This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315393 Worksheet S Parts I, II & III Peri od: From 01/01/2022

COMILEX COST IX	ELOKE SEKTITION AND SETTEMENT SUMMAKE			To 12/31/2022	Date/Time Prepared: 4/26/2023 11:57 am	
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost re	port		Date: 4/26/20	23 Time: 11:57 an	
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report en	ter the numbe	r of times the provider	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		
	(2) Settled without audit	8.[N] Last Cost Report for this Provider CCN				
	(3) Settled with audit	9. NPR Date:				
	(4) Reopened (5) Amended	10.[0]If I	ine 4, column 1 is "4":	 : Enter number of	times reopened	
		11. Contractor Vendor Code 4				
	5. Date Received:	12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.				

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

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 NEW COMMUNITY ECF (315393) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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	Elizab	eth Mbakaya	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	Elizabeth Mbakaya			2
3	Signatory Title	CF0			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	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	23, 086	7	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	23, 086	7	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.

Health Financial Systems NEW COMMUNITY ECF In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315393 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 4/26/2023 11:57 am 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 266 SOUTH ORANGE AVENUE PO Box: 1.00 2.00 City: NEWARK State: NJ Zi p Code: 07103 2.00 3.00 County: ESSEX CBSA Code: 35084 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF NEW COMMUNITY ECF 315393 12/01/1997 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 01/01/2022 12/31/2022 14.00 Cost Reporting Period (mm/dd/yyyy) 14.00 15.00 Type of Control (See Instructions) 15.00 2LLC Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 52, 511 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 52 511 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) Ν 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38, 00 39.00 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 0 41 00

Heal th	Financial Systems	NEW COMMUNITY	ECF		In Lie	u of Form CMS-2	2540-10
SKI LLE	SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315393 Period:					Worksheet S-2	
COMPLE	X INDENTIFICATION DATA				From 01/01/2022	Part I	
						4/26/2023 11:	57 am
						Y/N	
						1.00	
42.00	Are mal practice premiums and paid losse	es reported in other than	the Administra	ative and	General cost	N	42.00
	center? Enter Y or N. If yes, check box	k, and submit supporting s	schedule listir	ng cost c	enters and		
	amounts.			o .			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	apter 10?			N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and a	address o	f 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 nam	e and address o	of the ho	ome office on the	lines	
	bel ow.						
45.00	Name:	Contractor's Name:		Contract	or's Number:		45. 00
46.00	Street:	PO Box:					46. 00
47. 00	Ci ty:	State:		Zip Code	:		47. 00

Heal th	Financial Systems	NEW COMMUNITY	ECF		In Li€	eu of Form CMS-	2540-10
	O NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	epared:
					Y/N	4/26/2023 11: Date	37 alli
	General Instruction: For all column 1 responseresponses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column	1, "Y" fo	r Yes or "N"	1.00 for No. For all	the date	
1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N 1.00	Date 2.00	V/I 3. 00	
2.00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.			N	2.00	0.00	2.00
3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home office d to the provider or I, or members of the	es, drug its e board	Y			3.00
				Y/N 1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports		5			0.00	
4. 00	Column 1: Were the financial statements prepared 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" f te copy or enter dat	for te	Y	С		4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If reconciliation.			N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2:	Is the	provider the	N	N	6. 00
7. 00 8. 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	ng the cost reportir		for Nursing	N N		7. 00 8. 00
	School and/or Arried near til Programs (17N) Si	ee mstructrons.				Y/N 1.00	
9. 00 10. 00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb				t reporting	Y N	9. 00 10. 00
11. 00	<pre>period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement</pre>	d/or coinsurance wai	ved? If "	Y", see instr	ucti ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting peri	od? If "Y			N	12. 00
		Description	า	Y/N	rt A Date	Part B Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
13. 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.)			Υ	03/29/2023	Y	13. 00
14. 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.			N		N	14. 00
15. 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.			N		N	15. 00
16. 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.			N		N	16. 00
17 00	If line 13 or 14 is "Y", then were			N		N	17. 00
17. 00	adjustments made to PS&R data for Other? Describe the other adjustments:						

Heal th	Financial Systems NEW CC	MMUNI TY	ECF			In Lieu	of Form CM	S-2540	0-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		ARE	Provi der	No.: 315393	Period: From 01/0 To 12/3	01/2022	Worksheet S Part II Date/Time P 4/26/2023 1	- repar	ed:
			1	00		2.0	10		
	Cost Report Preparer Contact Information		1.	00		2. (
19. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3 respectively.	, KIT	ГҮ		BLISSIT			19	9. 00
20. 00	Enter the employer/company name of the cost report preparer.	HEAI	_TH CARE RE	SOURCES				20	0. 00
21. 00	Enter the telephone number and email address of the cos report preparer in columns 1 and 2, respectively.	t 609	-987-1440		KI TTY. BL	LI SSI T@H	CRNJ. NET	21	1. 00

Health Financial Systems NEW COMMUNITY ECF In Lieu of Form CMS-2540-10

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE

NEW COMMUNITY ECF
In Lieu of Form CMS-2540-10

Provider No.: 315393
Period: From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared:

COMPLE	X KELMBOKSEMENT GOESTLONNALKE			To 12/31/2022	
		Part B			17 207 2020 11: 07 un
		Date	1		
		4. 00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R	03/29/2023			13.0
	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.)				
14. 00	Was the cost report prepared using the PS&R				14.0
	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				
15. 00	4. If line 13 or 14 is "Y", were adjustments		+		15. (
15.00	made to PS&R data for additional claims that				15. (
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
	see Instructions.				
16. 00					16.0
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17.00	If line 13 or 14 is "Y", then were				17. (
	adjustments made to PS&R data for Other?				
	Describe the other adjustments:				
18. 00	Was the cost report prepared only using the				18.0
	provider's records? If "Y" see Instructions.				
			3.00	_	
	Cost Report Preparer Contact Information				
	Enter the first name, last name and the title	e/position	PREPARER		19. (
	held by the cost report preparer in columns 1	i, 2, and 3,			
	respecti vel y.				
20.00	Enter the employer/company name of the cost r	report			20.0
	preparer.				
21. 00	Enter the telephone number and email address				21.0
	report preparer in columns 1 and 2, respective	∕el y.			

In Lieu of Form CMS-2540-10 NEW COMMUNITY ECF Provi der No.: 315393

Health Financial Systems NEW COMMUN SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

					0 12/31/2022	4/26/2023 11: 5	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	180	65, 700				1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST		0				4. 00 5. 00
6. 00	Other Long Term Care SNF-Based CMHC	0	U				6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8. 00	Total (Sum of lines 1-7)	180	65, 700				8. 00
	1.555. (55 57	Inpatient D		_	Di scharges	33,133	2. 4.2
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	CKILLED MUDCING FACILLEY	6.00	7. 00 34, 067	8. 00	9. 00	10.00	1. 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	2, 827	34,067			0	2. 00
3.00	ICF/IID		0	U			3. 00
4. 00	HOME HEALTH AGENCY COST		0				4. 00
5. 00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0	0	0	0	0	7.00
8. 00	Total (Sum of lines 1-7)	2, 827	34, 067	0		5	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	92				6, 147. 00	1. 00
2.00	NURSING FACILITY	0				0.00	2. 00
3.00	ICF/IID	0	0			0.00	3. 00
4.00	HOME HEALTH AGENCY COST		0				4. 00 5. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	l o	U				6. 00
7. 00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	92	103				8. 00
	(Average Length			si ons	5,	<u> </u>
		of Stay					
	Component	Total	Title V	Title XVIII	Title XIX	Other	
1 00	CKILLED NUDCING FACILLEY	16.00	17. 00 0	18. 00	19. 00	20.00	1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	330. 75 0. 00	0	ŏ	5 0	96 0	1. 00 2. 00
3.00	ICF/IID	0.00			0		3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			0		4. 00
5. 00	Other Long Term Care	0.00				ol	5. 00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0. 00	0	0	0	0	7.00
8. 00	Total (Sum of lines 1-7)	330. 75		8	5	96	8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
			Payrol I	Workers			
1 00	CIVILLED NUDCING FACILLETY	21.00	22.00	23.00			1 00
1.00	SKILLED NURSING FACILITY	109	96. 30				1.00
2. 00 3. 00	NURSING FACILITY	0					2. 00 3. 00
4.00	HOME HEALTH AGENCY COST		0.00	0.00			4. 00
5. 00	Other Long Term Care	0	0. 00	0.00			5. 00
6. 00	SNF-Based CMHC		0.00				6. 00
7. 00	HOSPI CE	0					7. 00
8.00	Total (Sum of lines 1-7)	109	96. 30	0.00			8.00

Health Financial Systems In Lieu of Form CMS-2540-10 NEW COMMUNITY ECF Provi der No.: 315393 Peri od: Worksheet S-3

SNF WAGE INDEX INFORMATION

21.00 Physician Part B - WRC

instructions)

Total Adjusted Wage Related cost (see

22.00

From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 4/26/2023 11:57 am Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 ÷ Reported col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 5, 414, 313 5, 414, 313 200, 308. 00 27. 03 1.00 Physician salaries-Part A 0.00 2.00 0 0 0 0.00 2.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 3.00 Home office personnel 0 0 0 0.00 0.00 4.00 4.00 Sum of lines 2 through 4 0 0.00 5.00 0 0 0.00 5.00 0 200, 308. 00 27.03 6.00 Revised wages (line 1 minus line 5) 5, 414, 313 5, 414, 313 6.00 7.00 Other Long Term Care 0 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 8.00 9.00 CMHC 0 0.00 0.009.00 0 10.00 HOSPI CE 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0.00 0.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 0 0.00 0.00 12.00 12.00 through 11) Total Adjusted Salaries (line 6 minus line 13.00 5, 414, 313 C 5, 414, 313 200, 308. 00 27.03 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 14.00 413, 455 413, 455 8, 350. 00 49. 52 14.00 15.00 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 17.00 1, 464, 869 1, 464, 869 18.00 Wage-related costs other (See Part IV) 0 18.00 Wage related costs (excluded units) 0 19.00 0 20.00 Physician Part A - WRC 0 0 0 20.00

0

1, 464, 869

0

0

0

1, 464, 869

21.00

22.00

Health Financial Systems
SNF WAGE INDEX INFORMATION NEW COMMUNITY ECF Provi der No.: 315393

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared:

			Į Į	0 12/31/2022		
	Reported	Salaries from	Sal ari es (col.	Related to	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						
Employee Benefits	0	0	C	0.00	0.00	1. 00
Administrative & General	493, 384	0	493, 384	17, 409. 00	28. 34	2. 00
Plant Operation, Maintenance & Repairs	81, 389	0	81, 389	2, 472. 00	32. 92	3. 00
Laundry & Linen Service	26, 274	0	26, 274	2, 056. 00	12. 78	4. 00
Housekeepi ng	219, 798	0	219, 798	16, 664. 00	13. 19	5. 00
Di etary	375, 100	0	375, 100	26, 343. 00	14. 24	6. 00
Nursing Administration	311, 028	0	311, 028	15, 776. 00	19. 72	7. 00
Central Services and Supply	0	0	C	0.00	0.00	8. 00
Pharmacy	0	0	C	0.00	0.00	9. 00
Medical Records & Medical Records Library	0	0	C	0.00	0.00	10.00
Soci al Servi ce	58, 800	0	58, 800	3, 821. 00	15. 39	11. 00
Nursing and Allied Health Ed. Act.						12.00
Other General Service	166, 034	0	166, 034	13, 151. 00	12. 63	13. 00
Total (sum lines 1 thru 13)	1, 731, 807	0	1, 731, 807	97, 692. 00	17. 73	14. 00
	Employee Benefits Administrative & General Plant Operation, Maintenance & Repairs Laundry & Linen Service Housekeeping Dietary Nursing Administration Central Services and Supply Pharmacy Medical Records & Medical Records Library Social Service	PART III - OVERHEAD COST - DIRECT SALARIES Employee Benefits 0 Administrative & General 493, 384 Plant Operation, Maintenance & Repairs 81, 389 Laundry & Linen Service 26, 274 Housekeeping 219, 798 Dietary 375, 100 Nursing Administration 311, 028 Central Services and Supply 0 Pharmacy 0 Medical Records & Medical Records Library 0 Social Service 58,800 Nursing and Allied Health Ed. Act. Other General Service 166,034	Reported Salaries from Worksheet A-6 1.00 2.00 PART III - OVERHEAD COST - DIRECT SALARIES Employee Benefits 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Amount Reported Salaries from Worksheet A-6 1 ± col . 2) 1.00 2.00 3.00 PART III - OVERHEAD COST - DIRECT SALARIES	Amount Reported Reported Reported Reported Salaries from Worksheet A-6 Adjusted Salaries (col. 1 ± col. 2) Salary in col. 3	Amount Reported Reported Reclass. of Salaries (col. Worksheet A-6 1 ± col. 2) Salaries (col. Salary in col. 3 + col. 4) Awerage Hourly Reported Salaries (col. Worksheet A-6 1 ± col. 2) Salary in col. 3 + col. 4) Awerage Hourly Reported Salary in col. 3 + col. 4) Awerage Hourly Reported Salary in col. 3 + col. 4) Awerage Hourly Reported Salary in col. 3 + col. 4) Awerage Hourly Reported Salary in col. 3 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Awerage Hourly Reported Awerage Hourly Reported Salary in col. 5 + col. 4) Awerage Hourly Reported Awerage Hourly Reported

Health Financial Systems	NEW COMMUNITY ECF	In Lieu	u of Form CMS-2540-10
SNF WAGE RELATED COSTS		From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 4/26/2023 11:57 am

		To 12/31/2022	Date/Time Pre 4/26/2023 11:	
			Amount	
			Reported	
			1.00	
	PART IV - WAGE RELATED COSTS		•	
	Part A - Core List]
	RETI REMENT COST]
1.00	401K Employer Contributions		85, 797	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3. 00
4.00	Pri or Year Pensi on Servi ce Cost		0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			Ī
5.00	401K/TSA Plan Administration fees		0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6. 00
7.00	Employee Managed Care Program Administration Fees		0	7. 00
	HEALTH AND INSURANCE COST		•	
8.00	Health Insurance (Purchased or Self Funded)		959, 089	8. 00
9.00	Prescription Drug Plan		0	9. 00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		1, 043	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14. 00
15. 00			82, 428	15. 00
16, 00	Retirement Health Care Cost (Only current year, not the extraor	dinary accrual required by FASB 106.	0	1
	Non cumulative portion)			
	TAXES			
17.00	FICA-Employers Portion Only		303, 261	17. 00
18.00	Medicare Taxes - Employers Portion Only		0	18. 00
19.00	Unemployment Insurance		0	19. 00
20.00	State or Federal Unemployment Taxes		33, 251	20. 00
	OTHER		<u>' </u>	1
21.00	Executive Deferred Compensation		0	21. 00
22.00	Day Care Cost and Allowances		0	22. 00
23.00	Tuition Reimbursement		0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		1, 464, 869	24. 00
			Amount	
			Reported	
			1.00	
	Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25. 00
			•	•

Health Financial Systems
SNF REPORTING OF DIRECT CARE EXPENDITURES NEW COMMUNITY ECF Provi der No.: 315393

				T	0 12/31/2022		
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	
	3. 3	Reported		Salaries (col.		Wage (col. 3 ÷	
		'		1 + col. 2)	Salary in col.	col . 4)	
				,	3	ŕ	
		1.00	2.00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	710, 427	192, 210	902, 637	19, 939. 00		1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 462, 091	394, 762	1, 856, 853	30, 073. 00	61. 74	2. 00
3.00	Certified Nursing Assistant/Nursing	1, 509, 988	407, 694	1, 917, 682	52, 605. 00	36. 45	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 682, 506	994, 666	4, 677, 172			4. 00
5.00	Physical Therapists	0	0	0	0.00		5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00		6. 00
7.00	Physical Therapy Aides	0	0	0	0.00		7. 00
8.00	Occupational Therapists	0	0	0	0.00		8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00		9. 00
10.00	Occupational Therapy Aides	0	0	0	0.00		
11. 00	Speech Therapists	0	0	0	0.00		11. 00
12.00	Respi ratory Therapi sts	0	0	0	0.00		12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	0		0	0. 00		14.00
15. 00	Licensed Practical Nurses (LPNs)	0		0	0. 00		15.00
16. 00	Certified Nursing Assistant/Nursing	11, 175		11, 175	224. 00	49. 89	16. 00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	11, 175		11, 175			17. 00
18. 00	Physical Therapists	117, 600		117, 600			18. 00
19. 00	Physical Therapy Assistants	57, 340		57, 340	·		
20. 00	Physical Therapy Aides	17, 340		17, 340	·		20. 00
21. 00	Occupational Therapists	115, 150		115, 150			
22. 00	Occupational Therapy Assistants	62, 040		62, 040	·		
23. 00	Occupational Therapy Aides	17, 340		17, 340	·		23. 00
24. 00	Speech Therapists	15, 470		15, 470			24. 00
25. 00	Respiratory Therapists	0		0	0. 00		25. 00
26. 00	Other Medical Staff	0		0	0.00	0.00	26. 00

Peri od: Worksheet S-7 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 4/26/2023 11:57 am

	10 1.	2/31/2022	4/26/2023 11:	
		Group	Days	
100		1. 00	2. 00	1 00
1.00		RUX		1.00
2. 00 3. 00		RUL RVX		2. 00 3. 00
4.00		RVL		4. 00
5. 00		RHX		5. 00
6.00		RHL		6. 00
7.00		RMX		7. 00
8.00		RML		8. 00
9.00		RLX		9. 00
10. 00 11. 00		RUC RUB		10. 00 11. 00
12. 00		RUA		12.00
13. 00		RVC		13. 00
14. 00		RVB		14. 00
15. 00		RVA		15.00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00 19. 00		RHA RMC		18. 00 19. 00
20. 00		RMB		20. 00
21. 00		RMA		21. 00
22. 00		RLB		22. 00
23. 00		RLA		23. 00
24. 00		ES3		24. 00
25. 00 26. 00		ES2 ES1		25. 00 26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30. 00		HD1		30. 00
31. 00		HC2		31. 00
32. 00 33. 00		HC1 HB2		32. 00 33. 00
34. 00		HB1		34. 00
35. 00		LE2		35. 00
36. 00		LE1		36. 00
37. 00		LD2		37. 00
38.00		LD1		38. 00
39. 00 40. 00		LC2 LC1		39. 00 40. 00
41. 00		LB2		41. 00
42. 00		LB1		42. 00
43. 00		CE2		43.00
44. 00		CE1		44. 00
45.00		CD2		45. 00
46. 00 47. 00		CD1 CC2		46. 00 47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00
50. 00		CB1		50. 00
51. 00		CA2		51.00
52. 00		CA1		52. 00
53. 00 54. 00		SE3 SE2		53. 00 54. 00
55. 00		SE1		55. 00
56. 00		SSC		56. 00
57. 00		SSB		57.00
58. 00		SSA		58. 00
59. 00		I B2		59. 00
60. 00 61. 00		I B1 I A2		60. 00 61. 00
62. 00		I A2		62. 00
63. 00		BB2		63. 00
64. 00		BB1		64. 00
65. 00		BA2		65.00
66.00		BA1		66. 00
67. 00		PE2		67. 00
68. 00 69. 00		PE1 PD2		68. 00 69. 00
70. 00		PD1		70.00
71. 00		PC2		71. 00
72. 00		PC1		72.00
73.00		PB2		73. 00
74.00		PB1		74.00
75. 00		PA2		75. 00

Health Financial Systems	NEW COMMUNITY	ECF		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315393	Peri od:	Worksheet S-	7
				From 01/01/2022 To 12/31/2022		
				Group	Days	
				1. 00	2. 00	
76. 00				PA1	I	76. 00
99. 00				AAA	I	99. 00
100. 00 TOTAL						100. 00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Register Volu payments beginning 10/01/2003. Congress expecte expenses. For lines 101 through 106: Enter in c column 2 the percentage of total expenses for e line 1, column 3. Indicate in column 3 "Y" for with direct patient care and related expenses f (See instructions)	d this increase olumn 1 the amount ach category to yes or "N" for n	to be used nt of the total SNF o if the s	for direct pexpense for expense from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101. 00 Staffi ng					l	101. 00
102.00 Recruitment					I	102.00
103.00 Retention of employees					I	103. 00
104. 00 Trai ni ng					I	104.00
105. 00 OTHER (SPECIFY)					I	105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, line	1, column 3)				I	106. 00

Health Financial Systems	NEW COMMUNIT	Y ECF		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eri od:	Worksheet A	
				rom 01/01/2022 o 12/31/2022	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	4/26/2023 11: Reclassi fi ed	b/am
cost center bescription	Sai ai i es	Other	+ col . 2)	ons	Trial Balance	
			1 (01. 2)	Increase/Decre	(col . 3 +-	
				ase (Fr Wkst	col . 4)	
				À-6)	Í	
	1.00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES		1, 067, 966	1, 067, 966	I I	1, 067, 966	1. 00
3.00 00300 EMPLOYEE BENEFITS	0	1, 494, 494	1, 494, 494	· •	1, 494, 494	3. 00
4. 00 00400 ADMINI STRATI VE & GENERAL	493, 384	1, 120, 439			1, 613, 823	4.00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	81, 389	668, 597	749, 986	I I	749, 986	5. 00
6. 00 00600 LAUNDRY & LINEN SERVICE	26, 274	15, 406	41, 680	I I	41, 680	6.00
7. 00 00700 HOUSEKEEPI NG 8. 00 00800 DI ETARY	219, 798	35, 036	254, 834	I I	254, 834	7.00
	375, 100	422, 085 0	797, 185		797, 185	8. 00
9.00 00900 NURSING ADMINISTRATION	311, 028	0	311, 028	0	311, 028	9.00
10. 00 01000 CENTRAL SERVICES & SUPPLY 12. 00 01200 MEDICAL RECORDS & LIBRARY	0	0			0	10.00
13. 00 01300 SOCIAL SERVICE	58, 800	0	58, 800		58, 800	12. 00 13. 00
15. 00 01300 SOCIAL SERVICE 15. 00 01500 PATIENT ACTIVITIES		12, 958			178, 992	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	166, 034	12, 930	170, 992	.j Uj	170, 992	13.00
30. 00 03000 SKI LLED NURSING FACILITY	3, 682, 506	205, 667	3, 888, 173	lo	3, 888, 173	30. 00
31. 00 03100 NURSING FACILITY	0,002,000	203, 007	3,000,170		0,000,179	31. 00
32. 00 03200 CF/IID	0	0		1 1	0	32. 00
33. 00 03300 OTHER LONG TERM CARE	0	0			0	33. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>			1 0	- C	00.00
40. 00 04000 RADI OLOGY	o	5, 382	5, 382	. ol	5, 382	40. 00
41. 00 04100 LABORATORY	o	13, 200	13, 200	I I	13, 200	41.00
42. 00 04200 I NTRAVENOUS THERAPY	o	0	C	I I	0	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	o	0	C	o	0	43.00
44. 00 04400 PHYSI CAL THERAPY	o	387, 748	387, 748	-204, 164	183, 584	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	o	0	C	194, 907	194, 907	45. 00
46.00 04600 SPEECH PATHOLOGY	o	0	C	9, 257	9, 257	46. 00
47. 00 04700 ELECTROCARDI OLOGY	o	0	C	o	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	48. 00
49.00 O4900 DRUGS CHARGED TO PATIENTS	0	62, 337	62, 337	0	62, 337	49. 00
51. 00 05100 SUPPORT SURFACES	0	0	C	0	0	51. 00
OTHER REIMBURSABLE COST CENTERS						
71. 00 07100 AMBULANCE	0	7, 855	7, 855	I I		71. 00
73. 00 07300 CMHC	0	0	C	0	0	73. 00
SPECIAL PURPOSE COST CENTERS		0		ا		00.00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0	C	=	0	80.00
81. 00 08100 I NTEREST EXPENSE		0	C	0	0	81.00
82. 00 08200 UTILIZATION REVIEW - SNF	0	0		0	0	82.00
83.00 08300 HOSPICE 89.00 SUBTOTALS (sum of lines 1-84)	U F 414 212	U E E10 170	10 022 402	0	10 022 402	83. 00 89. 00
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	5, 414, 313	5, 519, 170	10, 933, 483	0	10, 933, 483	89.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	ol	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	0	0			0	91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES		0			0	92.00
93. 00 09300 NONPALD WORKERS		0			0	93. 00
94. 00 09400 PATI ENTS LAUNDRY	0	0			0	94. 00
95. 00 09500 BLANK		0			0	95. 00
95. 10 09510 MEDI CAL DAY CARE	o o	0	l o		0	95. 10
100. 00 TOTAL	5, 414, 313	5, 519, 170	10, 933, 483		10, 933, 483	
1 1 2				-1	.,	

NEW COMMUNITY ECF In Lieu of Form CMS-2540-10

Health Financial Systems NEW CRECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provi der No.: 315393 | Peri od: | Worksheet A | From 01/01/2022 | To 11/21/2023 | Date/Time Provided | Provided No.: 315393 | Provided N

				To 12/31/2022 Date/Time Pr 4/26/2023 11	
	Cost Center Description	Adjustments to	Net Expenses	47 207 2023 11	. 57 aiii
	,		For Allocation		
		Wkst A-8)	(col. 5 +-		
		Í	col. 6)		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-104, 682	963, 284		1. 00
3.00	00300 EMPLOYEE BENEFITS	0	.,,		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-259, 608			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	749, 986		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0			6. 00
7.00	00700 HOUSEKEEPI NG	0	254, 834		7. 00
8.00	00800 DI ETARY	-5, 838			8. 00
9. 00	00900 NURSING ADMINISTRATION	0	311, 028	·	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0			10. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0			12. 00
13. 00	01300 SOCI AL SERVI CE	0			13. 00
15. 00	01500 PATIENT ACTIVITIES	0	178, 992		15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T _	T		
30.00	03000 SKILLED NURSING FACILITY	0			30.00
31.00	03100 NURSING FACILITY	0		l .	31.00
	03200 CF/IID	0			32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS		F 202	T T T T T T T T T T T T T T T T T T T	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	-,	l .	40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	13, 200 0		42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0		43.00
44. 00	04400 PHYSI CAL THERAPY		1		44. 00
	04500 OCCUPATI ONAL THERAPY				45. 00
46. 00	04600 SPEECH PATHOLOGY		9, 257		46.00
47. 00	04700 ELECTROCARDI OLOGY	0	9, 237		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	_		48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	_		49. 00
	05100 SUPPORT SURFACES	0			51.00
011.00	OTHER REIMBURSABLE COST CENTERS				1 011 00
71. 00	07100 AMBULANCE	0	7, 855		71. 00
73.00	07300 CMHC	0	0		73. 00
	SPECIAL PURPOSE COST CENTERS				
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80. 00
81.00	08100 I NTEREST EXPENSE	0	0		81. 00
82.00	08200 UTILIZATION REVIEW - SNF	0	0		82. 00
83. 00	08300 H0SPI CE	0	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-370, 128	10, 563, 355		89. 00
	NONREI MBURSABLE COST CENTERS				
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	l .		90.00
	09100 BARBER AND BEAUTY SHOP	0	_		91.00
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		92.00
93.00	09300 NONPAI D WORKERS	0	0		93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0		94. 00
95. 00	09500 BLANK	0	0		95. 00
95. 10	09510 MEDICAL DAY CARE	0	0		95. 10
100.00	TOTAL	-370, 128	10, 563, 355		100. 00

Heal th Financi	al Systems	NEW COMMUNITY	ECF		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS			Provi der		Peri od:	Worksheet A-6	
					From 01/01/2022		
					To 12/31/2022		
						4/26/2023 11:	57 am_
				Increases			
		Cost Cente	r	Li ne #	Sal ary	Non Salary	
		2.00		3.00	4. 00	5. 00	
(1) A -	ALLOCATE PPS THERAPY BASED ON CHARG						
1. 00		OCCUPATI ONAL THERAP	PΥ	45.0	0 0	194, 907	1. 00
2. 00		SPEECH PATHOLOGY		46.0	0 0	9, 257	2. 00
TOTALS							
100.00		Total Reclassificat	ions (Sum		0	204, 164	100.00
		of columns 4 and 5	must				
		equal sum of column	ns 8 and				
		9)					

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	NEW COMMUNITY	ECF		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 4/26/2023 11:	pared: 57 am
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
(1) A - ALLOCATE PPS THERAPY BASED ON CHARG						
1. 00	PHYSICAL THERAPY		44. (0 0	194, 907	1. 00
2. 00	PHYSICAL THERAPY		44. (00	9, 257	2. 00
TOTALS						
100.00				0	204, 164	100. 00

⁽¹⁾ A letter (A, B, etc.) must be entered on each line to identify each reclassification entry. (2) Transfer to Worksheet A, col. 5, line as appropriate.

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS NEW COMMUNITY ECF In Lieu of Form CMS-2540-10 Provi der No.: 315393

				'	0 12/31/2022	4/26/2023 11:	
	·			Acqui si ti ons			
	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 BALANCES	S					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	470, 860	0	0	0	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	1, 256, 989	105, 455	0	105, 455		6. 00
7. 00	Subtotal (sum of lines 1-6)	1, 727, 849	105, 455	0	105, 455		7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	1, 727, 849	105, 455	0	105, 455	19, 116	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
	ANALYSIS OF SUMMORS IN SARITAL ASSET BALANSE	6.00	7. 00				
4 00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						4 00
1.00	Land	0	0				1.00
2.00	Land Improvements	170 010	0				2.00
3.00	Buildings and Fixtures	470, 860	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	1, 343, 328	0				6. 00
7.00	Subtotal (sum of lines 1-6)	1, 814, 188	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	1, 814, 188	0				9. 00

Provi der No.: 315393

From 01/01/2022

12/31/2022 Date/Time Prepared: 4/26/2023 11:57 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Description (1) (2) Basis For Amount Cost Center Li ne No. Adjustment 2.00 3.00 4.00 1.00 -864 CAP REL COSTS - BLDGS & 1 00 1 00 Investment income on restricted funds 1 00 В (chapter 2) FI XTURES 2.00 Trade, quantity, and time discounts (chapter r 0.00 2.00 3.00 Refunds and rebates of expenses (chapter 8) 0.00 3.00 Rental of provider space by suppliers C 0 00 4 00 4 00 (chapter 8) 5.00 Telephone services (pay stations excluded) 0.00 5.00 (chapter 21) Television and radio service (chapter 21) 6.00 0.00 6.00 Parking Lot (chapter 21) В -103, 818 CAP REL COSTS - BLDGS & 1.00 7.00 7.00 FI XTURES 8.00 Remuneration applicable to provider-based A-8-2 C 8.00 physician adjustment 9.00 Home office cost (chapter 21) 0.00 9.00 10.00 Sale of scrap, waste, etc. (chapter 23) 0 0.00 10.00 Nonallowable costs related to certain 11.00 C 0.00 11.00 Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with A-8-1 Ω 12.00 related organizations (chapter 10) Laundry and linen service 0.00 13.00 13.00 14.00 Revenue - Employee meals 0.00 14.00 Cost of meals - Guests 0.00 15.00 15.00 16.00 Sale of medical supplies to other than 0.00 16.00 pati ents 17.00 Sale of drugs to other than patients 0.00 17.00 18.00 18.00 Sale of medical records and abstracts 0.00 19.00 Vending machines 0.00 19.00 20.00 Income from imposition of interest, finance 0.00 20.00 or penalty charges (chapter 21) 21 00 Interest expense on Medicare overpayments 0.00 21.00 and borrowings to repay Medicare overpayments Utilization review--physicians' compensation 22.00 OUTILIZATION REVIEW - SNF 82.00 22.00 (chapter 21) 23.00 Depreciation--buildings and fixtures OCAP REL COSTS - BLDGS & 1.00 23.00 FLXTURES. 0 *** Cost Center Deleted *** Depreciation--movable equipment 2.00 24.00 24.00 25. 00 BAD DEBT EXPENSE Α -247, 385 ADMI NI STRATI VE & GENERAL 4.00 25.00 25. 01 RETAIL SALES В -5, 838 DI ETARY 8.00 25.01 25. 02 OTHER INCOME - AP WRITE OFF -12, 223 ADMI NI STRATI VE & GENERAL 4.00 25. 02 В 100.00 Total (sum of lines 1 through 99) (Transfer -370, 128 100.00 to Worksheet A, col. 6, line 100)

⁽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 NEW COMMUNI STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME NEW COMMUNITY ECF

Provi der No.: 315393 OFFICE COSTS

				4/26/2023 11:	
	Li ne No.	Cost (Center	Expense I tems	1
	1.00	2.	00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS OR	
CLAIMED HOME OFFICE COSTS:	T			T	1
1.00		DI ETARY		DI ETARY SERVI CES	1.00
2.00		ADMI NI STRATI VE		CORPORATE SERVICES GENERAL	2. 00
3.00		EMPLOYEE BENEF		WORKERS COMP	3.00
4. 00		PLANT OPERATIO	N, MAINI. &	SECURITY CONTRACT	4. 00
5. 00		REPAIRS ADMINISTRATIVE	9. CENEDAI	AUTO INSURANCE	5. 00
6.00		CAP REL COSTS		BUILDING RENT	6.00
0.00		FI XTURES	- DLD03 &	DOTEDTING KENT	0.00
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					10.00
6, line 100 to Worksheet A-8, column 3, line					
12.					
	Amount	Amount	Adjustments		
	Allowable In	Included in	(col. 4 minus		
	Cost	Wkst. A, col.	col . 5)		
	4.00	5 5. 00	6. 00	-	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR				D ORGANIZATIONS OR	
CLAIMED HOME OFFICE COSTS:	KED NO N KESOLI	OI TIVIISAOTIO	NO WITH KELKIE	D ONGAMI ZATI ONO ON	
1.00	410, 379	410, 379	C		1.00
2. 00	150, 000	150, 000			2. 00
3. 00	81, 418	81, 418	(3. 00
4.00	338, 635	338, 635	C)	4. 00
5. 00	9, 488	9, 488	C		5. 00
6. 00	996, 917	996, 917	C		6. 00
7. 00	0	0	(7. 00
8. 00	0	0	C)	8. 00
9. 00	0	0	(9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column	1, 986, 837	1, 986, 837	(0	10. 00
6, line 100 to Worksheet A-8, column 3, line					
12.			l		1

OFFICE COSTS

Worksheet A-8-1 From 01/01/2022 Parts I-II Date/Time Prepared: 12/31/2022

4/26/2023 11:57 am Symbol (1) Name Percentage of Ownershi p 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	A	NEW COMMUNITY	0.00	1.00
2. 00			0.00	2. 00
3. 00			0.00	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			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 rel ated 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 Ownership	Type of Business
DART LL LATERDEL ATLANGUER TO RELATER ARRANGE	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. 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		EXTENDED CARE FOOD SERVICES	0.00	FOOD SERVICE	1.00
2.00			0.00		2.00
3.00			0.00		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			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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	12/31/2022	Date/Time Pre 4/26/2023 11:	
			CAPI TAL			4/20/2023 11.	37 alli
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDGS &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	cost conton boson per on	for Cost	FIXTURES	BENEFITS	oubtota.	& GENERAL	
		Allocation	TTATORES	DEMETTIO		d orivervie	
		(from Wkst A					
		col . 7)					
		0	1.00	3.00	3A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	963, 284	963, 284				1.00
3.00	00300 EMPLOYEE BENEFITS	1, 494, 494	0	1, 494, 494			3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	1, 354, 215	109, 212	136, 187	1, 599, 614	1, 599, 614	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	749, 986		22, 466	816, 103		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	41, 680		7, 252	62, 218		6. 00
7. 00	00700 HOUSEKEEPI NG	254, 834	17, 741	60, 670	333, 245		7. 00
8. 00	00800 DI ETARY	791, 347	86, 867	103, 538	981, 752		8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	311, 028		85, 852	396, 880		9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	311,020		05, 052	370, 000	70, 823	10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY			0	0	0	12.00
13. 00	01300 SOCIAL SERVICE	58, 800		16, 230	75, 030		13. 00
15. 00	01500 PATIENT ACTIVITIES						
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	178, 992	0	45, 830	224, 822	40, 120	15. 00
30. 00	03000 SKILLED NURSING FACILITY	3, 888, 173	615, 359	1, 016, 469	5, 520, 001	985, 065	30.00
31. 00	03100 NURSING FACILITY	3,000,173	010, 309	1, 010, 409	5, 520, 001	965, 005	31. 00
			0	0	0	0	31.00
32. 00	03200 I CF/II D	0			0	0	
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	5, 382	0	O	5, 382	960	40. 00
41. 00	04100 LABORATORY	•	l .	-	•		40.00
	04200 I NTRAVENOUS THERAPY	13, 200			13, 200	2, 356 0	41.00
42. 00		0		0	0	1	
43. 00	04300 OXYGEN (INHALATION) THERAPY	100 504	20 110	١	221 (04	0	43.00
44. 00	04400 PHYSI CAL THERAPY	183, 584	38, 110		221, 694		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	194, 907	0	0	194, 907	34, 782	45. 00
46. 00	04600 SPEECH PATHOLOGY	9, 257	0	0	9, 257	1, 652	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	62, 337	0	0	62, 337	11, 124	49. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
71 00	OTHER REIMBURSABLE COST CENTERS	7 055	1 0	O	7 055	1 402	71 00
71.00	07100 AMBULANCE	7, 855			7, 855		71.00
73. 00	SPECIAL PURPOSE COST CENTERS	0	0	l ol	0	0	73. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82.00
83. 00	08300 HOSPI CE				0		
89. 00		10 5/2 255	024 224	1, 494, 494	10 524 207	1 502 (44	83. 00 89. 00
89.00	SUBTOTALS (sum of lines 1-84)	10, 563, 355	924, 226	1, 494, 494	10, 524, 297	1, 592, 644	89.00
00.00	NONREI MBURSABLE COST CENTERS						90. 00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	l .	0	2 102	0	
	09100 BARBER AND BEAUTY SHOP		, , ,	0	2, 182		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	93.00
94. 00	09400 PATIENTS LAUNDRY	0] 0	0	0	0	94. 00
95.00	09500 BLANK		1 2/ 27/	0	0 071	0	95. 00
95. 10	09510 MEDICAL DAY CARE	0	36, 876	0	36, 876		95. 10
98. 00	Cross Foot Adjustments	0	0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	D TOTAL	10, 563, 355	963, 284	1, 494, 494	10, 563, 355	1, 599, 614	100.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315393

				10) 12/31/2022	4/26/2023 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	·	OPERATI ON,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS					
		5.00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	961, 740					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	15, 767	89, 088				6.00
7.00	00700 HOUSEKEEPI NG	21, 054	0	413, 768			7.00
8.00	00800 DI ETARY	103, 087	0	46, 116	1, 306, 153		8.00
9.00	00900 NURSING ADMINISTRATION	0	0	o	0	467, 705	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	o	0	0	10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	o	0	0	12.00
13.00	01300 SOCI AL SERVI CE	0	0	l o	0	l o	13.00
15. 00	01500 PATIENT ACTIVITIES	0	0	o	0	O	15. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS	_					
30.00	03000 SKILLED NURSING FACILITY	730, 255	89, 088	326, 685	1, 306, 153	467, 705	30.00
31. 00	03100 NURSING FACILITY	0		0	0	0	31. 00
32. 00	03200 CF/IID	0	0	o	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		l .	Ö	0		33. 00
	ANCILLARY SERVICE COST CENTERS	_	-	-	-	_	
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY	0	0	o	0		41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	o	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	45, 226	0	20, 232	0	Ö	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	10,220	0	20, 202	0	Ö	45. 00
46. 00	04600 SPEECH PATHOLOGY		0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY		0	0	0	Ö	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	Ö	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		0		0		49. 00
51. 00	05100 SUPPORT SURFACES		_		0	0	51. 00
01.00	OTHER REIMBURSABLE COST CENTERS			۷			01.00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
73. 00	07300 CMHC				0		73. 00
	SPECIAL PURPOSE COST CENTERS	-	-	-1	-		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 H0SPI CE	0	0	o	0	o	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	915, 389	89, 088	393, 033	1, 306, 153	467, 705	89. 00
	NONREI MBURSABLE COST CENTERS		,		,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	2, 589	0	1, 158	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES		0	o	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	o	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	O	0	0	94.00
95.00	09500 BLANK	0	0	O	0	0	95.00
95. 10	09510 MEDICAL DAY CARE	43, 762	0	19, 577	0	0	95. 10
98. 00	Cross Foot Adjustments	0	0	o	0	0	98. 00
99. 00	Negative Cost Centers		Ō	l	0	Ö	99. 00
100.00		961, 740	89, 088	413, 768	1, 306, 153		

			1	o 12/31/2022	Date/lime Pre 4/26/2023 11:	
				OTHER GENERAL SERVI CE	472072023 11.	37 aiii
Cost Center Description	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	PATI ENT ACTI VI TI ES	Subtotal	
	10.00	12. 00	13. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS				10.00		
1.00 00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & 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	0					10. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	C				12. 00
13. 00 01300 SOCI AL SERVI CE	0	(88, 419			13. 00
15. 00 01500 PATIENT ACTIVITIES	0		0	264, 942		15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					0 770 010	
30. 00 03000 SKI LLED NURSI NG FACI LI TY	0	C		264, 942	9, 778, 313	30.00
31.00 03100 NURSING FACILITY	0	C	1	0	0	31. 00
32. 00 03200 1 CF/I I D	0	C			0	32. 00
33. 00 03300 OTHER LONG TERM CARE	0) 0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS	ما		J 0	0	(242	40.00
40. 00 04000 RADI OLOGY	0	(1		6, 342	40.00
41.00 04100 LABORATORY 42.00 04200 I NTRAVENOUS THERAPY	0	0			15, 556 0	41. 00 42. 00
43. 00 04300 0XYGEN (INHALATION) THERAPY	0			0	0	42.00
44. 00 04400 PHYSI CAL THERAPY	0			0	326, 714	44. 00
45. 00 04400 OCCUPATI ONAL THERAPY	0			0	229, 689	45. 00
46. 00 04600 SPEECH PATHOLOGY	0			0	10, 909	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	(0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	(0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	o	(0	73, 461	49. 00
51. 00 05100 SUPPORT SURFACES	o	Č		0	0	51. 00
OTHER REIMBURSABLE COST CENTERS	-1	-	-	-1		
71. 00 07100 AMBULANCE	0	C	0	0	9, 257	71. 00
73. 00 07300 CMHC	O	C	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 08100 I NTEREST EXPENSE						81. 00
82.00 08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 08300 HOSPI CE	0	C	0	0	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	0		88, 419	264, 942	10, 450, 241	89. 00
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	0	C	0	0	6, 318	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	93.00
94. 00 09400 PATIENTS LAUNDRY	0	(0	0	0	94. 00 95. 00
95. 00 09500 BLANK 95. 10 09510 MEDI CAL DAY CARE	0	(0 106, 796	95. 00 95. 10
98.00 Cross Foot Adjustments	0	C	ή '		106, 796	95. 10 98. 00
99.00 Negative Cost Centers	0	٢		0	0	99. 00
100. 00 TOTAL	0	(88, 419	264, 942	10, 563, 355	
100.00	٩		1 33,417	201, 742	10, 000, 000	. 50. 55

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS NEW COMMUNITY ECF

				4/26/2023 11:	
	Cost Center Description	Post Stepdown	Total	17 207 2020 111	1
	'	Adjustments			
		17. 00	18. 00		
	GENERAL SERVICE COST CENTERS	,			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				1. 00
3.00	00300 EMPLOYEE BENEFITS				3. 00
4.00	00400 ADMINISTRATIVE & 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 12. 00	01000 CENTRAL SERVI CES & SUPPLY 01200 MEDI CAL RECORDS & LI BRARY				10. 00 12. 00
13. 00	01300 SOCIAL SERVICE				13. 00
15. 00	01500 PATIENT ACTIVITIES				15.00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				15.00
30. 00	03000 SKILLED NURSING FACILITY	0	9, 778, 313		30.00
	03100 NURSING FACILITY	o o	0,770,010		31. 00
32. 00	03200 CF/11D	o	o		32. 00
	03300 OTHER LONG TERM CARE	0	0		33. 00
	ANCI LLARY SERVI CE COST CENTERS	-1	-	I	1
40.00	04000 RADI OLOGY	0	6, 342		40. 00
41.00	04100 LABORATORY	0	15, 556		41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		43. 00
44.00	04400 PHYSI CAL THERAPY	0	326, 714		44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	229, 689		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	10, 909		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	73, 461		49. 00
51. 00	05100 SUPPORT SURFACES	0	0		51. 00
71 00	OTHER REIMBURSABLE COST CENTERS		0.257	T	71 00
71. 00 73. 00	07100 AMBULANCE	0	9, 257 0		71.00
73.00	SPECIAL PURPOSE COST CENTERS	J O	U		1 /3.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES				80.00
81. 00	08100 INTEREST EXPENSE				81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF				82. 00
83. 00	08300 H0SPI CE	0	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	10, 450, 241		89. 00
	NONREI MBURSABLE COST CENTERS	-	,,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	6, 318		91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		92. 00
93.00	09300 NONPALD WORKERS	0	0		93. 00
94.00	09400 PATIENTS LAUNDRY	0	o		94. 00
95. 00	09500 BLANK	0	0		95. 00
95. 10	09510 MEDICAL DAY CARE	0	106, 796		95. 10
98. 00	Cross Foot Adjustments	0	0		98. 00
99. 00	Negative Cost Centers	0	0		99. 00
100.00	TOTAL	0	10, 563, 355		100. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315393

				To	12/31/2022	Date/Time Prep 4/26/2023 11:	
			CAPI TAL			47 207 2023 11.	37 diii
			RELATED COSTS				
	Cost Center Description	Directly	BLDGS &	Subtotal		ADMI NI STRATI VE	
		Assigned New	FI XTURES		BENEFI TS	& GENERAL	
		Capi tal					
		Related Costs	4.00	0.4	2.00	4.00	
	GENERAL SERVI CE COST CENTERS	0	1. 00	2A	3. 00	4. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS	0	0	0	0		3.00
4. 00	00400 ADMINISTRATIVE & GENERAL		109, 212	١	0	109, 212	4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS		43, 651		0	9, 943	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	o	13, 286	· ·	0	758	6. 00
7.00	00700 HOUSEKEEPI NG	o	17, 741	· ·	0	4, 060	7. 00
8.00	00800 DI ETARY	o	86, 867		0	11, 962	8. 00
9.00	00900 NURSING ADMINISTRATION	o	0	0	0	4, 836	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	o	0	0	0	0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13. 00	01300 SOCI AL SERVI CE	0	0	-	0	914	13.00
15.00	01500 PATIENT ACTIVITIES	0	0	0	0	2, 739	15. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	615, 359		0		30.00
31. 00	03100 NURSING FACILITY	0	0		0		31. 00
32.00	03200 CF/ I D	0	0		0		32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	33. 00
40. 00	04000 RADI OLOGY	O	0	0	0	66	40. 00
41.00	04100 LABORATORY	0	0	_	0	161	41.00
42. 00	04200 I NTRAVENOUS THERAPY		0		0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0	1	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	o	38, 110	-	0	2, 701	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	o	0		0	2, 375	45. 00
46.00	04600 SPEECH PATHOLOGY	o	0	0	0	113	46. 00
47.00	04700 ELECTROCARDI OLOGY	o	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	760	
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
	OTHER REIMBURSABLE COST CENTERS						
71. 00		0	0		0		
73. 00	07300 CMHC	0	0	0	0	0	73. 00
00 00	SPECIAL PURPOSE COST CENTERS			1			00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 HOSPI CE	0	0	0	0	o	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	924, 226	١	0		89. 00
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	724, 220	724, 220		100, 730	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	ol	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	o	2, 182	2, 182	0	27	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	o	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00	09500 BLANK	0	0	1 9	0	0	95. 00
95. 10	1	0	36, 876	36, 876	0	449	
98. 00	Cross Foot Adjustments			0			98. 00
99. 00	Negative Cost Centers	_	0	0	0	0	99. 00
100.00	D TOTAL	0	963, 284	963, 284	0	109, 212	100.00

Provi der No.: 315393

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared:

				10	12/31/2022	Date/lime Pre 4/26/2023 11:	
	Cost Center Description	PLANT OPERATION, MAINT. &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	J7 alli
		REPAI RS 5. 00	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	7.00	
1. 00 3. 00 4. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						1. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY	53, 594 879 1, 173 5, 745	14, 923 0	22, 974 2, 561	107, 135		5. 00 6. 00 7. 00 8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0 0	0	0	07, 135	4, 836 0	9. 00 10. 00
12. 00 13. 00 15. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01500 PATIENT ACTIVITIES	0 0	0	0 0	0 0 0	0 0 0	12. 00 13. 00 15. 00
30. 00	O3000 SKILLED NURSING FACILITY	40, 694	14, 923	18, 139	107, 135	4, 836	30.00
31. 00 32. 00 33. 00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0	0	0 0	0	0 0 0	31. 00 32. 00 33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 040001 RADI OLOGY	0	_	0	0	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	0	41. 00 42. 00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 2, 520	0	0 1, 123	0	0	43. 00 44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0		0	0	0	45. 00 46. 00
47. 00 48. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	47. 00 48. 00
49. 00 51. 00	04900 DRUGS CHARGED TO PATIENTS 05100 SUPPORT SURFACES	0	0	0	0	0	49. 00 51. 00
71. 00	OTHER REIMBURSABLE COST CENTERS 07100 AMBULANCE	0	0	0	0	0	71. 00
73. 00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	73. 00
80. 00 81. 00 82. 00 83. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0	0	0	0	80. 00 81. 00 82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS	51, 011	14, 923	21, 823	107, 135	-	
90. 00 91. 00 92. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0 144 0	0	0 64 0	0 0 0		90. 00 91. 00 92. 00
93. 00 94. 00 95. 00	09300 NONPALD WORKERS 09400 PATIENTS LAUNDRY 09500 BLANK	0	0	0	0	0 0	93. 00 94. 00 95. 00
95. 10 98. 00	09510 MEDICAL DAY CARE Cross Foot Adjustments	2, 439	0	1, 087 0	0	0	95. 10 98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	0 53, 594	0 14, 923	0 22, 974	0 107, 135	0 4, 836	99. 00 100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				1	0 12/31/2022	4/26/2023 11:	
			<u> </u>		OTHER GENERAL		
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE		Subtotal	
		SERVICES &	RECORDS &		ACTIVITIES		
		SUPPLY	LI BRARY				
	OFFICE AND ADDRESS OF A STATE OF	10.00	12. 00	13. 00	15. 00	16. 00	
4 00	GENERAL SERVICE COST CENTERS			T			4 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	OO3OO EMPLOYEE BENEFITS OO4OO ADMINISTRATIVE & GENERAL						3. 00 4. 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 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY	0					10. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		(12. 00
13. 00	01300 SOCIAL SERVICE	0	Č	1			13. 00
15. 00	01500 PATIENT ACTIVITIES	l ol	C				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	- 1			, -		
30.00	03000 SKILLED NURSING FACILITY	0	C	914	2, 739	871, 991	30. 00
31.00	03100 NURSING FACILITY	o	C	o		0	31. 00
32.00	03200 CF/IID	0	C	0	o	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	C	0	o	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	C	0	0	66	40. 00
41.00	04100 LABORATORY	0	C	0	0	161	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	C			0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	1		0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	C			44, 454	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	C	1		2, 375	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	C	ή		113	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	C	ή	"	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	1		0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	(760	49. 00
51. 00	05100 SUPPORT SURFACES OTHER REIMBURSABLE COST CENTERS	l d) 0	U U	0	51. 00
71. 00	07100 AMBULANCE	O	C) 0	ol	96	71. 00
73.00	07300 CMHC		C	1		0	73.00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>) 0	ı	0	73.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 H0SPI CE	o	C	ol o	o	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	Ċ	914	2, 739	920, 016	89. 00
	NONREI MBURSABLE COST CENTERS	·		'	· · · · · ·		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	C	0	o	2, 417	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	C	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	C	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	C	0	0	0	94. 00
95.00	09500 BLANK	0	C			0	95.00
95. 10	09510 MEDICAL DAY CARE	0	C	0	0	40, 851	95. 10
98. 00	Cross Foot Adjustments	0			0	0	98. 00
99. 00	Negative Cost Centers	0	C	0	0	0	99. 00
100.00	TOTAL	I 0	C	914	2, 739	963, 284	100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS NEW COMMUNITY ECF

Cost Center Description					То	12/31/2022		
Adjustments		Cost Center Description	Post Sten-Down	Total			4/20/2023	11. 57 alli
17.00 18.00 18.00		odst denter beserver on		lotai				
EMERAL SERVICE COST CENTERS 1.00				18. 00				
3.00		GENERAL SERVICE COST CENTERS	<u> </u>					
4. 00 00-400 ADMIN STRATTUR & GENERAL	1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 6.00 0070 001500 LANDRY & LINEN SERVICE 7.00 6.00 0070 001500 LANDRY & LINEN SERVICE 7.00 9.00 00700 001500 ELECTRON 9.00 9.00 00700 001500 ELECTRON 9.00 00700 001500 ELECTRON 9.00 10.00 00100 ELECTRON & LIDRARY 9.00 10.00 1	3.00	00300 EMPLOYEE BENEFITS						3. 00
6. 00	4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
7. 00 7. 00 7. 00 7. 00 7. 00 8. 00 9.	5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
8. 00	6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
9.00 00000 OURSING ADMINISTRATION 9.00 10.00 10.00 01000 OLODO CENTRAL SERVICES & SUPPLY 12.00 115.00 115.00 10	7.00	00700 HOUSEKEEPI NG						7. 00
10.00 01000 CENTRAL SERVICES & SUPPLY 12.00 13.00 01300 SOCIA & SERVICE 13.00	8.00	00800 DI ETARY						8. 00
12. 00 01200 MEDICAL RECORDS & LIBRARY	9.00	00900 NURSING ADMINISTRATION						9. 00
13. 00 01300 SOCIAL SERVICE 13. 00 15. 00 01500 PATIENT ROUTINE SERVICE COST CENTERS 15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 0100 031. 00 031. 00 18. 00 03000 SKI LLEA NURSING FACILITY 0 0 0 0 18. 00 03200 CF/I ID 00 0 31. 00 18. 00 03200 CF/I ID 00 0 32. 00 18. 00 03200 CF/I ID 00 0 0 32. 00 18. 00 03300 OTHER LONG TERM CARE 0 0 0 0 18. 00 03300 OTHER LONG TERM CARE 0 0 0 0 18. 00 03300 OTHER LONG TERM CARE 0 0 0 0 18. 00 04. 00 04. 00 04. 00 0 0 18. 00 04. 00 04. 00 04. 00 0 0 18. 00 04. 00 04. 00 04. 00 0 0 18. 00 04. 00 04. 00 04. 00 0 0 18. 00 04. 00 04. 00 04. 00 0 0 18. 00 04. 00 04. 00 04. 00 04. 00 18. 00 04. 00 04. 00 04. 00 04. 00 18. 00 04. 00 04. 00 04. 00 04. 00 18. 00 04. 00 04. 00 04. 00 04. 00 18. 00 04. 00 04. 00 04. 00 04. 00 18. 00 04. 00 04. 00 04. 00 04. 00 18. 00 04. 00 04. 00 04. 00 04. 00 18. 00 04. 00 04. 00 04. 00 04. 00 18. 00 04. 00 0	10.00	01000 CENTRAL SERVICES & SUPPLY						10. 00
15. 00 15. 00 15. 00 16. 00 17. 00	12.00	01200 MEDICAL RECORDS & LIBRARY						12. 00
INPATIENT ROUTINE SERVICE COST CENTERS	13.00	01300 SOCIAL SERVICE						13. 00
30. 00 03000 SKILLED NURSING FACILITY 0 0 871, 991 31. 00 3700 NURSIN REFACILITY 0 0 0 31. 00 32. 00 03200 1CF/I ID 0 0 0 32. 00 33. 00 03300 THER LONG TERM CARE 0 0 0 0 33. 00 03300 OTHER LONG TERM CARE 0 0 0 0 33. 00 04000 RADIOLOGY 0 0 66 40. 00 41. 00 04100 LABORATORY 0 161 161 41. 00 42. 00 04200 INTRAVENOUS THERAPY 0 0 161 41. 00 43. 00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 0 43. 00 44. 00 04400 PRYSI CAL THERAPY 1 0 0 0 0 44. 00 45. 00 04500 OCCUPATI ONAL THERAPY 0 0 144, 454 44. 00 46. 00 04600 SPECEH PATHOLOGY 0 113 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 113 46. 00 48. 00 04600 SPECEH PATHOLOGY 0 113 46. 00 49. 00 04900 PRUSS CHARGED TO PATIENTS 0 0 0 48. 00 49. 00 04900 PRUSS CHARGED TO PATIENTS 0 0 0 0 48. 00 49. 00 04900 PRUSS CHARGED TO PATIENTS 0 0 0 0 51. 00 50 05100 05100 SUPPORT SURFACES 0 0 0 0 51. 00 50 07100 ABBULANCE 0 0 96 571. 00 571. 00 07100 AMBULANCE 0 0 96 571. 00 572. 00 07100 AMBULANCE 0 0 96 573. 00 573. 00 07300 CMMC PRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUM	15.00	01500 PATIENT ACTIVITIES						15. 00
30. 00 03000 SKILLED NURSING FACILITY 0 0 871, 991 31. 00 3700 NURSIN REFACILITY 0 0 0 31. 00 32. 00 03200 1CF/I ID 0 0 0 32. 00 33. 00 03300 THER LONG TERM CARE 0 0 0 0 33. 00 03300 OTHER LONG TERM CARE 0 0 0 0 33. 00 04000 RADIOLOGY 0 0 66 40. 00 41. 00 04100 LABORATORY 0 161 161 41. 00 42. 00 04200 INTRAVENOUS THERAPY 0 0 161 41. 00 43. 00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 0 43. 00 44. 00 04400 PRYSI CAL THERAPY 1 0 0 0 0 44. 00 45. 00 04500 OCCUPATI ONAL THERAPY 0 0 144, 454 44. 00 46. 00 04600 SPECEH PATHOLOGY 0 113 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 113 46. 00 48. 00 04600 SPECEH PATHOLOGY 0 113 46. 00 49. 00 04900 PRUSS CHARGED TO PATIENTS 0 0 0 48. 00 49. 00 04900 PRUSS CHARGED TO PATIENTS 0 0 0 0 48. 00 49. 00 04900 PRUSS CHARGED TO PATIENTS 0 0 0 0 51. 00 50 05100 05100 SUPPORT SURFACES 0 0 0 0 51. 00 50 07100 ABBULANCE 0 0 96 571. 00 571. 00 07100 AMBULANCE 0 0 96 571. 00 572. 00 07100 AMBULANCE 0 0 96 573. 00 573. 00 07300 CMMC PRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 589. 00 07000 MALPRACTICE PREMIUM		INPATIENT ROUTINE SERVICE COST CENTERS						
32.00 03200 ICF/I ID 32.00 03300 OTHER LONG TERM CARE 0 0 0 0 33.00 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00		0	871, 991				30. 00
33.00	31.00	03100 NURSING FACILITY	O	O				31. 00
ANCILLARY SERVICE COST CENTERS	32.00	03200 CF/IID	O	O				32. 00
40. 00 04000 RADI OLDGY 0 66 40. 00 41. 00 04100 LABORATORY 0 161 41. 00 42. 00 04200 INTRAVENOUS THERAPY 0 0 0 43. 00 04300 OXYGEN (I NHALATION) THERAPY 0 0 0 44. 00 04400 PHYSIC LAT HERAPY 0 0 0 45. 00 04500 OCCUPATI ONAL THERAPY 0 0 44. 454 46. 00 04600 SPEECH PATHOLOGY 0 113 46. 00 04600 SPEECH PATHOLOGY 0 113 47. 00 04700 ELECTROCARDI OLOGY 0 113 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 49. 00 07100 OXIDER SUPPORT SURFACES 0 0 0 49. 00 07100 AMBULANCE 0 0 0 49. 00 07300 CMHC 0 0 0 49. 00 07300 CMHC 0 0 0 49. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80. 00 40. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80. 00 40. 00 08000 UTILI ZATI ON REVIEW - SNF 81. 00 40. 00 08000 UTILI ZATI ON REVIEW - SNF 82. 00 40. 00 09000 0500 0500 0500 0500 0500 40. 00 09000 0500 0500 0500 0500 0500 0500 0500 40. 00 09000 0500	33.00	03300 OTHER LONG TERM CARE	O	O				33. 00
41.00 04100 LABORATORY 0 161 41.00 42.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0 0 0 42.00 43.00 04300 OXYGEN (I NHALATION) THERAPY 0 0 0 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 0 44.454 44.00 04400 PHYSI CAL THERAPY 0 44.454 44.00 04400 PHYSI CAL THERAPY 0 2,375 45.00 46.00 04600 SPEECH PATHOLOGY 0 113 46.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS						
42. 00 04200 NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	40.00	04000 RADI OLOGY	0	66				40. 00
43.00 04300 0XYCEN (I INHALATI ON) THERAPY 0 0 0 0 0 0 0 0 0	41.00	04100 LABORATORY	o	161				41. 00
44. 00 04400 PHYSI CAL THERAPY 0 44. 454 45. 00 04500 OCCUPATI ONAL THERAPY 0 2. 375 45. 00 04500 OCCUPATI ONAL THERAPY 0 2. 375 45. 00 04500 OCCUPATI ONAL THERAPY 0 113 46. 00 04600 SPEECH PATHOLOGY 0 113 46. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42.00	04200 I NTRAVENOUS THERAPY	o	o				42.00
45. 00 04500 OCCUPATIONAL THERAPY 0 2,375 45. 00 46. 00 04600 SPEECH PATHOLOGY 0 0 113 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 760 49. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 71. 00 07100 AMBULANCE 0 9 96 73. 00 07300 CMLP CENTERS 80. 00 08000 MALPRACTI CE PREMI LUNS & PAI D LOSSES 81. 00 08200 UTI LI ZATI ON REVI EW - SNF 82. 00 82. 00 08200 UTI LI ZATI ON REVI EW - SNF 82. 00 89. 00 SUBTOTALS (sum of lines 1-84) 0 920, 016 NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 920, 016 NONREI MBURSABLE COST CENTERS 90. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 93. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 93. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 93. 00 94. 00 09400 PATE BUTS LAUNDRY 0 0 0 0 95. 00 09500 BLANK 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43.00	04300 OXYGEN (INHALATION) THERAPY	0	0				43. 00
46. 00 04600 SPEECH PATHOLOGY 0 113 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 49. 00 04900 DRUGS CHARGED TO PATI ENTS 0 0 760 49. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 71. 00 07100 AMBULANCE 0 0 96 71. 00 73. 00 07300 CMHC 0 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS 80. 00 08200 MALPRACTI CE PREMI UMS & PAI D LOSSES 81. 00 81. 00 08200 INTEREST EXPENSE 81. 00 82. 00 08200 INTEREST EXPENSE 81. 00 83. 00 08200 INTEREST EXPENSE 81. 00 83. 00 08200 INTEREST EXPENSE 82. 00 89. 00 08200 INTEREST EXPENSE 83. 00 89. 00 08200 INTEREST EXPENSE 83. 00 89. 00 08200 INTEREST EXPENSE 82. 00 89. 00 08200 INTEREST EXPENSE 83. 00 89. 00 08200 INTEREST EXPENSE 82. 00 89. 00 08200 INTEREST EXPENSE 83. 00 89. 00 08200 INTEREST EXPENSE 83. 00 89. 00 08200 INTEREST EXPENSE 84. 00 89. 00 08200 INTEREST EXPENSE 85. 00 89. 00 09200 INTERE	44.00	04400 PHYSI CAL THERAPY	0	44, 454				44. 00
47. 00 04700 ELECTROCARDIOLOGY	45.00	04500 OCCUPATI ONAL THERAPY	0	2, 375				45. 00
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 760 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 760 49. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46.00	04600 SPEECH PATHOLOGY	0	113				46. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 760 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47.00	04700 ELECTROCARDI OLOGY	0	0				47. 00
S1.00 O5100 SUPPORT SURFACES O O O O OTHER REI MBURSABLE COST CENTERS	48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				48. 00
OTHER REIMBURSABLE COST CENTERS O	49.00	04900 DRUGS CHARGED TO PATIENTS	0	760				49. 00
71. 00	51.00	05100 SUPPORT SURFACES	0	0				51. 00
73.00 07300 CMHC SPECIAL PURPOSE COST CENTERS S0.00 08100 NALPRACTICE PREMIUMS & PAID LOSSES S0.00 08100 INTEREST EXPENSE S1.00 08200 UTILIZATION REVIEW - SNF S2.00 S0.00 SUBTOTALS (sum of lines 1-84) O 920,016 S0.00 SUBTOTALS (sum of lines 1-84) O 920,016 S0.00 SUBTOTALS (sum of lines 1-84) O 920,016 S0.00 SO.00 SIT, FLOWER, COFFEE SHOPS & CANTEEN O 0 2,417 S0.00 SO.00 SARBER AND BEAUTY SHOP O 2,417 S0.00 SO.00 SO								
SPECIAL PURPOSE COST CENTERS 80.00								71. 00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81. 00 81. 00 08100 INTEREST EXPENSE 81. 00 82. 00 08200 UTI LI ZATI ON REVI EW - SNF 82. 00 83. 00 83. 00 SUBTOTALS (sum of lines 1-84) 0 920, 016 83. 00 NONREI MBURSABLE COST CENTERS 90. 00 O9000 GI FT , FLOWER, COFFEE SHOPS & CANTEEN 91. 00 O9100 BARBER AND BEAUTY SHOP 0 2, 417 91. 00 O9200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 O9200 O9200 PHYSI CI ANS PRI VATE OFFI CES 0 0 O O9300 NONPAI D WORKERS 0 0 O O9400 PATI ENTS LAUNDRY 0 O9500 BLANK 0 O9500 BLANK O O O9500 BLANK O O O9500 MEDI CAL DAY CARE O 40, 851 O9510 MEDI CAL DAY CARE O 40, 851 O9510 O96300 Norgati ve Cost Centers O O O O9900 O9	73.00		0	0				73. 00
81. 00								
82. 00 08200 UTILIZATION REVIEW - SNF	80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
83. 00 83. 00 83. 00 83. 00 83. 00 89.								•
SUBTOTALS (sum of lines 1-84) 0 920,016 89.00								
NONREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0			1	- 1				•
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0	89. 00		0	920, 016				89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 0 2,417 91. 00 92. 00 93. 00 93. 00 93. 00 93. 00 93. 00 94. 00 94. 00 95. 00 95. 00 95. 00 95. 10 95. 10 95. 10 96. 00 96.								
92. 00 92.00 93.00 9300 9000			9	-1				
93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 94. 00 95. 00 95. 00 95. 10 09510 MEDI CAL DAY CARE 0 40, 851 98. 00 99. 00 Negative Cost Centers 0 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 0 0 0 0 0 0 0 0		1	1					•
94. 00 94. 00 94. 00 95. 00 95. 00 95. 00 95. 10 95. 10 96. 00 96.			0	- 1				
95. 00 9500 BLANK 0 0 0 95. 00 95. 10 95. 10 95. 10 95. 10 95. 10 96. 10			0	9				
95. 10 09510 MEDI CAL DAY CARE 0 40,851 98.00 99.00 Negative Cost Centers 0 0 0 99.00 0 0 0 0 0 0 0 0 0		1	0	١				
98.00 Cross Foot Adjustments 0 0 98.00 99.00 Negative Cost Centers 0 0 99.00			0	-1				
99.00 Negative Cost Centers 0 0 99.00			0					
			0	١				
100.00 101AL 0 963, 284 100.00		1 1 9	-1	٦				1
	100.00	IUIAL	l O	963, 284				[100.00

| Period: | Worksheet B-1 | To 12/31/2022 | To Provi der No.: 315393

				T	o 12/31/2022	Date/Time Pre 4/26/2023 11:	
	Cost Center Description	CAPITAL RELATED COSTS BLDGS & FIXTURES (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM COST)	PLANT OPERATI ON, MAI NT. & REPAI RS (SQUARE FEET)	, a
		1.00	3. 00	4A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 3. 00 4. 00 5. 00 6. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	84, 322 0 9, 560 3, 821 1, 163	5, 414, 313 493, 384 81, 389 26, 274	-1, 599, 614 0 0	816, 103 62, 218	70, 941 1, 163	1. 00 3. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00 10. 00 12. 00	00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01200 MEDICAL RECORDS & LIBRARY	1, 553 7, 604 0 0	219, 798 375, 100 311, 028 0	0 0	333, 245 981, 752 396, 880 0	1, 553 7, 604 0 0 0	8. 00 9. 00
13. 00 15. 00	01300 SOCIAL SERVICE 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	58, 800 166, 034	1	75, 030 224, 822	0	13. 00 15. 00
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	53, 866 0 0 0	3, 682, 506 C C	0 0	0	53, 866 0 0 0	31. 00 32. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	O	C	0	F 202	0	40.00
40. 00 41. 00 42. 00 43. 00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	0 0	0	Ö	5, 382 13, 200 0 0	0 0 0	40. 00 41. 00 42. 00 43. 00
44. 00 45. 00 46. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPECH PATHOLOGY	3, 336	C C C	Ö	221, 694 194, 907 9, 257	3, 336 0 0	45. 00 46. 00
47. 00 48. 00 49. 00 51. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05100 SUPPORT SURFACES	0 0	C C C	Ö	0 0 62, 337 0	0 0 0 0	47. 00 48. 00 49. 00 51. 00
	OTHER REIMBURSABLE COST CENTERS						
71. 00 73. 00	07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	0	C	1		0	
80. 00 81. 00 82. 00 83. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0	0	0	0	
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	80, 903	5, 414, 313	-1, 599, 614	8, 924, 683	67, 522	
91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0 191 0 0	0 0 0 0	0	2, 182 0	0 191 0 0	91. 00 92. 00
94. 00 95. 00 95. 10 98. 00	09400 PATIENTS LAUNDRY 09500 BLANK 09510 MEDICAL DAY CARE Cross Foot Adjustments	0 0 3, 228	C C	Ö	-	0 0 3, 228	94. 00 95. 00 95. 10 98. 00
99. 00 102. 00		963, 284	1, 494, 494	ļ.	1, 599, 614	961, 740	99. 00 102. 00
103. 00 104. 00		11. 423875	0. 276027 0		0. 178454 109, 212	13. 556899 53, 594	103. 00 104. 00
105.00	1 1 *		0. 000000		0. 012184	0. 755473	105. 00

				Ť	o 12/31/2022	Date/Time Pre 4/26/2023 11:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	NURSI NG	CENTRAL	37 alli
	·	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON		
		(PATIENT DAYS)			(5) 5507	SUPPLY	
					(DI RECT NURSI NG)	(COSTED REQUIS.)	
		6. 00	7. 00	8. 00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7,00	0.00	7. 00	10100	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS					ı	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL					ı	4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	34, 067		•		ı	5. 00 6. 00
7. 00	00700 HOUSEKEEPING	34,007	68, 225			ı	7. 00
8.00	00800 DI ETARY	0	7, 604	l .		ı	8. 00
9.00	00900 NURSING ADMINISTRATION	0	0	C	102, 841	i	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	C	0	233, 102	10. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0	C	0	0	12.00
13. 00 15. 00	01300 SOCIAL SERVICE 01500 PATIENT ACTIVITIES	0	0		0	0	13. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	0			<u> </u>	0	15.00
30. 00	03000 SKILLED NURSING FACILITY	34, 067	53, 866	102, 201	102, 841	170, 765	30. 00
31.00	03100 NURSING FACILITY	0	0	· c	0	0	31. 00
32. 00	03200 CF/IID	0	0	C	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	<u>C</u>	0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS		0	J	O	0	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0	C	_	0	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0		0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	Ö	o c	o	0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	3, 336	o c	O	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	C	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	62, 337	49. 00
51. 00	05100 SUPPORT SURFACES	0	Ö	o c	o	0	51.00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	l e	-		0	71. 00
73. 00	07300 CMHC	0	0	<u> </u>	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 INTEREST EXPENSE					ı	81. 00
82. 00	08200 UTILIZATION REVIEW - SNF					ı	82. 00
83. 00	08300 H0SPI CE	0	0	C	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	34, 067	64, 806	102, 201	102, 841	233, 102	89. 00
00.00	NONREI MBURSABLE COST CENTERS			J		-	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	191		0	0	90. 00 91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0	0	92.00
93. 00		0	Ō	o c	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	o c	O	0	94. 00
95. 00	09500 BLANK	0			0	0	95. 00
95. 10	09510 MEDI CAL DAY CARE	0	3, 228	C	0	0	95. 10
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers					ı	98. 00 99. 00
99. 00 102. 00		89, 088	413, 768	1, 306, 153	467, 705	n	102.00
102.00	Part I)	07,000	1.0,700	1,000,100	1077700		102.00
103.00		2. 615082				0. 000000	
104.00		14, 923	22, 974	107, 135	4, 836	0	104. 00
105. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 438049	0. 336739	1. 048277	0. 047024	0. 000000	105.00
100.00		0. 430049	0. 330/39	1.0402//	0.047024	0.000000	105.00
	1	I	ı	1	ı		1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS NEW COMMUNITY ECF In Lieu of Form CMS-2540-10

| Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315393

Cost Conter Description						10	4/26/2023 1	
Cost Center Description						OTHER GENERAL	,	
RECORDS & CATHERT DAYS PATIENT DAYS PA								
LIBRAY CATIENT DAYS CATIENT DAYS CATIENT DAYS		Cost Cente	r Description		SOCI AL SERVI CE			
SENERAL SERVICE COST CENTERS					(0.47) 51/7 0.4/(0)			
GENERAL SERVICE COST CENTERS					(PATTENT DAYS)	(PATTENT DAYS)		
CENTRAL SERVICE COST CENTERS 1.00 0.000				•	13 00	15.00		
1.00		GENERAL SERVICE	COST CENTERS	12.00	15.00	15.00		
4.00	1.00							1.00
5.00 00SCO_PLANT_OPERATION, MAINT_ & REPAIRS 5.00 00SCO_LAMINDRY & LINEMS_SERVICES 6.60 00SCO_LAMINDRY & LINEMS_SERVICES 7.00 00FOO_LAMINDRY & LINEMS_SERVICES & SUPPLY 10.00 10.0	3.00	00300 EMPLOYEE B	ENEFI TS					3. 00
6.00 00000 LANDRY & LINEN SERVICE	4.00	00400 ADMI NI STRA	TIVE & GENERAL					4. 00
7.00	5.00	00500 PLANT OPER	ATION, MAINT. & REPAIRS					5. 00
8.00 0.0000 DETARY		1 1						1
9,00		1 1	NG					•
10. 00 010000 CENTRAL SERVICES & SUPPLY 34,067 13. 00 1300 01300 OSCILAL SERVICE 0 34,067 15. 00 15. 00 15. 00 15. 00 01500 PATIENT ACTIVITIES 0 0 34,067 34,067 35. 00 15. 00 15. 00 01500 PATIENT ACTIVITIES 0 0 34,067 34,067 34,067 30. 00 30. 00 30. 00 SKILLED NURSING FACILITY 0 0 0 0 0 31. 00 32. 00 32.00 CF/II D 0 0 0 0 0 0 32. 00 32.00 CF/II D 0 0 0 0 0 32. 00 32.00 CF/II D 0 0 0 0 0 0 32. 00 32.00 CF/II D 0 0 0 0 0 0 0 32. 00 32.00 CF/II D 0 0 0 0 0 0 0 0 0								1
12.00 01200 MEDICAL RECORDS & LIBRARY 34,067 13.00 13.00 13.00 01500 PATIENT ACTIVITIES 0 34,067 34,067 34,067 30.00 31.								1
13. 00 01300 SOCIAL SERVICE 0 34,067 15,00				04.047				
15.00 01500 PATENT ACTIVITIES 0 0 34,067 34,067 30,00 31,00		1 1			24.047	,		1
INPATI ENT ROUTINE SERVICE COST CENTERS 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 34,067 32,00 32				~		1		1
30.00 03000 03000 0300 031.00	13.00					34,007		15.00
31.00	30 00			34 067	34 067	34 067		30.00
32.00 03200 ICF/I ID 0 0 0 0 32.00				01,007	1			1
33.00 03300 0716FR LONG TERN CARE					1	•		1
ANCILLARY SERVICE COST CENTERS			TERM CARE	0	Ö	•		
41.00		ANCILLARY SERVIC	CE COST CENTERS					
42.00 04200 INTRAVERIOUS THERAPY 0 0 0 0 0 42.00 43.00 04300 OXYGEN (I MHALATION) THERAPY 0 0 0 0 0 44.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 44.00 04400 OXYGEN (I MHALATION) THERAPY 0 0 0 0 0 44.00 04500 OXCUPATIONAL THERAPY 0 0 0 0 0 45.00 04500 OXCUPATIONAL THERAPY 0 0 0 0 0 46.00 04600 SPECEH PATHOLIGY 0 0 0 0 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 48.00 04800 OXYGEN (I SUPPLIES CHARGED TO PATIENTS 0 0 0 0 49.00 04900 DRIUGS CHARGED TO PATIENTS 0 0 0 0 49.00 04900 DRIUGS CHARGED TO PATIENTS 0 0 0 0 51.00 OSTION SUPPLIES SURFACES 0 0 0 0 THER REI MBURSABLE COST CENTERS 0 0 0 0 THER REI MBURSABLE COST CENTERS 0 0 0 0 TO 7300 CMHC SPECIAL PURPOSE COST CENTERS 80.00 80.00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81.00 81.00 08100 INTEREST EXPENSE 82.00 82.00 08200 UTILIZATION REVIEW - SMF 82.00 83.00 03300 HOSPICE SUBJECTAL SUBJECTATION REVIEW - SMF 82.00 83.00 03300 HOSPICE SUBJECTAL SUBJECTATION REVIEW - SMF 82.00 80.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 09000 OSCORD HYNIC I ANS PRI VATE OFFICES 0 0 0 0 0 90.00 09000 OSCORD HYNIC I ANS PRI VATE OFFICES 0 0 0 0 0 90.00 09000 OSCORD HYNIC I ANS PRI VATE OFFICES 0 0 0 0 0 90.00 09000 OSCORD HYNIC I ANS PRI VATE OFFICES 0 0 0 0 0 90.00 09000 OSCORD HYNIC I ANS PRI VATE OFFICES 0 0 0 0 0 90.00 09000 OSCORD HYNIC I ANS PRI VATE OFFICES 0 0 0 0 90.00 09000 OSCORD HYNIC I ANS PRI VATE OFFICES 0 0 0 0 90.00 09000 OSCORD HYNIC I ANS PRI VATE OFFICES 0 0 0 0 90.00	40.00	04000 RADI OLOGY		0	0	0		40. 00
43.00 04300 DXYCEN (INHALATION) THERAPY 0 0 0 440.00 04400 PHYSICAL THERAPY 0 0 0 0 0 0 440.00 10 0 04500 DCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	1		1
44. 00 04400 PHYSICAL THERAPY 0 0 0 0 45. 00 04500 0CCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 0		1 1		0	0	1		
45. 00 04500 OCCUPATIONAL THERAPY 0 0 0 45. 00 46. 00 04600 SPEECH PATHOLOGY 0 0 0 0 47. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 00 07100 AUBULANCE 0 0 0 0 73. 00 07300 CMHC 07300 CMHC 07300 CMHC 73. 00 07300 CMHC 0 0 0 0 0 82. 00 08200 UTI LI ZATI ON REVIEW - SNF 82. 00 83. 00 8300 HOSPIC CE 8300 HOSPIC CE 8300 HOSPIC CE 8300 CMHC 8300 HOSPIC CE 8300 CMHC 8300 HOSPIC CE 0 0 0 0 0 0 89. 00 SUBTOTALS (sum of lines 1-84) 34,067 34,067 34,067 34,067 89.00 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 91. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 92. 00 92.00 PHYSIC LANS PRIVATE OFFICES 0 0 0 0 0 93. 00 09300 NONPAID WORKERS 0 0 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 95. 00 09500 BLANK 0 0 0 0 0 99. 00 Negative Cost Centers 99. 00 99. 00 Negative Cost Centers 99. 00 102. 00 Cross Foot Adjustments 99. 00 103. 00 Cross Foot Adjustments 99. 00 104. 00 Cross foot Adjustments 99. 00 105. 00 Unit cost multiplier (Wkst. B, Part I) 0. 000000 2. 595444 7. 777086 103. 00 104. 00 Cross foot adjustments 99. 00 105. 00 Unit cost multiplier (Wkst. B, Part I) 0. 000000 0. 026829 0. 080400 105. 00				0	0	1		
46. 00 04600 SPEECH PATHOLOGY 0 0 0 0 47. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 48. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 51. 00 SOTION SUPPACES 0 0 0 0 71. 00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 71. 00 O7300 CMHC 0 0 0 0 71. 00 O7300 O7300 CMHC 0 0 0 71. 00 O7300 O730				0	0	1		
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48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0								1
49.00 04900 DRIGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		1 1						1
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0								1
OTHER REIMBURSABLE COST CENTERS				0				1
73.00				<u>'</u>	•	•		
SPECIAL PURPOSE COST CENTERS 80. 00 80000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81. 00 81.00 81.00 81.00 81.00 81.00 81.00 82.00 82.00 82.00 82.00 82.00 82.00 83.	71.00	07100 AMBULANCE		0				71. 00
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 82. 00 82. 00 82. 00 82. 00 82. 00 83.	73.00			0	0	0		73. 00
81.00					ı			
82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 83.00 83.00 08300 HOSPICE 0 0 0 0 0 89.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 90.00 O9100 BARBER AND BEAUTY SHOP 0 0 0 0 91.00 O9200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 93.00 O9300 NONPAID WORKERS 0 0 0 0 94.00 O9400 PATIENTS LAUNDRY 0 0 0 0 95.00 O9500 BLANK 0 0 0 0 95.10 O9500 MEDICAL DAY CARE 0 0 0 99.00 O9500 Medical Day Care Stot Adjustments 0 0 0 99.00 O000 O000 O000 O000 99.00 O000 O000 O000 O000 99.00 O000 O000 99.00 O000 O000 O000 O000 O000 99.00 O000 O000 O000 O000 O000 99.00 O000 O000 O000 O000 O000 O000 99.00 O								1
83. 00 89. 00 89. 00 89. 00 SUBTOTALS (sum of lines 1-84) NONNEI MBURSABLE COST CENTERS 90. 00 90. 00 91. 00 91. 00 91. 00 92. 00 92. 00 93. 00 94. 00 94. 00 95. 00 95. 10 96. 00 95. 10 96. 00 97. 00 98. 00 99. 00 9		1 1						1
SUBTOTALS (sum of lines 1-84) 34,067 34,06		1 1	N REVIEW - SINF	0				•
NONREI MBURSABLE COST CENTERS O		1 1	(sum of lines 1-84)	34 067	34 067	34 067		
91. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91. 00 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 93. 00 94. 00 94. 00 95. 00 09500 BLANK 0 0 0 0 0 95. 00 95. 10 09510 MEDI CAL DAY CARE 0 0 0 0 0 95. 10 99. 00 Nogative Cost Centers 0 0 0 0 0 0 0 0 0	07.00			01,007	01,007	01,007		- 07.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92. 00 93. 00 09300 NONPAID WORKERS 0 0 0 0 0 94. 00 94. 00 95. 00 09500 BLANK 0 0 0 0 0 95. 00 95. 10 09510 MEDICAL DAY CARE 0 0 0 0 95. 10 09500 Negative Cost Centers 0 0 0 0 0 0 0 0 0	90.00	09000 GIFT, FLOW	ER, COFFEE SHOPS & CANTEEN	0	C	0		90. 00
93. 00 09300 NONPAI D WORKERS 0 0 0 0 93. 00 94. 00 94. 00 95. 00 09500 BLANK 0 0 0 0 0 95. 10 95. 10 09510 MEDI CAL DAY CARE 0 0 0 0 0 95. 10 98. 00 Cross Foot Adjustments 98. 00 Negative Cost Centers 99. 00 Cost to be allocated (per Wkst. B, Part I) 0.000000 2.595444 7.777086 103. 00 104. 00 Cost to be allocated (per Wkst. B, Part II) 0.000000 0.026829 0.080400 105. 00 105.	91.00	09100 BARBER AND	BEAUTY SHOP	0	0	0		91. 00
94. 00 994. 00 994. 00 995. 00				0	0	0		92. 00
95. 00 09500 BLANK 0 0 0 0 0 0 95. 00 95. 10 95. 10 95. 10 98. 00 99. 00 0 0 0 0 0 0 98. 00 99. 00 0 0 0 0 0 0 0 0 0	93.00	09300 NONPALD WO	RKERS	0	0	0		93. 00
95. 10		1 1	AUNDRY	0	0	•		
98.00 99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 105.00 Cost to be allocated (per Wkst. B, Part I) 105.00 Cost to be allocated (per Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Part II) Unit cost multiplier (Wkst. B, Part III) 105.00 Part III) 105.00 Part III) 105.00		1 1		0	0			
99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) 0.000000 2.595444 7.777086 103.00 2.739 104.00 105.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.026829 0.080400		1 1		0	0	0		
102.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 2.595444 7.777086 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 0.026829 0.080400 105.00								
Part I) 103.00 104.00 105.00 Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) 105.00 Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII					00 410	344 043		
103.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 2.595444 7.777086 104.00 Cost to be allocated (per Wkst. B, Part II) 0 914 2,739 105.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.026829 0.080400	102.00		arrocated (per WKST. B,		88, 419	264, 942		102.00
104.00 Cost to be allocated (per Wkst. B, Part 0.000000 0.026829 0.080400 105.00 104.00	103. 00	1 /	multiplier (Wkst. B. Part I)	0. 000000	2. 595444	7. 777086		103. 00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.026829 0.080400 105.00				0.000000	l .	1		1
		Part II)						
	105. 00		multiplier (Wkst. B, Part	0. 000000	0. 026829	0. 080400		105. 00
		11)			l	1		

Heal th	Financial Systems NEW COM	MUNITY ECF		In Lie	eu of Form CMS-2	2540-10
RATI 0	OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTI	RS Provi der	No.: 315393 P	eri od:	Worksheet C	
				rom 01/01/2022		
			T	o 12/31/2022		
	Coot Contar Decemintion		Total (from	Total Changes	4/26/2023 11:	o/am
	Cost Center Description		Wkst. B, Pt I,		Ratio (col. 1	
			· · · · ·		di vi ded by	
			col . 18)	2. 00	col . 2 3.00	
	ANOULL ADV. CEDVICE COCT CENTEDS		1.00	2.00	3.00	
40.00	ANCI LLARY SERVI CE COST CENTERS			_	0.00000	
40. 00	04000 RADI OLOGY		6, 342		0. 000000	
41. 00	04100 LABORATORY		15, 556	0	0. 000000	41. 00
42.00	04200 I NTRAVENOUS THERAPY		0	0	0. 000000	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY		0	0	0.000000	43.00
44.00	04400 PHYSI CAL THERAPY		326, 714	183, 584	1. 779643	44.00
45.00	04500 OCCUPATI ONAL THERAPY		229, 689	194, 907	1. 178454	45. 00
46.00	04600 SPEECH PATHOLOGY		10, 909	9, 257	1, 178460	46. 00
47.00	04700 ELECTROCARDI OLOGY		. 0	. 0	0. 000000	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0.000000	
49. 00	04900 DRUGS CHARGED TO PATIENTS		73, 461	62, 337	1. 178449	
51. 00	05100 SUPPORT SURFACES		70,101	02,007	0. 000000	51. 00
01.00	OUTPATIENT SERVICE COST CENTERS				0.000000	01.00
71. 00	07100 AMBULANCE		9, 257	0	0.000000	71. 00
100.00			671, 928		l	100.00
100.00	n local		0/1,920	430, 063	I .	100.00

Health Financial Systems	NEW COMMUI	NITY ECF		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315393	Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		nared.
				10 12/01/2022	4/26/2023 11:	57 am
		Title	XVIII (1)	Skilled Nursing	PPS	
	1			Facility		
		Heal th Care Pr	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C			Í		
	Column 3)					
	1.00	2.00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	I ENT COST					
ANCILLARY SERVICE COST CENTERS					_	
40. 00 04000 RADI OLOGY	0. 000000			0	0	
41. 00 04100 LABORATORY	0. 000000			0	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000					42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY	0. 000000			0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 779643			0 81, 333	l .	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	1. 178454			0 54, 585	1	
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	1. 178460				0	46. 00 47. 00
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000	l .				47.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 000000 1. 178449					
51. 00 05100 SUPPORT SURFACES	0. 000000					
OUTPATIENT SERVICE COST CENTERS	0.000000	<u> </u>		O _I	, ₁	31.00
71. 00 07100 AMBULANCE (2)	0. 000000			0		71. 00
100.00 Total (Sum of lines 40 - 71)	0.000000	92, 021		0 135, 918		100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	I V	72,021		0 133, 910	,	1100.00

⁽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 Fina	ncial Systems	NEW COMMUN	NITY ECF		In Lie	u of Form CMS-2	2540-10
APPORTI ONME	NT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2022 To 12/31/2022		
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		·			1. 00	
PART	II - APPORTIONMENT OF VACCINE COST					1.00	
1. 00 2. 00 3. 00	Drugs charged to patients - ratio of co Program vaccine charges (From your reco Program costs (Line 1 x line 2) (Title E, Part I, line 18)	ords, or the PS	&R)		,	1. 178449 900 1, 061	1. 00 2. 00 3. 00
	Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	(From Wkst. B, Part I, Col.	Allied Health Costs to Tota	I I, Col. 4)	& Allied Health Costs for Pass	
		1.00	2.00	Costs - Part (Col. 2 / Col 1) 3.00		Through (Col. 3 x Col. 4)	
PART	III - CALCULATION OF PASS THROUGH COSTS			0.00	1. 00	0.00	
	LLARY SERVICE COST CENTERS	TON HONOTHO W	7.EE1 E5 11E7.E111				
40.00 04000		6, 342 15, 556		0. 00000 0. 00000	0	0	40. 00 41. 00
	O INTRAVENOUS THERAPY O OXYGEN (INHALATION) THERAPY	0	(0. 00000 0. 00000		0	42. 00 43. 00
44. 00 04400	O PHYSI CAL THERAPY	326, 714	C	0.00000	0 81, 333	0	44. 00
	OCCUPATIONAL THERAPY	229, 689	C	0.00000		0	45. 00
	O SPEECH PATHOLOGY O ELECTROCARDI OLOGY	10, 909	(0. 00000 0. 00000		0	46. 00 47. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ď	0.00000		0	48. 00
	D DRUGS CHARGED TO PATIENTS	73, 461	C	0. 00000	0 0	0	49. 00
	SUPPORT SURFACES	0	c	0.00000		0	51.00
100.00	Total (Sum of lines 40 - 52)	662, 671	()	135, 918	0	100. 00

	Financial Systems NEW COMMUNITY			u of Form CMS-2	2540-10	
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315393	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 4/26/2023 11:	pared:	
		Title XVIII	Skilled Nursing Facility	PPS		
				1. 00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00		
	I NPATI ENT DAYS					
1.00	Inpatient days including private room days			34, 067	1. 00	
2.00	Private room days			0	2. 00	
3.00	Inpatient days including private room days applicable to the Pr	3		505		
4.00	Medically necessary private room days applicable to the Program	1		0	4.00	
5. 00	Total general inpatient routine service cost			9, 778, 313	5. 00	
6. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			9, 044, 957	6.00	
7. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		1. 081079		
8. 00	Enter private room charges from your records	vided by Title 0)		0.001077	8.00	
9. 00	Average private room per diem charge (Private room charges line	8 divided by private	room days. Line	0.00		
	2)					
10. 00	00 Enter semi-private room charges from your records					
11. 00						
	semi -pri vate room days)				12.00	
12.00	,					
13. 00 14. 00						
	Private room cost differential adjustment (Line 2 times line 13 General inpatient routine service cost net of private room cost		minus Lino 14)	0 9, 778, 313	14. 00 15. 00	
13.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Eine 5	III Tius TTTIE 14)	7, 770, 313	15.00	
16. 00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		287. 03	16.00	
17. 00	Program routine service cost (Line 3 times line 16)	,		144, 950		
18. 00	Medically necessary private room cost applicable to program (I	ine 4 times line 13)		0	18.00	
19. 00	Total program general inpatient routine service cost (Line 17	. ,		144, 950		
20. 00	Capital related cost allocated to inpatient routine service cos	ts (From Wkst. B, Par	t II column 18,	871, 991	20.00	
21 00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			25 (0	21 00	
21. 00 22. 00	Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21)			25. 60 12. 928		
23. 00	Inpatient routine service cost (Line 3 times line 21)			132, 022		
24. 00	Aggregate charges to beneficiaries for excess costs (From prov	ider records)		132, 022	•	
25. 00						
26. 00	Enter the per diem limitation (1)	(2 20		132, 022	25. 00 26. 00	
27. 00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27. 00	
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)				28. 00	
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be use	ed for title V and or t	itle XIX	'	•	
				1. 00		

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	34, 067	1. 00
2.00	Program inpatient days (see instructions)	505	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. 014824	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	NEW COMMUNITY	ECF	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FO	OR TITLE XVIII	Provi der No.: 315393	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 4/26/2023 11:57 am
		Title XVIII	Skilled Nursing	

		In the Aviii	Facility	PP3	
			1 4 5 1 1 1 1		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)			282, 579	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)			282, 579	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			73, 716	5. 00
6.00	Allowable bad debts (From your records)			72, 841	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		46, 389	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			47, 347	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)			256, 210	11. 00
12.00	Interim payments (See instructions)			229, 077	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			596	14. 75
14. 99	Sequestration amount (see instructions)			3, 451	14. 99
15.00	Balance due provider/program (see Instructions)			23, 086	15. 00
16.00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2, s	section 115.2)	0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - T	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			1, 061	18. 00
19.00	Total reasonable costs (Sum of lines 17 and 18)			1, 061	
20.00	Medicare Part B ancillary charges (See instructions)			900	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			900	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 instru	ctions)		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)			900	
26. 00	Interim payments (See instructions)			882	
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. 99	Sequestration amount (see instructions)			11	
29. 00	Balance due provider/program (see instructions)			7	29. 00
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2, s	section 115.2	0	30. 00

From 01/01/2022 To 12/31/2022

Date/Time Prepared: 4/26/2023 11:57 am

Title XVIII Skilled Nursing

PPS

				Facility		
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		257, 446		882	1. 00
2.00	Interim payments payable on individual bills, either		0		o	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program				_	
3.50	ADJUSTMENTS TO PROGRAM	06/15/2022	28, 369		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-28, 369		0	3. 99
4. 00	- 3.98)		220 077		882	4. 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line		229, 077		882	4.00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					,
6. 00	Determined net settlement amount (balance due) based on					6. 00
/ O1	the cost report. (1) PROGRAM TO PROVIDER		22.007		_	6. 01
6. 01			23, 086 0		7	
6. 02	PROVIDER TO PROGRAM		252, 163		0 889	6. 02
7. 00	Total Medicare program liability (see instructions)		Contract	or Name	Contractor	7. 00
			COILLIACT	.OI Name	Number	
			1. (00	2. 00	
8, 00	Name of Contractor		1.		2.00	8. 00
	Thams of contractor				·	0.00

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

Health Financial Systems NEW COMMUNITY ECF In Lieu of Form CMS-2540-10

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

4/26/2023 11:57 am Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 Assets CURRENT ASSETS 1.00 1.00 Cash on hand and in banks 384, 207 0 0 2.00 Temporary investments 0 0 2.00 0 3 00 3 00 Notes receivable 0 o 4.00 Accounts receivable 1, 881, 409 0 0 4.00 ol 5.00 Other receivables 5.00 6.00 Less: allowances for uncollectible notes and accounts -946, 044 0 0 0 6.00 recei vabl e 7 00 Inventory 8, 429 0 0 0 7 00 0 8.00 Prepaid expenses 58.480 0 0 8.00 9.00 0 9.00 Other current assets 0 Due from other funds 0 10.00 10.00 Λ 11.00 TOTAL CURRENT ASSETS (Sum of lines 1 - 10) 1, 386, 481 0 0 11.00 FIXED ASSETS 0 0 0 12.00 12.00 Land 0 0 13.00 Land improvements C 0 13.00 14.00 Less: Accumulated depreciation 0 0 14.00 0 15.00 Bui I di ngs 470, 860 0 0 0 0 0 0 0 0 0 0 0 15.00 0 16 00 Less Accumulated depreciation -457 570 0 16 00 0 17.00 Leasehold improvements 0 17.00 Less: Accumulated Amortization 0 0 18.00 18.00 C 19.00 Fi xed equipment 0 19.00 0 0 0 Less: Accumulated depreciation 20.00 C 0 20 00 21.00 Automobiles and trucks C 0 0 21.00 22.00 Less: Accumulated depreciation 0 22.00 Major movable equipment 1 343 328 0 23 00 23 00 0 0 24.00 Less: Accumulated depreciation -1, 207, 576 0 24.00 Mi nor equi pment - Depreci abl e 0 25.00 0 0 Mi nor equi pment nondepreciable 0 0 26.00 26.00 Other fixed assets 0 0 27 00 27 00 0 28.00 TOTAL FIXED ASSETS (Sum of lines 12 - 27) 149,042 0 28.00 OTHER ASSETS 29.00 Investments 0 0 0 29.00 0 0 0 30.00 Deposits on Leases 30.00 31.00 Due from owners/officers 1, 051, 835 0 0 0 31.00 0 32.00 Other assets 2, 703, 626 0 32.00 TOTAL OTHER ASSETS (Sum of lines 29 - 32) 3, 755, 461 0 0 0 33.00 33.00 TOTAL ASSETS (Sum of lines 11, 28, and 33) 0 34.00 5, 290, 984 0 0 34.00 Liabilities and Fund Balances CURRENT LIABILITIES 1, 033, 722 0 0 35.00 35.00 Accounts payable 0 36.00 Salaries, wages, and fees payable 799, 483 0 36.00 37.00 Payroll taxes payable 21, 534 0 0 37.00 38. 00 Notes & Loans payable (Short term) 0 0 38.00 0 39.00 Deferred income C 0 0 39.00 40.00 Accelerated payments C 40.00 41.00 Due to other funds 41.00 o 9, 251, 257 0 42.00 42.00 Other current liabilities 0 TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) 43.00 11, 105, 996 0 0 0 43.00 LONG TERM LIABILITIES 44.00 0 0 0 44.00 Mortgage payable 0 45.00 Notes payable C 0 0 45.00 46.00 Unsecured Loans C 0 0 46.00 47.00 Loans from owners: 0 0 47.00 0 Other long term liabilities 0 48.00 48.00 0 OTHER (SPECIFY) 0 49 00 C Λ 49 00 50.00 TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 0 0 0 50.00 TOTAL LIABILITIES (Sum of lines 43 and 50) 51.00 11, 105, 996 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance -5, 815, 012 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55 00 0 55 00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant 0 57.00 Plant fund balance - reserve for plant improvement, 58.00 0 58.00 replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) 59 00 -5, 815, 012 0 0 0 59 00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 5, 290, 984 0 0 0 60.00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2540-10 NEW COMMUNITY ECF Provi der No.: 315393

| Peri od: | Worksheet G-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

					10	12/31/2022	4/26/2023 11:	
		Genera	Fund	Speci al	Pur	pose Fund	Endowment Fund	37 diii
				·				
		4.00	0.00	2.00		4.00	F 00	
1 00	Trund halanan at hankankan as anni ad	1.00	2.00	3. 00		4. 00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)		-4, 698, 513 -1, 116, 500			Ü		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)		-1, 116, 500 -5, 815, 013			0		3. 00
4.00	Additions (credit adjustments)		-5, 615, 015			0		4. 00
5.00	ROUNDI NG	1			0		o	5. 00
6.00	NO MET NO	Ö			0		0	6. 00
7. 00		o			Ō		o	7. 00
8.00		O			0		O	8. 00
9.00		o			0		0	9. 00
10.00	Total additions (sum of line 5 - 9)		1			0		10.00
11.00	Subtotal (line 3 plus line 10)		-5, 815, 012			0		11.00
12.00	Deductions (debit adjustments)							12.00
13.00		0			0		0	13.00
14.00		0			0		0	14.00
15. 00		0			0		0	15.00
16. 00		0			0		0	16. 00
17. 00	T	0			0		0	17. 00
18.00	Total deductions (sum of lines 13 - 17)		0			0		18.00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-5, 815, 012			0		19. 00
	Silect (Little 11 - 111le 10)	Endowment Fund	PI ant	Fund				
		6. 00	7.00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments)							4.00
5.00	ROUNDI NG		0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8.00			0					7. 00 8. 00
9. 00			0					9. 00
10. 00	Total additions (sum of line 5 - 9)		O		0			10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	Deductions (debit adjustments)							12. 00
13. 00			0					13. 00
14.00			0					14.00
15.00			0					15.00
16.00			0					16.00
17. 00			0					17.00
18. 00	Total deductions (sum of lines 13 - 17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (Line 11 - line 18)							

Health Financial Systems	NEW COMMUNITY ECF		In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315393	From 01/01/2022	Worksheet G-2 Parts I-II Date/Time Pre 4/26/2023 11:	pared:
Cost Center Description		Inpati ent	Outpati ent	Total	
		1.00	2. 00	3. 00	

STATEM	ENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	
					4/26/2023 11:	57 am
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1. 00	SKILLED NURSING FACILITY		9, 044, 95	7	9, 044, 957	1. 00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		9, 044, 95	7	9, 044, 957	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		450, 08	5 0	450, 085	6.00
7.00	CLINIC			0	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	CMHC			0	0	11. 00
12.00	HOSPI CE			0 0	0	12.00
13.00	OTHER (SPECIFY)			o o	0	13.00
14.00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	to	9, 495, 04	2 0	9, 495, 042	14.00
	Worksheet G-3, Line 1)					
	Cost Center Description		1			
	•			1. 00	2. 00	
	PART II - OPERATING EXPENSES			<u> </u>		
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				10, 933, 483	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	Ĭ	9. 00
10. 00	bedder (Specify)			0		10. 00
11. 00						11. 00
12. 00						12.00
13. 00						13. 00
	Total Deductions (Sum of lines 9 - 13)				0	
	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				10, 933, 483	
13.00	Trotal operating Expenses (Sam of Times Fand 6, millias Time 14)				10, 733, 403	13.00

Heal th	n Financial Systems NEW COM	MUNITY ECF	In Lie	u of Form CMS-2	2540-10
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315393	Peri od:	Worksheet G-3	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre	
				4/26/2023 11:	o/am
				1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3,	line 14)		9, 495, 042	1. 00
2.00	Less: contractual allowances and discounts on patients a	ccounts		346, 494	2.00
3.00	Net patient revenues (Line 1 minus line 2)			9, 148, 548	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part	II, line 15)		10, 933, 483	4.00
5.00	Net income from service to patients (Line 3 minus 4)			-1, 784, 935	5.00
	Other income:				
6.00	Contributions, donations, bequests, etc			1, 550	6.00
7.00	Income from investments			864	7.00
0 00	D C ' ' ' ' ' T ' ' '				0 00

		4/26/2023 11:	or alli
		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	9, 495, 042	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	346, 494	2. 00
3.00	Net patient revenues (Line 1 minus line 2)	9, 148, 548	
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	10, 933, 483	
5.00	Net income from service to patients (Line 3 minus 4)	-1, 784, 935	5. 00
	Other income:		
6.00	Contributions, donations, bequests, etc	1, 550	
7. 00	Income from investments	864	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		0	10. 00
11. 00	Rebates and refunds of expenses	0	11. 00
12.00		0	12.00
13.00	,	0	13. 00
14.00		0	14. 00
15. 00		0	15. 00
16. 00		0	16. 00
17.00		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		5, 838	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	NON PATIENT REVENUE	168, 649	24. 00
24. 01	MI SC	318, 033	24. 01
24. 50	COVI D-19 PHE Fundi ng	173, 501	24. 50
25.00	Total other income (Sum of lines 6 - 24)	668, 435	25. 00
26.00	Total (Line 5 plus line 25)	-1, 116, 500	26. 00
27.00	Other expenses (specify)	0	27. 00
28.00		0	28. 00
29. 00		0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-1, 116, 500	31.00