The Optimizer Systems, LLC WinLASH 2540 System [Version: 2.5.12]
In lieu of Form CMS-2540-24

JOB HAINES HOME FOR AGED PEOPLE
Provider CCN: 31-5392
Period from 1/1/2025 to 12/31/2025

Form Approved
OMB No. 0938-0463
Approval Expires 7-31-2027

Worksheet S Saturday, May 30, 2026 at 7:14:00 PM

Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Report Certification and Settlement Summary

PART I - COST REPORT STATUS

			Date:	Time:
1.	Electronically Prepared	[Y]	05/30/2026	19:14:00 00
2.	Manually Prepared			
3.	If Amended, Number of times Report Resubmitted			
4.	Medicare Utilization	[F]		
5.	Contractor: HCRIS Status Code			
6.	Contractor: Cost Report Received Date			
7.	Contractor: Contractor Number			
8.	Contractor: Initial Cost Report For This CCN			
9.	Contractor: Final Cost Report For This CCN			
10.	Contractor: NPR Date			
11.	Contractor: ADR Software Vendor Code			
12.	Contractor: Reopening Number			

Date and time of ECR file creation: 05/30/2026 19:14

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

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS COST 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 Job Haines Home for Aged People (31-5392) for the cost report period beginning January 1, 2025 and ending December 31, 2025, and that 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 FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX
	1	2
1	Noreen E Haveron	

I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

2	Printed Name	Noreen E Haveron
3	Title	President
4	Signature Date	June 4, 2026

PART III - SETTLEMENT SUMMARY

CMS #		Title V	Title XVIII Part A	Title XVIII Part B	Title XIX
		1	2	3	4
1	SNF	0	6,296	0	0
2	NF	0			0
3	ICF / IID				0
4	SNF-BASED HHA	0	0	0	0
100	Total	0	6,296	0	0

ECR Encryption Information:	PI Encryption Information:
05/30/2026 19:14	05/30/2026 19:14
zhoihtnvNjZ2wIrxHxq6XHrPtlogR0	3ETJGSEmMCkpd502Axj.Ny5ISk5JS0
uAdAi0T6GY2Ovp:UMcpQGlqsWC0Xnu	aM2v80ZillnNDIWTo6KWL:ene8fjOG
4usX0b:oWf0zok:s	MCv93z3Vh501LCv3

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