0		
	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0		
	04400 PHYSI CAL THERAPY	0	0		0 0	0	
	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	1
	04600 SPEECH PATHOLOGY	0	0			0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		° .	0	
	04900 DRUGS CHARGED TO PATIENTS 05100 SUPPORT SURFACES	0	0		0 0 0 0	0	
	OUTPATIENT SERVICE COST CENTERS	0				0	51.0
-	06200 FQHC						62.0
	OTHER REIMBURSABLE COST CENTERS						02.0
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.0
1.00	07100 AMBULANCE	0	0		0 0	0	71.0
	07300 CMHC	0	0		0 0	0	
0	SPECIAL PURPOSE COST CENTERS						
9.00	SUBTOTALS (sum of lines 1-84)	97,001	14, 832	3, 58	8 83, 185	126, 019	89. C
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0		
	09100 BARBER & BEAUTY SHOP	0	0		0 0		
	09200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	
	09300 NONPAI D WORKERS	0	0		0 0	0	
	09400 PATIENTS' LAUNDRY	0	0		0 0	0	
	09500 OTHER NONREIMBURSABLE COST	0	0		0 0	0	
. 00	Cross Foot Adjustments	0				0	1
). 00)0. 00	Negative Cost Centers	0	0		0 0	0	
	TOTAL	97,001	14, 832	3, 58	8 83, 185	126, 019	1100 0

COST ALLOCATION - C	ENERAL SERVICE COSTS		Provi der	No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pr 8/23/2024 1	repared 1:45 pm
Cost Ce	nter Description	Subtotal	Post Stepdown Adjustments	Total			
		16.00	17.00	18.00			
	CE COST CENTERS	1	1				
	COSTS - BLDGS & FIXTURES						1. (
3.00 00300 EMPLOYE							3.0
	TRATIVE & GENERAL						4.0
	PERATION, MAINT. & REPAIRS						5.0
	& LINEN SERVICE						6.0
7.00 00700 HOUSEKE							7.0
3. 00 00800 DI ETAR							8.0
	ADMI NI STRATI ON						9. (
	SERVICES & SUPPLY						10.0
11.00 01100 PHARMA							11. (
	RECORDS & LI BRARY						12.0
13.00 01300 SOCI AL							13.0
15.00 01500 PATIEN							15.0
	ITI NE SERVI CE COST CENTERS	1	-				-
	NURSING FACILITY	3, 208, 126		3, 208, 1			30.0
1.00 03100 NURSI NO		C			0		31.0
	ONG TERM CARE	C	0 0		0		33. 0
	VICE COST CENTERS	1	-				-
10.00 04000 RADI OLO		4, 584		4, 5			40.0
1.00 04100 LABORA		151		1	151		41.0
12.00 04200 I NTRAVE		C	-		0		42.0
	(INHALATION) THERAPY	7,132		7, 1			43.0
14.00 04400 PHYSI CA		90, 941		90, 9			44.0
	I ONAL THERAPY	24, 847		24, 8			45.0
6.00 04600 SPEECH		10, 092		10, 0			46.0
	SUPPLIES CHARGED TO PATIENTS	0			0		48.0
	HARGED TO PATIENTS	14, 337		14, 3			49.0
51.00 05100 SUPPOR		C	0 0		0		51.0
	RVICE COST CENTERS						
2.00 06200 FQHC	CARLE COCT CENTERS						62.0
	SABLE COST CENTERS				0		- 70 (
70.00 07000 HOME HE					0		70.0
71.00 07100 AMBULAN 73.00 07300 CMHC	CE.				0		73.0
	SE COST CENTERS		ر ا		0		- /3.0
	LS (sum of lines 1-84)	2 2(0 210		2 2(0)	210		89.0
	LS (Sum of Trines 1-84) BLE COST CENTERS	3, 360, 210	0	3, 360, 2	210		- 89.0
		0	0		0		
	LOWER, COFFEE SHOPS & CANTEEN	-	-	1 /	0		90.0
	& BEAUTY SHOP	1, 694		1, 6			
	ANS' PRIVATE OFFICES	0	-		0		92.
3. 00 09300 NONPAI [0		0		93.
4. 00 09400 PATIEN		C			0		94.
1 1	ONREI MBURSABLE COST	C	, s		0		95.
	oot Adjustments		0		0		98.0
5	e Cost Centers		0		0		99. (
00.00 TOTAL		3, 361, 904	0	3, 361, 9	704		100.

ALLOOA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315467	Period: From 01/01/2023 To 12/31/2023		nared
					10 12/31/2023	8/23/2024 11:	45 pm
			CAPI TAL				
			RELATED COSTS				
	Cost Center Description	Directly	BLDGS &	Subtotal		ADMI NI STRATI VE	
		Assigned New Capital	FIXTURES		BENEFITS	& GENERAL	
		Rel ated Costs					
		0	1.00	2A	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS	0	0		0 0		3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	0	2, 086	2, 08	6 0	2, 086	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	834	83		138	•
6.00	00600 LAUNDRY & LINEN SERVICE	0	3, 337	3, 33		27	•
7.00	00700 HOUSEKEEPI NG	0	834	83		84	
8.00	00800 DI ETARY	0	5,006	5,00		253	•
9.00	00900 NURSI NG ADMI NI STRATI ON	0	2,086	2, 08		122	•
	01000 CENTRAL SERVICES & SUPPLY	0	834	83		59	•
		0	0		0 0	9	•
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	834	83			
	01500 PATIENT ACTIVITIES	0	0		0 0		•
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	/0	15.00
30.00	03000 SKI LLED NURSING FACILITY	0	102, 617	102, 61	7 0	1, 181	30.00
	03100 NURSING FACILITY	0	02,017	102,01	0 0		1
	03300 OTHER LONG TERM CARE	0	0		0 0		•
	ANCI LLARY SERVICE COST CENTERS	1 -	-				1
40.00	04000 RADI OLOGY	0	0		0 0	3	40.00
41.00	04100 LABORATORY	0	0		0 0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	4	•
	04400 PHYSI CAL THERAPY	0	6, 674	6, 67	4 0	44	•
	04500 OCCUPATI ONAL THERAPY	0	0		0 0	15	•
	04600 SPEECH PATHOLOGY	0	0		0 0	6	•
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	•
	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0		•
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVICE COST CENTERS	0	0		0 0	0	51.00
62.00	06200 FQHC						62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	0		0 0	0	
73.00	07300 СМНС	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
89.00	SUBTOTALS (sum of lines 1-84)	0	125, 142	125, 14	2 0	2, 085	89.00
	NONREI MBURSABLE COST CENTERS	1					
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0		•
	09100 BARBER & BEAUTY SHOP	0	0		0 0		•
	09200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0	-	•
	09300 NONPALD WORKERS	0	0		0 0	-	
	09400 PATIENTS' LAUNDRY	0	0		0 0	-	
95.00	09500 OTHER NONREI MBURSABLE COST	0	0		0 0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		0		0 0	0	98.00 99.00

Heal th	Financial Systems LIT	TLE BROOK NURSI	ING & CONV.	HOME		In Lie	u of Form CMS-2	2540-10
	TION OF CAPITAL RELATED COSTS			der No.: 315467	Period: From 01/0 To 12/3		Worksheet B Part II Date/Time Pre 8/23/2024 11:	pared:
	Cost Center Description	PLANT OPERATI ON, MAI NT. & REPAI RS 5. 00	LAUNDRY LI NEN SERV 6. 00		NG DIET		NURSI NG ADMI NI STRATI ON 9. 00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.	00	9.00	
1.00 3.00 4.00 5.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	972						1.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION	27 7 40 17	3,	391 0 0	925 39 16	5, 338 0	2, 241	6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY	7 0 7		0	7 0 7	0 0 0	0 0 0	10. 00 11. 00 12. 00
13.00 15.00 30.00	01300 SOCIAL SERVICE 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	814	3,	391	0 0 804	5, 338	0 0 2, 241	13.00 15.00 30.00
31. 00 33. 00	03100 NURSING FACILITY 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0		0	0	0	0	31.00 33.00
40.00 41.00 42.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0		0 0 0	0 0 0	0 0 0	0	40.00 41.00 42.00
42.00 43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0		0	0 52	0	0 0 0	42.00 43.00 44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0		0	0	0	0	45.00 46.00
48.00 49.00 51.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05100 SUPPORT SURFACES	0 0 0		0 0 0	0 0 0	0 0 0	0 0 0	48.00 49.00 51.00
62.00	OUTPATIENT SERVICE COST CENTERS 06200 FQHC OTHER REIMBURSABLE COST CENTERS							62.00
70.00 71.00 73.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0		0 0 0	0 0 0	0 0 0	0 0 0	70.00 71.00 73.00
89.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	972	3,	391	925	5, 338	2, 241	89.00
90.00 91.00 92.00 93.00 94.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER & BEAUTY SHOP 09200 PHYSICIANS' PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS' LAUNDRY	0 0 0 0 0		0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0 0	90.00 91.00 92.00 93.00 94.00
95.00 98.00 99.00 100.00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments Negative Cost Centers TOTAL	0 0 972	3,	0 0 0 391	0 0 925	0 0 5, 338	0 0 2, 241	95.00 98.00 99.00 100.00

Heal th	Financial Systems LIT	TLE BROOK NURSI	NG & CONV. HO	ME	In Lie	eu of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315467	Period: From 01/01/2023 To 12/31/2023		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES & SUPPLY		RECORDS & LI BRARY	10.00	ACTI VI TI ES	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	15.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6,00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	907					10.00
11.00	01100 PHARMACY	0	(9			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	(2 84	19		12.00
13.00	01300 SOCIAL SERVICE	0	(D	0 52		13.00
15.00	01500 PATIENT ACTIVITIES	0	(D	0 0	78	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	907	(9 84	19 52	78	30.00
31.00	03100 NURSING FACILITY	0	(C	0 0	0	31.00
33.00	03300 OTHER LONG TERM CARE	0	(D	0 0	0	33.00
	ANCILLARY SERVICE COST CENTERS			-1	_		
	04000 RADI OLOGY	0		C	0 0		
	04100 LABORATORY	0		C	0 0		
	04200 I NTRAVENOUS THERAPY	0		C	0 0		
	04300 OXYGEN (INHALATION) THERAPY	0		C	0 0	0	
	04400 PHYSI CAL THERAPY	0		C	0 0	0	
	04500 OCCUPATIONAL THERAPY	0		C	0 0	0	
	04600 SPEECH PATHOLOGY	0	(°.	0 0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		D C	0 0	0	
	04900 DRUGS CHARGED TO PATIENTS	0			0 0	0	
51.00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	(2	0 0	0	51.00
62.00	06200 FQHC						62.00
02.00	OTHER REIMBURSABLE COST CENTERS	II		1	_	I	02.00
70.00	07000 HOME HEALTH AGENCY COST	0	(D	0 0	0	70.00
	07100 AMBULANCE	0			0 0		
73.00	07300 CMHC	0	(D C	0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS						1
89.00	SUBTOTALS (sum of lines 1-84)	907	(9 84	19 52	78	89.00
	NONREI MBURSABLE COST CENTERS			_			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		C	0 0		90.00
	09100 BARBER & BEAUTY SHOP	0		C	0 0		
92.00	09200 PHYSI CLANS' PRI VATE OFFI CES	0		C	0 0	0	
93.00	09300 NONPAI D WORKERS	0		C	0 0	0	
94.00	09400 PATIENTS' LAUNDRY	0		C	0 0	0	
	09500 OTHER NONREI MBURSABLE COST	0		C	0 0	0	
98.00	Cross Foot Adjustments	0		C		0	
99.00	Negative Cost Centers	0		0	0 0	0	
100.00	TOTAL	907	C C	9 84	19 52	78	100.00

Heal th	Fi nanc	ial Syst	ems
	TLON OF	OADL TAL	

In Lieu of Form CMS-2540-10

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315467	Period: Worksheet From 01/01/2023 Part II	t B
					To 12/31/2023 Date/Time	Prepared:
	Cost Center Description	Subtotal	Post Step-Dow	n Total	872372024	1 11:45 pm
			Adjustments			
		16.00	17.00	18.00		
	GENERAL SERVICE COST CENTERS	[1	-1		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300 EMPLOYEE BENEFITS					3.00
4.00	00400 ADMINI STRATI VE & GENERAL					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600 LAUNDRY & LINEN SERVICE					6.00
7.00	00700 HOUSEKEEPI NG					7.00
8.00	00800 DI ETARY					8.00
9.00	00900 NURSI NG ADMI NI STRATI ON					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY					10.00
11.00	01100 PHARMACY					11.00
12.00	01200 MEDICAL RECORDS & LIBRARY					12.00
13.00	01300 SOCI AL SERVI CE					13.00
15.00	01500 PATIENT ACTIVITIES					15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	440.004		140.00	24	
30.00	03000 SKI LLED NURSI NG FACI LI TY	118, 281		118, 28		30.00
31.00		0		D	0	31.00
33.00	O3300 OTHER LONG TERM CARE	0		D	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS	0				40.00
40.00	04000 RADI OLOGY	3			3	40.00
41.00		0			0	41.00
42.00	04200 INTRAVENOUS THERAPY	0				42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	4			4	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	6, 823		6,82		44.00
45.00		15			15	45.00
48.00	04600 SPEECH PATHOLOGY	0			6	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0			9	48.00 49.00
49.00 51.00	05100 SUPPORT SURFACES	9			0	49.00 51.00
51.00	OUTPATIENT SERVICE COST CENTERS	0		J	0	51.00
62.00	06200 FQHC					62.00
02.00	OTHER REIMBURSABLE COST CENTERS					02.00
70.00	07000 HOME HEALTH AGENCY COST	0		b	0	70.00
71.00	07100 AMBULANCE	0			0	71.00
73.00	07300 CMHC	0			0	73.00
70.00	SPECIAL PURPOSE COST CENTERS			5		/ 0. 00
89.00	SUBTOTALS (sum of lines 1-84)	125, 141		0 125, 14	41	89.00
07.00	NONREI MBURSABLE COST CENTERS	125,141		120,11		07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		b	0	90.00
91.00	09100 BARBER & BEAUTY SHOP	1			1	91.00
92.00	09200 PHYSI CI ANS' PRI VATE OFFI CES	0			0	92.00
93.00	09300 NONPAI D WORKERS	0		2	0	93.00
94.00	09400 PATI ENTS' LAUNDRY	0			0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST	0			0	95.00
98.00	Cross Foot Adjustments	0			0	98.00
99.00	Negative Cost Centers	n n		b	0	99.00
100.00		125, 142		125, 14	42	100.00
					1	

OST ALLO	nancial Systems LIT CATION - STATISTICAL BASIS	TEE DROOK MONOT	NG & CONV. HOM Provider		Peri od:	u of Form CMS- Worksheet B-1	
JOT MELO					From 01/01/2023 To 12/31/2023	Date/Time Pre	pare
	Cost Center Description	CAPI TAL RELATED COSTS BLDGS & FI XTURES (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	PLANT OPERATI ON, MAI NT. & REPAI RS (SOUARE FEET)	<u>45 p</u>
		1.00	3.00	4A	4.00	5.00	-
GEN	NERAL SERVICE COST CENTERS						
. 00 003 . 00 004 . 00 005 . 00 006	100 CAP REL COSTS - BLDGS & FIXTURES 300 EMPLOYEE BENEFITS 400 ADMINISTRATIVE & GENERAL 500 PLANT OPERATION, MAINT. & REPAIRS 500 LAUNDRY & LINEN SERVICE 700 HOUSEKEEPING	7, 500 0 125 50 200 50	1, 855, 362 254, 403 52, 921 18, 795 69, 711	-815, 56	6 2, 546, 338 0 168, 265 0 32, 698 0 102, 902	7, 325 200 50	6.
00 008 00 009 0.00 010 .00 011 2.00 012	300 DI ETARY 200 NURSI NG ADMI NI STRATI ON 200 CENTRAL SERVI CES & SUPPLY 100 PHARMACY 200 MEDI CAL RECORDS & LI BRARY	300 125 50 0 50	157, 507 123, 114 0 0 0 0		308, 672 148, 806 71, 586 11, 234 84	300 125 50 0 50	8. 9. 10. 11. 12.
5.00 015	300 SOCIAL SERVICE 500 PATIENT ACTIVITIES	0	52, 868 66, 194		0 63, 005 0 95, 448	0	
. 00 030 . 00 031 . 00 033	PATIENT ROUTINE SERVICE COST CENTERS DOO SKILLED NURSING FACILITY 100 NURSING FACILITY 300 OTHER LONG TERM CARE DILLARY SERVICE COST CENTERS	6, 150 0 0	998, 093 0 0) (D 1,441,487 D 0 D 0	6, 150 0 0	31
0.00 040 .00 041 .00 042 .00 043 .00 043 .00 044 .00 044 .00 044 .00 044 .00 044 .00 044 .00 044 .00 044 .00 044 .00 044 .00 044 .00 045 .00 045	Direction of the cost o	0 0 0 400 0 0 0 0 0 0 0 0	0 0 39, 551 15, 791 6, 414 0 0 0		0 3, 472 0 114 0 5, 402 0 53, 808 0 18, 819 0 7, 644 0 0 0 10, 859 0 0	0 0 400 0 0 0 0 0 0	41 42 43 44 45 46 48 49
							62
0.00 070 .00 071 .00 073	HER REIMBURSABLE COST CENTERS DOO HOME HEALTH AGENCY COST 100 AMBULANCE 300 CMHC ECIAL PURPOSE COST CENTERS	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	71
. 00	SUBTOTALS (sum of lines 1-84)	7, 500	1, 855, 362	-815, 56	6 2, 545, 055	7, 325	89
0.00 090 .00 091 .00 092 .00 093 .00 094 .00 095 .00 095	IREI MBURSABLE COST CENTERS OOO GIFT, FLOWER, COFFEE SHOPS & CANTEEN IOO BARBER & BEAUTY SHOP OO PHYSI CLANS' PRI VATE OFFICES OO NONPAI D WORKERS HOO PATIENTS' LAUNDRY OTHER NONREI MBURSABLE COST Cross Foot Adjustments Newsting Content Contents	0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 1,283 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	91 92 93 94 95 98
2.00 2.00 3.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	125, 142 16. 685600	355, 741 0. 191737		815, 566 0. 320290	222, 159 30. 328874	
4.00	Cost to be allocated (per Wkst. B, Part II)		0		2, 086	972	104
5.00	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 000819	0. 132696	105

COST 4	ALLOCATION - STATISTICAL BASIS		Provi der	No.: 315467	Period:	Worksheet B-1	2540-10
0001 7	LEOCATION - STATISTICAE DASIS		110VI dei	NO 313407	From 01/01/2023		
					To 12/31/2023	Date/Time Pre 8/23/2024 11:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	NURSI NG	CENTRAL	
		LINEN SERVICE	(SQUARE	(PATI ENT	ADMI NI STRATI ON	SERVICES &	
		(PATI ENT DAYS)	FEET)	DAYS)	(PATI ENT	SUPPLY (PATI ENT	
		DATS)			DAYS)	DAYS)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	Т	1	1			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS						1.00
3.00 4.00	00400 ADMINISTRATIVE & GENERAL						3.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE	10, 377					6.00
7.00	00700 HOUSEKEEPI NG	0	7, 075				7.00
8.00	00800 DI ETARY	0	300		7		8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	125		0 10, 377		9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	50		0 0	10, 377	10.00
11.00	01100 PHARMACY	0	0)	0 0	0	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	50		0 0	0	12.00
13.00	01300 SOCIAL SERVICE	0	0		0 0	0	
15.00	01500 PATIENT ACTIVITIES	0	0)	0 0	0	15.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10.077		10.05		40.077	
30.00	03000 SKI LLED NURSI NG FACI LI TY	10, 377	6, 150			10, 377	
31.00	03100 NURSING FACILITY	0	0		0 0	0	
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0)	0 0	0	33.00
40.00	04000 RADI OLOGY	0	C	J	0 0	0	40.00
40.00	04100 LABORATORY	0			0 0	0	
42.00	04200 I NTRAVENOUS THERAPY	0			0 0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0			0 0	0	1
44.00	04400 PHYSI CAL THERAPY	0	400		0 0	0	1
45.00	04500 OCCUPATIONAL THERAPY	0	C		0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	0	46.00
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
51.00	05100 SUPPORT SURFACES	0	C)	0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS			1			1 / 2 . 2 .
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	C		0 0	0	70.00
71.00	07100 AMBULANCE	0			0 0	0	
73.00	07300 CMHC	0			0 0	0	
	SPECIAL PURPOSE COST CENTERS				<u> </u>		
89.00	SUBTOTALS (sum of lines 1-84)	10, 377	7,075	10, 37	7 10, 377	10, 377	89.00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
	09100 BARBER & BEAUTY SHOP	0	0)	0 0	0	
	09200 PHYSI CLANS' PRI VATE OFFI CES	0	C)	0 0	0	1
	09300 NONPAI D WORKERS	0	0		0 0	0	
94.00	09400 PATIENTS' LAUNDRY	0	0)	0 0	0	
95.00	09500 OTHER NONREI MBURSABLE COST	0	0)	0 0	0	
98.00 99.00	Cross Foot Adjustments						98.00 99.00
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	49, 237	137, 376	422, 46	202, 685	07 001	102.00
102.00	Part I)	47,237	137,370	422,40	202,085	97,001	102.00
103.00		4. 744820	19. 417102	40. 71128	19. 532138	9.347692	103.00
104.00		3, 391	925				104.00
	Part II)				_,	,	
105.00		0. 326780	0. 130742	0. 51440	0. 215958	0.087405	105.00
		1	1	1			1

	u of Form CMS-2540-10
Period:	Worksheet B-1
To 12/31/2023	Worksheet B-1 Date/Time Prepared:

				T	o 12/31/2023	Date/Time Prepared:
					OTHER GENERAL	8/23/2024 11:45 pm
					SERVI CE	
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		(PATI ENT DAYS)	RECORDS &		ACTI VI TI ES (PATI ENT	
		DAYS)	LI BRARY (PATI ENT	(PATI ENT DAYS)	DAYS)	
			DAYS)	bitto)	bitto)	
		11.00	12.00	13.00	15.00	
4 00	GENERAL SERVICE COST CENTERS					1.00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL					3.00 4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600 LAUNDRY & LINEN SERVICE					6.00
7.00	00700 HOUSEKEEPI NG					7.00
8.00	00800 DI ETARY					8.00
9.00	00900 NURSI NG ADMI NI STRATI ON					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	10 077				10.00
11.00 12.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	10, 377 0	10, 377	,		11.00
13.00		0	10, 377			13.00
15.00		0	Ő			15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•		
30.00		10, 377	10, 377	10, 377	10, 377	30.00
31.00		0	0			31.00
33.00		0	0	0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0		0	40.00
40.00		0	0		-	40.00
42.00		0	C	-	-	42.00
43.00		0	C	0	0	43.00
44.00		0	C	0	0	44.00
45.00		0	0	0	-	45.00
46.00		0	0	0	-	46.00
48.00 49.00		0	0			48.00 49.00
49.00 51.00		0	0		-	49.00 51.00
51.00	OUTPATIENT SERVICE COST CENTERS	0		, <u> </u>	0	31.00
62.00						62.00
	OTHER REIMBURSABLE COST CENTERS	1 1		1	1	
70.00		0	0			70.00
71.00 73.00	07100 AMBULANCE	0	0			71.00
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	0	0	73.00
89.00		10, 377	10, 377	10, 377	10, 377	89.00
	NONREI MBURSABLE COST CENTERS			, · · · ·		
90.00		0	0		-	90.00
91.00		0	0	-	-	91.00
92.00		0	0	0		92.00
93.00	09300 NONPAI D WORKERS 09400 PATI ENTS' LAUNDRY	0	0	-		93.00 94.00
94.00 95.00		0	0			94.00
98.00		0	0	Ĭ		98.00
99.00	Negative Cost Centers					99.00
102.00		14, 832	3, 588	83, 185	126, 019	102.00
	Part I)					
103.00		1. 429315	0. 345765			103.00
104.00	0 Cost to be allocated (per Wkst. B, Part II)	9	849	52	78	104.00
105.00		0.000867	0. 081816	0. 005011	0.007517	105.00

Health Financial Systems LITTLE BROOK NURSING	& CONV. HON	ΛE	In Lie	eu of Form CMS-:	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der	No.: 315467	Peri od:	Worksheet C	
			From 01/01/2023		
			To 12/31/2023		
		1		8/23/2024 11:	<u>45 pm</u>
Cost Center Description		Total (from	Total Charges		
		Wkst. B, Pt I	1	di vi ded by	
		col. 18)		col. 2	
		1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS					
40. 00 04000 RADI OLOGY		4, 58	4 3, 472	1. 320276	40.00
41. 00 04100 LABORATORY		15	1 114	1. 324561	41.00
42. 00 04200 I NTRAVENOUS THERAPY			o c	0. 000000	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY		7, 13	2 5, 402	1. 320252	43.00
44. 00 04400 PHYSI CAL THERAPY		90, 94	1 39, 551	2.299335	44.00
45. 00 04500 OCCUPATI ONAL THERAPY		24, 84	7 15, 791	1.573491	45.00
46.00 04600 SPEECH PATHOLOGY		10, 09	2 6, 414	1. 573433	46.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			0 0	0. 000000	48.00
49. 00 04900 DRUGS CHARGED TO PATIENTS		14, 33	7 10, 859	1. 320287	49.00
51.00 05100 SUPPORT SURFACES			0 0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS					1
62.00 06200 FQHC					62.00
71. 00 07100 AMBULANCE			0 0	0. 000000	71.00
100. 00 Total		152, 08	4 81, 603	8	100.00

Health Financial Systems LI	TTLE BROOK NURS	ING & CONV. HOM	ΛE	In Lie	eu of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Period: From 01/01/2023 To 12/31/2023		
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care P	rogram Charges	6 Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT ANCILLARY SERVICE COST CENTERS	TENT COST					
40. 00 04000 RADI OLOGY	1. 320276	0		0 0	0	40.00
41.00 04100 LABORATORY	1. 324561			0 0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 320252	0		0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	2. 299335	3, 473		0 7, 986	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	1. 573491	465		0 732	0	45.00
46.00 04600 SPEECH PATHOLOGY	1. 573433	0		0 0	0	46.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 320287	4, 092		0 5, 403	0	49.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
62.00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 000000			0	0	71.00
100.00 Total (Sum of Lines 40 - 71)		8, 030		0 14, 121	0	100. 00
(1) For title V and VIV use columns 1 2 and 4 and						

(1) For title 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.

Health Financial Systems LIT	TLE BROOK NURSI	NG & CONV. HO	ИЕ	In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315467	Period: From 01/01/2023 To 12/31/2023		
		Titl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST						
1.00Drugs charged to patients - ratio of co2.00Program vaccine charges (From your reco	rds, or the PS&	&R)		r	1. 320287 0	1.00 2.00
3.00 Program costs (Line 1 x line 2) (Title E, Part I, line 18)		viders, transf		t to Worksheet	0	3.00
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
	(From Wkst. B,			Cost (From	& Allied	
		(From Wkst. B,			Health Costs	
	18		Costs to Tota		for Pass	
		14)	Costs - Part		Through (Col.	
			(Col . 2 / Col		3 x Col. 4)	
	1.00	2.00	1)	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS			3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	FUR NURSING &	ALLIED HEALIH				
40. 00 04000 RADI OLOGY	4, 584	0	0.0000	0	0	40.00
41. 00 04100 LABORATORY	4, 584		0.00000		0	40.00
42. 00 04200 I NTRAVENOUS THERAPY	131		0.00000		0	41.00
43. 00 04300 0XYGEN (INHALATION) THERAPY	7, 132		0.00000		0	42.00
44. 00 04400 PHYSICAL THERAPY	90, 941		0.00000		°	43.00
45. 00 04500 OCCUPATI ONAL THERAPY	24, 847		0.00000		0	45.00
46. 00 04600 SPEECH PATHOLOGY	10, 092		0.00000		0	46.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 072		0.00000		0	48.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	14, 337		0.00000		-	49.00
51. 00 05100 SUPPORT SURFACES	14, 337		0.00000		0	51.00
100.00 Total (Sum of Lines 40 - 52)	152,084			14, 121	-	100.00
		, °	I		, °	1.22.00

)MPUT.	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315467	Period: From 01/01/2023 To 12/31/2023		pared
		Title XVIII	Skilled Nursing Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				1
00	Inpatient days including private room days			10, 377	1.
	Private room days			0	2.
	Inpatient days including private room days applicable to t			209	3.
	Medically necessary private room days applicable to the Pr	rogram		0	
	Total general inpatient routine service cost			3, 208, 126	5.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00	General inpatient routine service charges			4, 027, 440	
00	General inpatient routine service cost/charge ratio (Line	e 5 divided by line 6)		0. 796567	
00	Enter private room charges from your records			0	
00	Average private room per diem charge (Private room charges 2)	s line 8 divided by private	room days, line	0.00	9.
0. 00					
. 00	Average semi-private room per diem charge (Semi-private r semi-private room days)	room charges line 10, divide	d by	388. 11	11.
2. 00	Average per diem private room charge differential (Line 9	minus line 11)		0.00	12.
	Average per diem private room cost differential (Line 7 ti			0.00	13.
. 00	Private room cost differential adjustment (Line 2 times li	ne 13)		0	14.
	General inpatient routine service cost net of private room	n cost differential (Line 5	minus line 14)	3, 208, 126	15.
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		309.16	
	Program routine service cost (Line 3 times line 16)			64, 614	
	Medically necessary private room cost applicable to progra			0	
	Total program general inpatient routine service cost (Lir		+ 11 10	64, 614	
. 00	Capital related cost allocated to inpatient routine servic line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ce costs (From WKSt. B, Par	t II column 18,	118, 281	20
. 00	Per diem capital related costs (Line 20 divided by line 1	1)		11.40	21
	Program capital related costs (Line 3 times line 21)	• /		2, 383	
	Inpatient routine service cost (Line 19 minus line 22)			62, 231	
	Aggregate charges to beneficiaries for excess costs (From	n provider records)		02, 231	
	Total program routine service costs for comparison to the		nus line 24)	62, 231	
	Enter the per diem limitation (1)	cost min tation (Line 23 mi	103 1110 27)	02,231	26.
	Inpatient routine service cost limitation (Line 3 times th	ne per diem limitation line	26) (1)		27
	Reimbursable inpatient routine service costs (Line 22 plus				28
	(Transfer to Worksheet E, Part II, line 4) (See instruction				1 20

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	10, 377	1.00
2.00	Program inpatient days (see instructions)	209	2.00
3.00	Total nursing & allied health costs. (see instructions) (Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 020141	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Т

Heal th	Financial Systems LITTLE BROOK NURSING	& CONV. HOME	In Lie	u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315467	Peri od:	Worksheet E	
			From 01/01/2023 To 12/31/2023	Part I Date/Time Prem	arod
			10 12/31/2023	8/23/2024 11:4	
-		Title XVIII	Skilled Nursing	PPS	
			Facility		
	r			1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBUR	SEMENT			
1.00	Inpatient PPS amount (See Instructions)			110, 276	1.00
2.00	Nursing and Allied Health Education Activities (pass through p	bayments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			110, 276	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			11, 600	5.00
6.00	Allowable bad debts (From your records)			0	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instr	fuctions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			0	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			98, 676	
12.00	Interim payments (See instructions)			96, 702	12.00
13.00	Tentative adjustment			0	13.00
14.00 14.50	OTHER adjustment (See instructions)			0	14.00 14.50
14.50	Demonstration payment adjustment amount before sequestration Demonstration payment adjustment amount after sequestration			0	14.50 14.55
14. 55	Sequestration for non-claims based amounts (see instructions)			0	14. 55
14.75	Sequestration amount (see instructions)			1, 974	
14.99	Balance due provider/program (see Instructions)			1, 9/4	14.99
	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub 15-2 s	action 115(2)	0	16.00
10.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER			0	10.00
17.00	Ancillary services Part B			0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			Ő	18.00
19.00	Total reasonable costs (Sum of Lines 17 and 18)			Ő	19.00
20.00	Medicare Part B ancillary charges (See instructions)			Ő	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			ō	21.00
22.00	Primary payor amounts			0	22.00
23.00	Coinsurance and deductibles			0	23.00
24.00	Allowable bad debts (From your records)			0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instr	ructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)			0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.00
26.00	Interim payments (See instructions)			0	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50	Demonstration payment adjustment amount before sequestration			0	28.50
28.55	Demonstration payment adjustment amount after sequestration			0	28.55
28.99	Sequestration amount (see instructions)			0	28.99
29.00	Balance due provider/program (see instructions)			0	29.00
20 00	Protested amounts (Nonallowable cost report items) in accordar	nce with CMS Pub.15-2. s	ection 115.2	0	30.00

	Financial Systems LITTLE BROOK NURSING			u of Form CMS-	-2540-
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY	Provider No.: 315467	Period: From 01/01/2023	Worksheet E Part II	
			To 12/31/2023		
		Title XIX	Skilled Nursing	8/23/2024 11: Cost	45 pi
			Facility	0001	
				1.00	
. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient ancillary services (see Instructions)			(0 1.0
. 00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, lin	e 5)		C	
. 00	Outpatient services	6 5)		(
. 00	Inpatient routine services (see instructions)			-	2 4.
. 00 . 00	Utilization reviewphysicians' compensation (from provider re	cords)		(
. 00 . 00	Cost of covered services (Sum of Lines 1 - 5)			(-
. 00	Differential in charges between semiprivate accommodations and	less than semi-private	accommodations	(
. 00	SUBTOTAL (Line 6 minus line 7)	ress than sem private		C	
. 00	Primary payor amounts) 9.
	Total Reasonable Cost (Line 8 minus line 9)			-	10.
0.00	REASONABLE CHARGES			Ĺ	1 10.
1 00	Inpatient ancillary service charges			(11.
	Outpatient service charges			-) 12.
	Inpatient routine service charges) 13.
	Differential in charges between semiprivate accommodations and	Less than semi-private	accommodations	-) 14.
	Total reasonable charges	ress than sempirvate		-) 15.
5.00	CUSTOMARY CHARGES			L. L.	<u> </u>
6.00	Aggregate amount actually collected from patients liable for p	avment for services on	a charge basis	(16.
7.00	Amounts that would have been realized from patients liable for	5	U U		17.
7.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services o	in a charge basis	C	1
8.00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.00000	18.
	Total customary charges (see instructions)) 19.
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
D. 00	Cost of covered services (see Instructions)			(20.
	Deducti bl es				21.
	Subtotal (Line 20 minus line 21)			-	22.
	Coinsurance			-	23.
	Subtotal (Line 22 minus line 23)			-	24.
	Allowable bad debts (from your records)			-	25.
	Subtotal (sum of lines 24 and 25)				26.
7.00	Unrefunded charges to beneficiaries for excess costs erroneous	ly collected based on c	orrection of	-	20.
/.00	cost limit	ry connected based on e		C	27.
8.00	Recovery of excess depreciation resulting from provider termin	ation or a decrease in	nrogram	C	28.
0.00	utilization		program		20.
9.00	Other Adjustments (see instructions) Specify			ſ	29.
0.00	Amounts applicable to prior cost reporting periods resulting f	rom disposition of depr	eciable assets (-	30.
2.00	if minus, enter amount in parentheses)			c c	
1.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		C	31.
	Interim payments			-	32.
3.00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see		33.
		pagmonto in paront		c	- 00.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provi der			Worksheet E-1 Date/Time Prep 8/23/2024 11:4	pared
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	F
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		96, 7	/02 0	0	2. (
00	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					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	
03				0	0	
04				0	0	3.
05	Dravidar to Dragram			0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	
53				0	0	3.
54				0	0	3.
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		96, 7	702	0	4.
~ ~	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
02				0	0	
03				0	0	
	Provider to Program					1
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52	Subtatal (Sum of Lines E 01 - E 40 minus sum of Lines E 50			0	0	
99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0		1 5
00	Determined net settlement amount (balance due) based on					6.
D1	the cost report. (1) PROGRAM TO PROVIDER			0	0	6.
)2	PROVIDER TO PROVIDER			0	0	
02	Total Medicare program liability (see instructions)		96.7		0	
-				actor Name	Contractor	
					Number	
				1.00	2.00	

	(If you are nonproprietary and do not maintain bunting records, complete the "General Fund" column	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet G Date/Time Pre 8/23/2024 11:	
		General Fund	Speci fi c	Endowment Fund		45
		1.00	Purpose Fund 2.00	3.00	4.00	-
Assets			2.00	0.00		
	ASSETS					
	hand and in banks	-669, 260		0 0	0	
	ry investments eceivable	0		0 0	0	
	s recei vabl e	1, 354, 912		0 0	0	
	ecei vabl es	0		0 0	0	
	llowances for uncollectible notes and accounts	0		0 0	0	
recei va						
00 Invento	5	6, 150		0 0	0	
	expenses urrent assets	72, 200		0 0	0	
	m other funds	2,270		0 0	0	
	URRENT ASSETS (Sum of Lines 1 - 10)	766, 272		0 0	0	
FI XED A		100/2/2		0		1.
00 Land		0		0 0	0	12
00 Land in	provements	0		0 0	0) 13
	ccumulated depreciation	0		0 0	0	
00 Buildir	5	0		0 0	0	
	cumulated depreciation	0		0 0	0	
	ld improvements ccumulated Amortization	315, 307 -121, 522		0 0	0	
	quipment	-121, 322		0 0	0	
	ccumulated depreciation	0		0 0	0	
	iles and trucks	122, 842		0 0	0	
.00 Less: A	ccumulated depreciation	-73, 845		0 0	0	22
.00 Major m	ovable equipment	424, 222		0 0	0) 23
	ccumulated depreciation	-418, 660		0 0	0	
	quipment - Depreciable	0		0 0	0	
	quipment nondepreciable	0		0 0	0	
	ixed assets	249.244		0 0	0	
. 00 TOTAL F OTHER A	IXED ASSETS (Sum of lines 12 - 27)	248, 344		0 0	0	<u>'</u> 20
. 00 Investr		0		0 0	0	29
	s on Leases	0		0 0	0	
	m owners/officers	0		0 0	0	31
.00 Other a	ssets	600, 000		0 0	0) 32
	THER ASSETS (Sum of lines 29 - 32)	600, 000		0 0	0	
	SSETS (Sum of Lines 11, 28, and 33)	1, 614, 616		0 0	0) 34
	ti es and Fund Balances LI ABI LI TI ES					-
	s payable	261, 181		0 0	0	35
	s, wages, and fees payable	51, 191		0 0	0	
	taxes payable	0		0 0	0	
	loans payable (Short term)	0		0 0	0	
.00 Deferre	d income	0		0 0	0) 39
	ated payments	0				40
	other funds	0		0 0	0	
	urrent liabilities	-29, 114		0 0	0	
	URRENT LIABILITIES (Sum of lines 35 - 42) RM LIABILITIES	283, 258		0 0	0	43
	e payable	0		0 0	0	0 44
00 Notes p	1 5	0		0 0	0	
	ed Loans	0		0 0	0	46
.00 Loans f	rom owners:	0		0 0	0	47
	ong term liabilities	69, 777		0 0	0	
	SPECIFY)	0		0 0	0	
	ONG TERM LIABILITIES (Sum of lines 44 - 49	69, 777		0 0	0	
	ACCOUNTS (Sum of lines 43 and 50)	353, 035		0 0	0) 5'
	fund bal ance	1, 261, 581				52
	c purpose fund	1,201,001		0		5
	reated - endowment fund balance - restricted			0		54
	reated - endowment fund balance - unrestricted			0		55
	ng body created - endowment fund balance			0		56
	und balance - invested in plant				0	
	und balance - reserve for plant improvement,				0	58
	ment, and expansion	1 0/1 501			~	\ _ <i>_</i>
	UND BALANCES (Sum of lines 52 thru 58) IABILITIES AND FUND BALANCES (Sum of lines 51 and	1, 261, 581 1, 614, 616			0	
	THE THE AND TOND DALANCES (SUM OF TIMES ST AND	1,014,010		0		

SIME	MENT OF CHANGES IN FUND BALANCES		Provi der		Peri		Worksheet G-		
						01/01/2023 12/31/2023	Date/Time Pr 8/23/2024 11	epar	
		General	Fund	Speci al	Purpo	se Fund	Endowment Fun	b	
			0.00				5 00		
1.00	Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00	1	1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)		1, 243, 896 15, 685 1, 261, 581			0		2	2.00 3.00
4.00 5.00	Additions (credit adjustments)	0			0				4.0C 5.0C
5.00 6.00		0			0				5. UC 6. OC
7.00		0			0				7. OC
8.00		0			0				8. OC
9.00		0	_		0	_			9. OC
10.00	Total additions (sum of line 5 - 9)		0			0			0.00
11.00 12.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments)		1, 261, 581			0			1.0C 2.0C
13.00		0			0				3. OC
14.00		0			0				4. OC
15.00		0			0				5. OC
16.00 17.00		0			0				6.0C 7.0C
17.00	Total deductions (sum of lines 13 - 17)	0	0		0	0			7.00 8.00
19.00	Fund balance at end of period per balance sheet (Line 11 - Line 18)		1, 261, 581			0			9. OC
		Endowment Fund	Pl ant	Fund					
		6.00	7.00	8.00	_				
1.00	Fund balances at beginning of period	0			0				1. OC
2.00 3.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	О			0			3	2.00 3.00
4.00 5.00	Additions (credit adjustments)		0						4.0C 5.0C
6.00			0						6. OC
7.00			0						7. OC
8.00			0						8.00
9.00			0		~				9.00
10.00 11.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0			0				0. OC 1. OC
12.00	Deductions (debit adjustments)				Ŭ				2.00
13.00			0						3. OC
14.00			0						4.00
15.00 16.00			0						5.0C 6.0C
17.00			0						6.UC 7.OC
18.00	Total deductions (sum of lines 13 - 17)	О	0		0				8. OC
10.00	Fund balance at end of period per balance	0	1		0				9.00

Heal th	Financial Systems LITTLE BROOK NURSI	ING & CONV. HO	ME	In Lie	eu of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315467	Period: From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
4 00	General Inpatient Routine Care Services		1 007 4	10	4 007 440	1 00
1.00	SKILLED NURSING FACILITY		4, 027, 4	40	4, 027, 440	1.00
2.00	NURSING FACILITY			0	0	2.00
3.00	OTHER LONG TERM CARE			0	-	3.00
4.00 5.00	Total general inpatient care services (Sum of lines 1 - 4)		4,027,4	10	0 4, 027, 440	4.00 5.00
5.00	All Other Care Services		4, 027, 4	40	4, 027, 440	5.00
6.00	ANCI LLARY SERVICES		44,0	64 0	44,064	6.00
7.00	CLINIC		44,0	04 0	44,004 0	7.00
8.00	HOME HEALTH AGENCY COST			0	0	8.00
9.00	AMBULANCE			0	0	9.00
10.00	RURAL HEALTH CLINIC			0	0	10.00
10.10	FQHC			0	0	10.10
11.00	СМНС			0	0	11.00
12.00	HOSPICE			0 0	0	12.00
13.00	OTHER (SPECIFY)			0 0	0	13.00
14.00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer colu Worksheet G-3, Line 1)	ımn 3 to	4, 071, 5	04 0	4, 071, 504	14.00
	Cost Center Description					
	·			1.00	2.00	
	PART II - OPERATING EXPENSES				•	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				3, 539, 551	1.00
2.00	Add (Specify)			0		2.00
3.00				0		3.00
4.00				0		4.00
5.00				0		5.00
6.00				0		6.00
7.00				0		7.00
8.00	Total Additions (Sum of lines 2 - 7)				0	8.00
9.00	Deduct (Specify)			0		9.00
10.00				0		10.00
11.00				0		11.00
12.00				0		12.00
13.00	Tatal Deductions (Sum of Lines 0 12)			0		13.00
	Total Deductions (Sum of lines 9 - 13) Total Operating Expenses (Sum of lines 1 and 8, minus line	14)			0 3, 539, 551	14.00 15.00
10.00	Trotal operating Expenses (sum of times i and o, infinus time	17)		Ι	3, 039, 051	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315467 Period: From 01/01/2023 To 12/31/2023 Worksheet C-3 Date/Time Prepared: 8/23/2024 11:45 pm 04/23/2024 11:45 pm 04/23/23/21 04/23/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/2023 04/20/21/20/21/2023 04/20/21/20/21/2023 04/20/21/20/21/2023 04/20/21/20/2	Heal th	Financial Systems LITTLE BROOK NURSING	& CONV. HOME	In Lie	u of Form CMS-2	2540-10	
To 12/31/203 Date/Time Prepared: 8/23/2024 11:45 pm 1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14) 4.071,504 1.00 2.00 Less: contractual allowness and discunts on patients accounts 900,140 2.00 3.00 Net patient revenues (Line 1 minus line 2) 3, 171,364 3.00 4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15) 3, 539, 551 4.00 0.00 Income from service to patients (Line 3 minus 4) -368,187 5.00 0.01 Income from investments 0 6.00 0 0.00 Revenues from communications, (Telephone and Internet service) 0 8.00 9.00 Revenues from andradio service 0 1.00 1.00 Parking lot receipts 0 11.00 1.00 Revenue from landry and linen service 0 12.00 1.00 Revenue from sel of medical and surgical supplies to other than patients 0 13.00 1.00 Revenue from sel of drugs to other than patients 0 15.00 15.00 1.00 Revenue from sel							
Image: 1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14) 1.00 1.00 Less: contractual allowances and discounts on patients accounts 900, 140 2.00 3.00 Net patient revenues (Line 1 minus line 2) 3, 171, 364 3.00 3.00 Net patient revenues (Line 1 minus line 2) 3, 171, 364 3.00 0.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15) 3, 539, 551 4.00 5.00 Net income from service to patients (Line 3 minus 4) -368, 187 5.00 0 Income from investments 0 6.00 6.00 0.00 Revenues from communications (Telephone and Internet service) 0 8.00 9.00 0.00 Revenue from communications of expenses 0 10.00 10.00 10.00 0.00 Revenue from communications of expenses 0 11.00 8.00 9.00 0.00 Revenue from communications of expenses 0 11.00 10.00 0.00 Revenue from camula of living quarters 0 12.00 13.00 0.00 Revenue from sa							
Image: 1.00 Image: 1.00 1.00 Image: 1.00 1.00 2.00 Less: contractual allowances and discounts on patients accounts 900,140 2.00 3.00 Net patient revenues (Line 1 minus Line 2) 3,171,364 3.00 4.00 Less: total operating expenses (From Worksheet G-2, Part II, Line 15) 3,539,551 4.00 0.00 Less: total operating expenses (From Worksheet G-2, Part II, Line 15) 3,539,551 4.00 0.01 Income service to patients (Line 3 minus 4) 366,187 5.00 0.01 Income from investments 0 6.00 0.00 Pervenues from communications, telephone and Internet service) 0 8.00 9.00 Pervenue from television and radio service 0 9.00 0.00 Purchase discounts 0 11.00 10.00 Parking lot receipts 0 12.00 10.00 Revenue from sel of medical and surgical supplies to other than patients 0 14.00 10.00 Revenue from sel of fmedical records and abstracts 0 15.00 16.00 10.00				To 12/31/2023			
1.00 Total patient revenues (From Wist. G-2, Part I, col. 3, line 14) 4, 071, 504 1.00 2.00 Less: contractual allowances and discounts on patients accounts 900, 140 2.00 3.00 Net patient revenues (Line 1 minus line 2) 3, 171, 364 3.00 4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15) 3, 553, 551 4.00 5.00 Net income from service to patients (Line 3 minus 4) -366, 187 5.00 0.01 Income from investments 0 6.00 7.00 1.00 Revenues from communications, bequests, etc 0 8.00 9.00 0.00 Revenues from communications of expenses 0 10.00 10.00 1.00 Parking lot receipts 0 11.00 11.00 1.00 Revenue from rental of living quarters 0 13.00 14.00 14.00 1.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 15.00 1.00 Revenue from alaudry and linen service 0 14.00 14.00 1.00 Reve		· · · · · · · · · · · · · · · · · · ·			8/23/2024 11:	45 pm	
2.00 Less: contractual allowances and discounts on patients accounts 900,140 2.00 3.00 Net patient revenues (Line 1 minus line 2) 3,171,364 3.00 4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15) 3,539,551 4.00 5.00 Net income from service to patients (Line 3 minus 4) -368,187 5.00 0 Contributions, donations, bequests, etc 0 6.00 6.00 0.00 Revenues from communications (Telephone and Internet service) 0 8.00 9.00 0.00 Revenue from television and radio service 0 10.00 10.00 10.00 Rebates and refunds of expenses 0 11.00 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 13.00 Revenue from meals sold to employees and guests 0 14.00 14.00 15.00 Revenue from sale of medical net surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of medical net cords and abstracts 0 18.00 18.00 10.00 Rev					1.00		
3.00 Net patient revenues (Line 1 minus line 2) 3,171,364 3.00 4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15) 3,539,551 4.00 0ther income from service to patients (Line 3 minus 4) -368,187 5.00 0ther income -368,187 5.00 0ther income -368,187 5.00 0.00 Contributions, donations, bequests, etc 6.00 0.00 Revenues from communications (Telephone and Internet service) 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 11.00 11.00 Parking lot receipts 0 12.00 13.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from sale of drugs to other than patients 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical mactoris, etc.) 0 19.00 19.00 10.00 Revenue from sale of drugs to ot	1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		4, 071, 504	1.00	
4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15) 3, 539, 551 4.00 0.10 Net income from service to patients (Line 3 minus 4) -368, 187 5.00 0.00 Contributions, donations, bequests, etc 0 6.00 0.00 Revenues from communications (Telephone and Internet service) 182 7.00 0.00 Revenue from television and radio service 0 9.00 0.00 Revenue from television and radio service 0 10.00 0.00 Revenue from television and radio service 0 10.00 0.00 Revenue from television and radio service 0 10.00 0.00 Revenue from laundry and linen service 0 11.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 13.00 13.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 15.00 Revenue from sale of medical records and abstracts 0 17.00 10.00 Revenue from sale of flower, coffee shops, canteen 0 12.00 10.00 Rental of vending machine	2.00	Less: contractual allowances and discounts on patients account	s		900, 140	2.00	
5.00 Net income from service to patients (Line 3 minus 4) -368,187 5.00 Other income: 0 6.00 Contributions, donations, bequests, etc 0 6.00 6.00 7.00 Income from investments 182 7.00 8.00 9.00 Revenues from communications (Telephone and Internet service) 0 9.00 8.00 9.00 182 7.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 Rebates and refunds of expenses 0 12.00 12.00 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 15.00 15.00 15.00 15.00 16.00 17.00 18.00 19.00 20.00 17.00 18.00 19.00 20.00 17.00 18.00 19.00 18.00 19.00 18.00 19.00 19.00 10.00 19.00 20.00 18.00 19.00 20.00 18.00 19.00 20.00 17.00 18.00 19.00	3.00	Net patient revenues (Line 1 minus line 2)			3, 171, 364	3.00	
Other income:Image: Contributions, donations, bequests, etc06.00Contributions, donations, bequests, etc07.00Income from investments1828.00Revenues from communications (Telephone and Internet service)09.00Revenue from television and radio service09.00Revenue from television and radio service010.00Purchase discounts011.00Rebates and refunds of expenses012.00Parking lot receipts013.00Revenue from meals sold to employees and guests015.00Revenue from sale of medical and surgical supplies to other than patients016.00Revenue from sale of medical records and abstracts017.00Revenue from sale of flower, coffee shops, canteen018.00Revenue from gifts, flower, coffee shops, canteen019.00Revenue from gifts, flower, coffee shops, canteen010.00Rovernmental appropriations021.00Revenue from gifts, flower, coffee shops, canteen022.00Rotal appropriations023.00Governmental appropriations023.00Total other income (Sum of lines 6 - 24)332,99825.00Total other expenses (specify)026.00Total other expenses (Sum of lines 27 - 29)0	4.00	Less: total operating expenses (From Worksheet G-2, Part II, I	ine 15)		3, 539, 551	4.00	
6.00 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments 182 7.00 8.00 Revenue from communications (Telephone and Internet service) 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from meals sold to employees and guests 0 13.00 14.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 15.00 Revenue from sale of medical records and abstracts 0 18.00 17.00 Revenue from sale of textbooks, uniforms, etc.) 0 18.00 18.00 Revenue from gifts, flower, coffee shops, canteen 0 21.00 20.00 Revalue from gifts, flower, coffee shops, canteen 0 21.00 21.00 Revalue from gifts, flower, coffee shops, canteen 0 22.00 20.00 Revalue from gifts, flower, coffee shops, canteen 0 21.00<	5.00	Net income from service to patients (Line 3 minus 4)			-368, 187	5.00	
7.00 Income from investments 182 7.00 8.00 Revenues from communications (Telephone and Internet service) 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from rental of living quarters 0 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from sale of textbooks, uniforms, etc.) 0 19.00 10.00 Rental of skilled nursing space 0 21.00 22.00 Rental of skilled nursing space 0 23.00 23.00 Governmental appropriations 0 23.00 24.00 Other income (Sum of lines 6 - 24) 32.998 24.50 25.00 Total other income (Other income:					
8.00 Revenues from communications (Telephone and Internet service) 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase di scounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 3.00 Revenue from nandry and linen service 0 13.00 14.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical necords and abstracts 0 17.00 19.00 Tuit ion (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revalue from gifts, flower, coffee shops, canteen 0 20.00 21.00 Rental of skilled nursing space 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.09 24.50 Coll D-19 PHE Funding 332.998 24.50 232.90	6.00	Contributions, donations, bequests, etc				6.00	
9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from rental of living quarters 0 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 10.00 Rental of skilled nursing space 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 22.00 24.50 COVID-19 PHE Funding 332, 998 24.50 25.00 Total other income (Sum of lines 6 - 24) 0 27.00 28.00 Postal of there spaces (specify) 0 27.00 28.00 29.00 0 27	7.00				182	7.00	
10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from sel of medical and surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flower, coffee shops, canteen 0 19.00 20.00 Rental of vending machines 0 21.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.50 COVID-19 PHE Funding 332, 998 24.50 25.00 Total other income (Sum of lines 6 - 24) 383, 872 25.00 26.00 Total other expenses (specify) 0 27.00 28.00 29.00 30.00 Tot	8.00	Revenues from communications (Telephone and Internet service)			0	8.00	
11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking Lot receipts 0 12.00 13.00 Revenue from laundry and Linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of Living quarters 0 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flower, coffee shops, canteen 0 17.00 19.00 Revial of skilled nursing space 0 21.00 20.00 Rental of skilled nursing space 0 22.00 21.00 Rental of skilled nursing space 0 23.00 22.00 CoVID-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of lines 6 - 24) 333,872 25.00 26.00 Total (ine 5 plus Line 25) 15,665 26.00 0 27.00 28.00 0 27.00 0 28.00 0 28.00	9.00	Revenue from television and radio service			0		
12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 0 19.00 20.00 Revenue from gifts, flower, coffee shops, canteen 0 22.00 21.00 Rental of vending machines 0 22.00 22.00 Rental of skilled nursing space 0 23.00 23.00 Governmental appropriations 0 23.00 24.00 Total other income (Sum of lines 6 - 24) 332, 982 24.50 25.00 Total other income (Sum of lines 6 - 24) 333, 872 25.00 25.00 Total other expenses (specify) 0 27.00 </td <td></td> <td>Purchase di scounts</td> <td></td> <td></td> <td>0</td> <td>10.00</td>		Purchase di scounts			0	10.00	
13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flower, coffee shops, canteen 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Rental of vending machines 0 20.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.50 CVID-19 PHE Funding 332,998 24.50 25.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 0 28.00 0 27.00 0 28.00 0 10.00 28.00 0 28.00 0 29.00 0 0 10.00 0 29.00 0	11.00	Rebates and refunds of expenses			0	11.00	
14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flower, coffee shops, canteen 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.50 CVID-19 PHE Funding 332.998 24.50 25.00 Total other income (Sum of lines 6 - 24) 333.872 25.00 26.00 Total (Line 5 plus line 25) 0 27.00 29.00 0 28.00 28.00 28.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00	12.00	Parking lot receipts			0	12.00	
15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 16.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flower, coffee shops, canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 50, 692 24.00 25.00 Total other income (Sum of lines 6 - 24) 332, 998 24.50 25.00 Total other expenses (specify) 0 27.00 0 28.00 0 0 27.00 0 28.00 0 27.00 29.00 0 0 0 27.00 0 30.00 0 30.00	13.00				0	13.00	
16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 18.00 20.00 Revenue from gifts, flower, coffee shops, canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 332,998 24.50 25.00 Total other income (Sum of lines 6 - 24) 383,872 25.00 25.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 0 28.00 0 28.00 29.00 0 0 29.00 0 30.00	14.00				0	14.00	
17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flower, coffee shops, canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 50,692 24.00 24.50 COVID-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of Lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 29.00 0 0 29.00 0 29.00 30.00 Total other expenses (Sum of Lines 27 - 29) 0 30.00	15.00	Revenue from rental of living quarters			0	15.00	
18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flower, coffee shops, canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 23.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 50,692 24.00 24.50 COVID-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of Lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 0 27.00 0 27.00 29.00 0 0 29.00 0 30.00	16.00	Revenue from sale of medical and surgical supplies to other th	an patients		0	16.00	
19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flower, coffee shops, canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 50,692 24.00 24.50 COVID-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of Lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 0 27.00 0 27.00 29.00 0 0 29.00 0 0 29.00	17.00				0	17.00	
20.00 Revenue from gifts, flower, coffee shops, canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 50,692 24.00 24.50 COVID-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 0 29.00 0 29.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00	18.00	Revenue from sale of medical records and abstracts			0	18.00	
21.00 Rental of vending machines 0 21.00 22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 50,692 24.00 24.50 COVID-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of Lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 0 29.00 0 29.00 30.00 Total other expenses (Sum of Lines 27 - 29) 0 30.00	19.00				0		
22.00 Rental of skilled nursing space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 50,692 24.00 24.50 COVI D-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 0 29.00 0 29.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00					0		
23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME 50,692 24.00 24.50 COVID-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 0 29.00 0 29.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00					0		
24.00 OTHER INCOME 50,692 24.00 24.50 COVID-19 PHE Funding 332,998 24.50 25.00 Total other income (Sum of Lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00	22.00	Rental of skilled nursing space			0		
24. 50 COVID-19 PHE Funding 332,998 24. 50 25. 00 Total other income (Sum of Lines 6 - 24) 383,872 25. 00 26. 00 Total (Line 5 plus line 25) 15,685 26. 00 27. 00 Other expenses (specify) 0 27. 00 28. 00 29. 00 0 29. 00 30. 00 Total other expenses (Sum of Lines 27 - 29) 0 30. 00		Governmental appropriations			0		
25.00 Total other income (Sum of lines 6 - 24) 383,872 25.00 26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 29.00 0 29.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00	24.00	OTHER INCOME					
26.00 Total (Line 5 plus line 25) 15,685 26.00 27.00 Other expenses (specify) 0 27.00 28.00 29.00 0 29.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00	24.50	COVI D-19 PHE Fundi ng			332, 998	24.50	
27.00 0ther expenses (specify) 0 27.00 28.00 0 28.00 0 28.00 29.00 0 29.00 0 30.00 10ther expenses (Sum of lines 27 - 29) 0 30.00	25.00	Total other income (Sum of lines 6 - 24)			383, 872	25.00	
28.00 0 28.00 0 29.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00	26.00	Total (Line 5 plus line 25)			15, 685		
29.00 0 29.00 0 29.00 0 30.00		Other expenses (specify)			0	27.00	
30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00					0		
	29.00				0	29.00	
31.00 Net income (or loss) for the period (Line 26 minus line 30) 15,685 31.00	30.00	Total other expenses (Sum of Lines 27 - 29)					
	31.00	Net income (or loss) for the period (Line 26 minus line 30)			15, 685	31.00	