

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).	FORM APPROVED OMB NO. 0938-0463 EXPIRES: 12/31/2021
NEW COMMUNITY ECF Provider CCN: 315393	Period: From: 01/01/2024 To: 12/31/2024 Run Date Time: 4/25/2025 10:09 am MCRIF32 Version: 10.23.179.0



**SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

**Worksheet S
 Parts I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report. 3.01. <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.	Date:	Time:
Contractor use only:	4. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____	6. Contractor No.: _____	7. <input type="checkbox"/> First Cost Report for this Provider CCN
		8. <input type="checkbox"/> Last Cost Report for this Provider CCN	9. NPR Date: _____
		10. If line 4, column 1 is "4": Enter number of times reopened <u>0</u>	11. Contractor Vendor Code: <u>4</u>
		12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED 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 {Provider Name(s) and CCN(s)} for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.


	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1	1	2		
1	<i>Elizabeth Mbakaya</i>	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: CFO			3
4	Signature Date: (Dated when report is electronically signed.)			4

PART III - SETTLEMENT SUMMARY

	Cost Center Description	Title V	Title XVIII		Title XIX	
			Part A	Part B		
		1.00	2.00	3.00	4.00	
1.00	SKILLED NURSING FACILITY	0	16,103	0	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	16,103	0	0	100.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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Provider CCN: 315393			

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

Worksheet S-2
Part I
PPS

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street:	266 SOUTH ORANGE AVENUE	P.O. Box:				1.00	
2.00	City:	NEWARK	State:	NJ	ZIP Code:	07103	2.00	
3.00	County:	ESSEX	CBSA Code:	35084	Urban / Rural:	U	3.00	
3.01	CBSA on/after October 1 of the Cost Reporting Period (if applicable)							3.01


SNF and SNF-Based Component Identification:								
Component	Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)				
				V	XVIII	XIX		
		1.00	2.00	3.00	4.00	5.00	6.00	
4.00	SNF	NEW COMMUNITY ECF	315393	12/01/1997	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							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				
14.00	Cost Reporting Period (mm/dd/yyyy)		01/01/2024	12/31/2024				14.00
15.00	Type of Control (See Instructions)		2 - Voluntary Nonprofit, Other		LLC			15.00
							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 section 483.5?		N	16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?		N	17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.		Y	18.00

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.		N	19.01

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.				
20.00	Straight Line		45,186	20.00
21.00	Declining Balance		0	21.00
22.00	Sum of the Year's Digits		0	22.00
23.00	Sum of line 20 through 22		45,186	23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.		0	24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)		N	25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)		N	26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)		N	27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)		N	28.00
		Part A	Part B	Other
		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		N	N	29.00
30.00	Nursing Facility			N	30.00
31.00	ICF/IID				31.00
32.00	SNF-Based HHA		N	N	32.00
33.00	SNF-Based RHC				33.00
34.00	SNF-Based FQHC				34.00
35.00	SNF-Based CMHC			N	35.00
36.00	SNF-Based OLTC				36.00
			Y/N		
			1.00	2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)		Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)		N		38.00

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

Worksheet S-2
Part I
PPS

				Y/N		
				1.00		2.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.					39.00
		Premiums	Paid Losses	Self Insurance		
		1.00	2.00	3.00		
41.00	List malpractice premiums and paid losses:					41.00
		0	0	0		
				Y/N		
				1.00		
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.				N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?				N	43.00
				Provider CCN		
				1.00		
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.					44.00
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.						
45.00	Name:	Contractor Name:	Contractor Number:			45.00
46.00	Street:	P.O. Box:				46.00
47.00	City:	State:	ZIP Code:			47.00

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

Worksheet S-2
Part II
PPS

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

Completed by All Skilled Nursing Facilities

Provider Organization and Operation

		Y/N	Date	
		1.00	2.00	
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00

Financial Data and Reports

4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	

Approved Educational Activities

6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N		8.00
			Y/N	
			1.00	

Bad Debts

9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.		Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		N	11.00

Bed Complement

12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		N	12.00
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	Description	Part A		Part B	
		Y/N	Date	Y/N	Date
	0	1.00	2.00	3.00	4.00

PS&R Data

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.)	Y	04/10/2025	Y	04/10/2025	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 adjustments made to PS&R data for Other? Describe the other adjustments:	N		N		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N		18.00
		1.00	2.00	3.00		

Cost Report Preparer Contact Information

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.	KITTY	BLISSIT	PREPARER	19.00
20.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES			20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	KITTY.BLISSIT@HCRNJ.NET		21.00

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

Worksheet S-3
Part I
PPS

	Component	Number of Beds	Bed Days Available	Inpatient Days/Visits					Discharges					
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
1.00	SKILLED NURSING FACILITY	180	65,880	0	374	29,356	1,781	31,511	0	7	0	137	144	1.00
2.00	NURSING FACILITY	0	0	0	0	0	0	0	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	0	0	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST													4.00
5.00	Other Long Term Care	0	0				0	0				0	0	5.00
6.00	SNF-Based CMHC													6.00
7.00	HOSPICE	0	0	0	0	0	0	0	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	180	65,880	0	374	29,356	1,781	31,511	0	7	0	137	144	8.00

	Component	Average Length of Stay				Admissions					Full Time Equivalent		
		Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers	
		13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00	
1.00	SKILLED NURSING FACILITY	0.00	53.43	0.00	218.83	0	11	0	132	143	95.80	0.00	1.00
2.00	NURSING FACILITY	0.00		0.00	0.00	0		0	0	0	0.00	0.00	2.00
3.00	ICF/IID			0.00	0.00			0	0	0	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST												4.00
5.00	Other Long Term Care				0.00				0	0	0.00	0.00	5.00
6.00	SNF-Based CMHC										0.00	0.00	6.00
7.00	HOSPICE	0.00	0.00	0.00	0.00	0	0	0	0	0	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	0.00	53.43	0.00	218.83	0	11	0	132	143	95.80	0.00	8.00

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SNF WAGE INDEX INFORMATION

Worksheet S-3
Part II
PPS

PART II - DIRECT SALARIES							
		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
SALARIES							
1.00	Total salaries (See Instructions)	4,564,986	0	4,564,986	200,175.00	22.80	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	4,564,986	0	4,564,986	200,175.00	22.80	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST						8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
10.00	HOSPICE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	4,564,986	0	4,564,986	200,175.00	22.80	13.00
OTHER WAGES & RELATED COSTS							
14.00	Contract Labor: Patient Related & Mgmt	928,443	0	928,443	23,344.00	39.77	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs core (See Part IV)	1,151,728	0	1,151,728			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	1,151,728	0	1,151,728			22.00

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SNF WAGE INDEX INFORMATION

Worksheet S-3
Part III
PPS

PART III - OVERHEAD COST - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	361,946	0	361,946	16,368.00	22.11	2.00
3.00	Plant Operation, Maintenance & Repairs	155,583	0	155,583	7,282.00	21.37	3.00
4.00	Laundry & Linen Service	29,358	0	29,358	1,950.00	15.06	4.00
5.00	Housekeeping	248,500	0	248,500	15,994.00	15.54	5.00
6.00	Dietary	409,849	0	409,849	23,130.00	17.72	6.00
7.00	Nursing Administration	390,315	0	390,315	15,233.00	25.62	7.00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Social Service	64,138	0	64,138	3,834.00	16.73	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	145,935	0	145,935	10,323.00	14.14	13.00
14.00	Total (sum lines 1 thru 13)	1,805,624	0	1,805,624	94,114.00	19.19	14.00

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SNF WAGE RELATED COSTS

Worksheet S-3
Part IV
PPS

PART IV - WAGE RELATED COSTS		Amount Reported	
		1.00	
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	99,339	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	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
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)	589,086	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)	1,008	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	Workers' Compensation Insurance	91,115	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	332,415	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	38,765	20.00
OTHER			
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)	1,151,728	24.00
		Amount Reported	
		1.00	
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

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SNF REPORTING OF DIRECT CARE EXPENDITURES

Worksheet S-3
Part V
PPS

	OCCUPATIONAL CATEGORY	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	693,511	174,970	868,481	20,832.00	41.69	1.00
2.00	Licensed Practical Nurses (LPNs)	885,303	223,358	1,108,661	25,645.00	43.23	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,180,549	297,848	1,478,397	59,584.00	24.81	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,759,363	696,176	3,455,539	106,061.00	32.58	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	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)	529		529	10.00	52.90	14.00
15.00	Licensed Practical Nurses (LPNs)	197,755		197,755	4,395.00	45.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	362,251		362,251	12,070.00	30.01	16.00
17.00	Total Nursing (sum of lines 14 through 16)	560,535		560,535	16,475.00	34.02	17.00
18.00	Physical Therapists	109,200		109,200	1,560.00	70.00	18.00
19.00	Physical Therapy Assistants	62,275		62,275	1,325.00	47.00	19.00
20.00	Physical Therapy Aides	8,704		8,704	512.00	17.00	20.00
21.00	Occupational Therapists	106,400		106,400	1,520.00	70.00	21.00
22.00	Occupational Therapy Assistants	57,575		57,575	1,225.00	47.00	22.00
23.00	Occupational Therapy Aides	8,704		8,704	512.00	17.00	23.00
24.00	Speech Therapists	15,050		15,050	215.00	70.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Worksheet S-7

PPS

	Group	Days	
	1.00	2.00	
1.00	RUX		1.00
2.00	RUL		2.00
3.00	RVX		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	RUC		10.00
11.00	RUB		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	RHA		18.00
19.00	RMC		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	ES2		25.00
26.00	ES1		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	HC1		32.00
33.00	HB2		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	LC2		39.00
40.00	LC1		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	CD1		46.00
47.00	CC2		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	SE3		53.00
54.00	SE2		54.00
55.00	SE1		55.00
56.00	SSC		56.00
57.00	SSB		57.00

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Worksheet S-7

PPS

	Group	Days		
	1.00	2.00		
58.00	SSA		58.00	
59.00	IB2		59.00	
60.00	IB1		60.00	
61.00	IA2		61.00	
62.00	IA1		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	PE1		68.00	
69.00	PD2		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	
76.00	PA1		76.00	
99.00	AAA		99.00	
100.00			100.00	
		Expenses	Percentage	Y/N
		1.00	2.00	3.00

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)

101.00	Staffing				101.00
102.00	Recruitment				102.00
103.00	Retention of employees				103.00
104.00	Training				104.00
105.00	OTHER (SPECIFY)				105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)				106.00

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A

PPS

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1,062,452	1,062,452	0	1,062,452	-554,877	507,575	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,154,997	1,154,997	0	1,154,997	0	1,154,997	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	361,946	1,110,712	1,472,658	0	1,472,658	-11,094	1,461,564	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	155,583	799,523	955,106	0	955,106	215,374	1,170,480	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	29,358	53,529	82,887	0	82,887	0	82,887	6.00
7.00	00700	HOUSEKEEPING	248,500	43,793	292,293	0	292,293	0	292,293	7.00
8.00	00800	DIETARY	409,849	520,209	930,058	0	930,058	-9,523	920,535	8.00
9.00	00900	NURSING ADMINISTRATION	390,315	0	390,315	0	390,315	0	390,315	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	64,138	0	64,138	0	64,138	0	64,138	13.00
15.00	01500	PATIENT ACTIVITIES	145,935	23,958	169,893	0	169,893	0	169,893	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	SKILLED NURSING FACILITY	2,759,362	786,033	3,545,395	0	3,545,395	0	3,545,395	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	04000	RADIOLOGY	0	3,520	3,520	0	3,520	0	3,520	40.00
41.00	04100	LABORATORY	0	19,945	19,945	0	19,945	0	19,945	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	378,254	378,254	-187,729	190,525	0	190,525	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	172,679	172,679	0	172,679	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	15,050	15,050	0	15,050	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	92,432	92,432	0	92,432	0	92,432	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	07100	AMBULANCE	0	5,527	5,527	0	5,527	0	5,527	71.00
73.00	07300	CMHC	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE		0	0	0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	4,564,986	6,054,884	10,619,870	0	10,619,870	-360,120	10,259,750	89.00
NONREIMBURSABLE COST CENTERS										
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	0	0	94.00
95.00	09500	BLANK	0	0	0	0	0	0	0	95.00
95.10	09510	MEDICAL DAY CARE	0	0	0	0	0	0	0	95.10
100.00		TOTAL	4,564,986	6,054,884	10,619,870	0	10,619,870	-360,120	10,259,750	100.00

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RECLASSIFICATIONS

Worksheet A-6

PPS

Increases					Decreases				
Cost Center	Line #	Salary	Non Salary		Cost Center	Line #	Salary	Non Salary	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - ALLOCATE PPS THERAPY BASED ON CHARG									
1.00	OCCUPATIONAL THERAPY	45.00	0	172,679	PHYSICAL THERAPY	44.00	0	172,679	1.00
2.00	SPEECH PATHOLOGY	46.00	0	15,050	PHYSICAL THERAPY	44.00	0	15,050	2.00
100.00	TOTAL RECLASSIFICATIONS (Sum of columns 4 and 5 must equal sum of columns 8 and 9 (2))		0	187,729			0	187,729	100.00

- (1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
- (2) Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COSTS CENTERS

Worksheet A-7

PPS

		Acquisitions							
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES									
1.00	Land	0	0	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	470,860	0	0	0	0	470,860	0	3.00
4.00	Building Improvements	0	0	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	0	0	5.00
6.00	Movable Equipment	1,367,410	63,150	0	63,150	0	1,430,560	0	6.00
7.00	Subtotal (sum of lines 1-6)	1,838,270	63,150	0	63,150	0	1,901,420	0	7.00
8.00	Reconciling Items	0	0	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	1,838,270	63,150	0	63,150	0	1,901,420	0	9.00

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ADJUSTMENTS TO EXPENSES

Worksheet A-8

PPS

	Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
				Cost Center	Line No.
				1.00	2.00
1.00	Investment income on restricted funds (chapter 2)	B	-1,730	CAP REL COSTS - BLDGS & FIXTURES	1.00 1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00 3.00
4.00	Rental of provider space by suppliers (chapter 8)		0		0.00 4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00 5.00
6.00	Television and radio service (chapter 21)		0		0.00 6.00
7.00	Parking lot (chapter 21)	B	-83,400	CAP REL COSTS - BLDGS & FIXTURES	1.00 7.00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0		8.00
9.00	Home office cost (chapter 21)		0		0.00 9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 10.00
11.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00 11.00
12.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-102,079		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Revenue - Employee meals		0		0.00 14.00
15.00	Cost of meals - Guests		0		0.00 15.00
16.00	Sale of medical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts		0		0.00 18.00
19.00	Vending machines		0		0.00 19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 21.00
22.00	Utilization review--physicians' compensation (chapter 21)		0	UTILIZATION REVIEW - SNF	82.00 22.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00 23.00
24.00	Depreciation--movable equipment		0	*** Cost Center Deleted ***	2.00 24.00
25.00	BAD DEBT EXPENSE	A	-150,375	ADMINISTRATIVE & GENERAL	4.00 25.00
25.01	RETAIL SALES	B	-9,523	DIETARY	8.00 25.01
25.02	OTHER INCOME - AP WRITE OFF	B	-7,441	ADMINISTRATIVE & GENERAL	4.00 25.02
25.03	SPECIAL EVENTS	A	-5,572	ADMINISTRATIVE & GENERAL	4.00 25.03
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-360,120		100.00

(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.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Worksheet A-8-1
Parts I & II
PPS

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

Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
1.00	8.00	DIETARY	409,852	409,852	0	1.00
2.00	4.00	ADMINISTRATIVE & GENERAL	150,000	150,000	0	2.00
3.00	3.00	EMPLOYEE BENEFITS	91,115	91,115	0	3.00
4.00	5.00	PLANT OPERATION, MAINT. & REPAIRS	373,210	373,210	0	4.00
5.00	4.00	ADMINISTRATIVE & GENERAL	9,889	9,889	0	5.00
6.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	0	996,917	-996,917	6.00
7.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	341,371	0	341,371	7.00
8.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	136,722	0	136,722	8.00
9.00	5.00	PLANT OPERATION, MAINT. & REPAIRS	174,749	0	174,749	9.00
9.01	5.00	PLANT OPERATION, MAINT. & REPAIRS	40,625	0	40,625	9.01
9.02	1.00	CAP REL COSTS - BLDGS & FIXTURES	49,077	0	49,077	9.02
9.03	4.00	ADMINISTRATIVE & GENERAL	18,611	0	18,611	9.03
9.04	4.00	ADMINISTRATIVE & GENERAL	133,683	0	133,683	9.04
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 10 to Worksheet A-8, column 3, line 12.		1,928,904	2,030,983	-102,079	10.00

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 II of this worksheet.

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

Line No.	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
1.00	B	NEW COMMUNITY	0.00	EXTENDED CARE FOOD SERVICES	0.00	FOOD SERVICE	1.00
2.00	B	NEW COMMUNITY	0.00	NEW COMMUNITY URC	0.00	REALTY	2.00
3.00			0.00		0.00		3.00
4.00			0.00		0.00		4.00
5.00			0.00		0.00		5.00
6.00			0.00		0.00		6.00
7.00			0.00		0.00		7.00
8.00			0.00		0.00		8.00
9.00			0.00		0.00		9.00
10.00			0.00		0.00		10.00

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

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

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FIXTURES	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		0	1.00	3.00	3A	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	507,575	507,575							1.00
3.00	EMPLOYEE BENEFITS	1,154,997	0	1,154,997						3.00
4.00	ADMINISTRATIVE & GENERAL	1,461,564	76,977	91,577	1,630,118	1,630,118				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	1,170,480	23,000	39,364	1,232,844	232,882	1,465,726			5.00
6.00	LAUNDRY & LINEN SERVICE	82,887	7,001	7,428	97,316	18,383	25,174	140,873		6.00
7.00	HOUSEKEEPING	292,293	9,348	62,873	364,514	68,856	33,616	0	466,986	7.00
8.00	DIETARY	920,535	45,772	103,697	1,070,004	202,122	164,597	0	54,633	8.00
9.00	NURSING ADMINISTRATION	390,315	0	98,754	489,069	92,384	0	0	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	0	0	12.00
13.00	SOCIAL SERVICE	64,138	0	16,228	80,366	15,181	0	0	0	13.00
15.00	PATIENT ACTIVITIES	169,893	0	36,923	206,816	39,067	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	3,545,395	324,246	698,153	4,567,794	862,844	1,165,993	140,873	387,013	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	3,520	0	0	3,520	665	0	0	0	40.00
41.00	LABORATORY	19,945	0	0	19,945	3,768	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	190,525	20,081	0	210,606	39,783	72,212	0	23,968	44.00
45.00	OCCUPATIONAL THERAPY	172,679	0	0	172,679	32,619	0	0	0	45.00
46.00	SPEECH PATHOLOGY	15,050	0	0	15,050	2,843	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	92,432	0	0	92,432	17,460	0	0	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	5,527	0	0	5,527	1,044	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	10,259,750	506,425	1,154,997	10,258,600	1,629,901	1,461,592	140,873	466,614	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	1,150	0	1,150	217	4,134	0	1,372	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	BLANK	0	0	0	0	0	0	0	0	95.00
95.10	MEDICAL DAY CARE	0	0	0	0	0	0	0	0	95.10
98.00	Cross Foot Adjustments	0	0	0	0	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	10,259,750	507,575	1,154,997	10,259,750	1,630,118	1,465,726	140,873	466,986	100.00

NEW COMMUNITY ECF	Period:	Run Date Time:	4/25/2025 10:09 am
Provider CCN: 315393	From: 01/01/2024	MCRIF32	2540-10
	To: 12/31/2024	Version:	10.23.179.0



COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	Post Stepdown Adjustments	
		8.00	9.00	10.00	12.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING									7.00
8.00	DIETARY	1,491,356								8.00
9.00	NURSING ADMINISTRATION	0	581,453							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0						10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0					12.00
13.00	SOCIAL SERVICE	0	0	0	0	95,547				13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	245,883			15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	1,491,356	581,453	0	0	95,547	245,883	9,538,756	0	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	0	0	4,185	0	40.00
41.00	LABORATORY	0	0	0	0	0	0	23,713	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	0	346,569	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	205,298	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	17,893	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	109,892	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	0	0	6,571	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	1,491,356	581,453	0	0	95,547	245,883	10,252,877	0	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	6,873	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	BLANK	0	0	0	0	0	0	0	0	95.00
95.10	MEDICAL DAY CARE	0	0	0	0	0	0	0	0	95.10
98.00	Cross Foot Adjustments	0	0	0	0	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	1,491,356	581,453	0	0	95,547	245,883	10,252,750	0	100.00

NEW COMMUNITY ECF	Period:	Run Date Time:	4/25/2025 10:09 am
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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

Cost Center Description	Total	
	18.00	
GENERAL SERVICE COST CENTERS		
1.00 CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00 EMPLOYEE BENEFITS		3.00
4.00 ADMINISTRATIVE & GENERAL		4.00
5.00 PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00 LAUNDRY & LINEN SERVICE		6.00
7.00 HOUSEKEEPING		7.00
8.00 DIETARY		8.00
9.00 NURSING ADMINISTRATION		9.00
10.00 CENTRAL SERVICES & SUPPLY		10.00
12.00 MEDICAL RECORDS & LIBRARY		12.00
13.00 SOCIAL SERVICE		13.00
15.00 PATIENT ACTIVITIES		15.00
INPATIENT ROUTINE SERVICE COST CENTERS		
30.00 SKILLED NURSING FACILITY	9,538,756	30.00
31.00 NURSING FACILITY	0	31.00
32.00 ICF/IID	0	32.00
33.00 OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS		
40.00 RADIOLOGY	4,185	40.00
41.00 LABORATORY	23,713	41.00
42.00 INTRAVENOUS THERAPY	0	42.00
43.00 OXYGEN (INHALATION) THERAPY	0	43.00
44.00 PHYSICAL THERAPY	346,569	44.00
45.00 OCCUPATIONAL THERAPY	205,298	45.00
46.00 SPEECH PATHOLOGY	17,893	46.00
47.00 ELECTROCARDIOLOGY	0	47.00
48.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00 DRUGS CHARGED TO PATIENTS	109,892	49.00
51.00 SUPPORT SURFACES	0	51.00
OTHER REIMBURSABLE COST CENTERS		
71.00 AMBULANCE	6,571	71.00
73.00 CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS		
80.00 MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00 INTEREST EXPENSE		81.00
82.00 UTILIZATION REVIEW - SNF		82.00
83.00 HOSPICE	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	10,252,877	89.00
NONREIMBURSABLE COST CENTERS		
90.00 GIFT, FLOWER, COFFEE SHOPS & CANTEN	0	90.00
91.00 BARBER AND BEAUTY SHOP	6,873	91.00
92.00 PHYSICIANS PRIVATE OFFICES	0	92.00
93.00 NONPAID WORKERS	0	93.00
94.00 PATIENTS LAUNDRY	0	94.00
95.00 BLANK	0	95.00
95.10 MEDICAL DAY CARE	0	95.10
98.00 Cross Foot Adjustments	0	98.00
99.00 Negative Cost Centers	0	99.00
100.00 TOTAL	10,259,750	100.00

NEW COMMUNITY ECF	Period:	Run Date Time:	4/25/2025 10:09 am
Provider CCN: 315393	From: 01/01/2024	MCRIF32	2540-10
	To: 12/31/2024	Version:	10.23.179.0



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		0	1.00	2A	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
3.00	EMPLOYEE BENEFITS	0	0	0	0					3.00
4.00	ADMINISTRATIVE & GENERAL	0	76,977	76,977	0	76,977				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	0	23,000	23,000	0	10,997	33,997			5.00
6.00	LAUNDRY & LINEN SERVICE	0	7,001	7,001	0	868	584	8,453		6.00
7.00	HOUSEKEEPING	0	9,348	9,348	0	3,251	780	0	13,379	7.00
8.00	DIETARY	0	45,772	45,772	0	9,544	3,818	0	1,565	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	4,362	0	0	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	0	0	12.00
13.00	SOCIAL SERVICE	0	0	0	0	717	0	0	0	13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	1,845	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	0	324,246	324,246	0	40,748	27,044	8,453	11,088	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	31	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	178	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	20,081	20,081	0	1,879	1,675	0	687	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	1,540	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	134	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	824	0	0	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	49	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	506,425	506,425	0	76,967	33,901	8,453	13,340	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	1,150	1,150	0	10	96	0	39	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	BLANK	0	0	0	0	0	0	0	0	95.00
95.10	MEDICAL DAY CARE	0	0	0	0	0	0	0	0	95.10
98.00	Cross Foot Adjustments								0	98.00
99.00	Negative Cost Centers		0	0	0	0	0	0	0	99.00
100.00	TOTAL	0	507,575	507,575	0	76,977	33,997	8,453	13,379	100.00

NEW COMMUNITY ECF	Period:	Run Date Time:	4/25/2025 10:09 am
Provider CCN: 315393	From: 01/01/2024	MCRIF32	2540-10
	To: 12/31/2024	Version:	10.23.179.0



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	Post Step-Down Adjustments	
		8.00	9.00	10.00	12.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING									7.00
8.00	DIETARY	60,699								8.00
9.00	NURSING ADMINISTRATION	0	4,362							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0						10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0					12.00
13.00	SOCIAL SERVICE	0	0	0	0	717				13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	1,845			15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	60,699	4,362	0	0	717	1,845	479,202	0	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	0	0	31	0	40.00
41.00	LABORATORY	0	0	0	0	0	0	178	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	0	24,322	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	1,540	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	134	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	824	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	0	0	49	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	60,699	4,362	0	0	717	1,845	506,280	0	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	1,295	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	BLANK	0	0	0	0	0	0	0	0	95.00
95.10	MEDICAL DAY CARE	0	0	0	0	0	0	0	0	95.10
98.00	Cross Foot Adjustments	0	0	0	0	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	60,699	4,362	0	0	717	1,845	507,575	0	100.00

NEW COMMUNITY ECF	Period:	Run Date Time:	4/25/2025 10:09 am
Provider CCN: 315393	From: 01/01/2024	MCRIF32	2540-10
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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	EMPLOYEE BENEFITS		3.00
4.00	ADMINISTRATIVE & GENERAL		4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	LAUNDRY & LINEN SERVICE		6.00
7.00	HOUSEKEEPING		7.00
8.00	DIETARY		8.00
9.00	NURSING ADMINISTRATION		9.00
10.00	CENTRAL SERVICES & SUPPLY		10.00
12.00	MEDICAL RECORDS & LIBRARY		12.00
13.00	SOCIAL SERVICE		13.00
15.00	PATIENT ACTIVITIES		15.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	SKILLED NURSING FACILITY	479,202	30.00
31.00	NURSING FACILITY	0	31.00
32.00	ICF/IID	0	32.00
33.00	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	RADIOLOGY	31	40.00
41.00	LABORATORY	178	41.00
42.00	INTRAVENOUS THERAPY	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	PHYSICAL THERAPY	24,322	44.00
45.00	OCCUPATIONAL THERAPY	1,540	45.00
46.00	SPEECH PATHOLOGY	134	46.00
47.00	ELECTROCARDIOLOGY	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	824	49.00
51.00	SUPPORT SURFACES	0	51.00
OTHER REIMBURSABLE COST CENTERS			
71.00	AMBULANCE	49	71.00
73.00	CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS			
80.00	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	INTEREST EXPENSE		81.00
82.00	UTILIZATION REVIEW - SNF		82.00
83.00	HOSPICE	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	506,280	89.00
NONREIMBURSABLE COST CENTERS			
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEN	0	90.00
91.00	BARBER AND BEAUTY SHOP	1,295	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	NONPAID WORKERS	0	93.00
94.00	PATIENTS LAUNDRY	0	94.00
95.00	BLANK	0	95.00
95.10	MEDICAL DAY CARE	0	95.10
98.00	Cross Foot Adjustments	0	98.00
99.00	Negative Cost Centers	0	99.00
100.00	TOTAL	507,575	100.00

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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	BLDGS & FIXTURES (SQ. FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQ. FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQ. FEET)	DIETARY (MEALS SERVED)	
		1.00	3.00	4A	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	84,322								1.00
3.00	EMPLOYEE BENEFITS	0	4,564,986							3.00
4.00	ADMINISTRATIVE & GENERAL	12,788	361,946	-1,630,118	8,629,632					4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	3,821	155,583	0	1,232,844	67,713				5.00
6.00	LAUNDRY & LINEN SERVICE	1,163	29,358	0	97,316	1,163	31,511			6.00
7.00	HOUSEKEEPING	1,553	248,500	0	364,514	1,553	0	64,997		7.00
8.00	DIETARY	7,604	409,849	0	1,070,004	7,604	0	7,604	94,533	8.00
9.00	NURSING ADMINISTRATION	0	390,315	0	489,069	0	0	0	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	0	0	12.00
13.00	SOCIAL SERVICE	0	64,138	0	80,366	0	0	0	0	13.00
15.00	PATIENT ACTIVITIES	0	145,935	0	206,816	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	53,866	2,759,362	0	4,567,794	53,866	31,511	53,866	94,533	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	3,520	0	0	0	0	40.00
41.00	LABORATORY	0	0	0	19,945	0	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	3,336	0	0	210,606	3,336	0	3,336	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	172,679	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	15,050	0	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	92,432	0	0	0	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	5,527	0	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	84,131	4,564,986	-1,630,118	8,628,482	67,522	31,511	64,806	94,533	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	191	0	0	1,150	191	0	191	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	BLANK	0	0	0	0	0	0	0	0	95.00
95.10	MEDICAL DAY CARE	0	0	0	0	0	0	0	0	95.10
98.00	Cross Foot Adjustments									98.00
99.00	Negative Cost Centers									99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	507,575	1,154,997		1,630,118	1,465,726	140,873	466,986	1,491,356	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	6.019485	0.253012		0.188898	21.646154	4.470598	7.184732	15.776036	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		76,977	33,997	8,453	13,379	60,699	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.008920	0.502075	0.268256	0.205840	0.642093	105.00


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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	PATIENT ACTIVITIES (PATIENT DAYS)	
		9.00	10.00	12.00	13.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	EMPLOYEE BENEFITS						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	122,536					9.00
10.00	CENTRAL SERVICES & SUPPLY	0	264,490				10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	31,511			12.00
13.00	SOCIAL SERVICE	0	0	0	31,511		13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	31,511	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	SKILLED NURSING FACILITY	122,536	172,058	31,511	31,511	31,511	30.00
31.00	NURSING FACILITY	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	0	0	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	92,432	0	0	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS							
71.00	AMBULANCE	0	0	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	INTEREST EXPENSE						81.00
82.00	UTILIZATION REVIEW - SNF						82.00
83.00	HOSPICE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	122,536	264,490	31,511	31,511	31,511	89.00
NONREIMBURSABLE COST CENTERS							
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	BLANK	0	0	0	0	0	95.00
95.10	MEDICAL DAY CARE	0	0	0	0	0	95.10
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	581,453	0	0	95,547	245,883	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	4.745161	0.000000	0.000000	3.032179	7.803085	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	4,362	0	0	717	1,845	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.035598	0.000000	0.000000	0.022754	0.058551	105.00


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RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Worksheet C

PPS

	Cost Center Description	Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	RADIOLOGY	4,185	0	0.000000	40.00
41.00	LABORATORY	23,713	0	0.000000	41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	PHYSICAL THERAPY	346,569	54,567	6.351256	44.00
45.00	OCCUPATIONAL THERAPY	205,298	64,418	3.186966	45.00
46.00	SPEECH PATHOLOGY	17,893	3,171	5.642699	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	48.00
49.00	DRUGS CHARGED TO PATIENTS	109,892	92,432	1.188896	49.00
51.00	SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
71.00	AMBULANCE	6,571	0	0.000000	71.00
100.00	Total	714,121	214,588		100.00

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APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS


Worksheet D
Part I
PPS

Title XVIII Skilled Nursing Facility

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost		
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	0.000000	0	0	0	0	40.00
41.00	LABORATORY	0.000000	0	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	6.351256	30,450	0	193,396	0	44.00
45.00	OCCUPATIONAL THERAPY	3.186966	30,448	0	97,037	0	45.00
46.00	SPEECH PATHOLOGY	5.642699	2,554	0	14,411	0	46.00
47.00	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	1.188896	0	0	0	0	49.00
51.00	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
71.00	AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		63,452	0	304,844	0	100.00

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

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APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS


Worksheet D
Parts II-III
PPS

Title XVIII Skilled Nursing Facility

PART II - APPORTIONMENT OF VACCINE COST		
		1.00
1.00	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.188896
2.00	Program vaccine charges (From your records, or the PS&R)	898
3.00	Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	1,068

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH						
	Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)
		1.00	2.00	3.00	4.00	5.00

ANCILLARY SERVICE COST CENTERS						
40.00	RADIOLOGY	4,185	0	0.000000	0	0 40.00
41.00	LABORATORY	23,713	0	0.000000	0	0 41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0 42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0 43.00
44.00	PHYSICAL THERAPY	346,569	0	0.000000	193,396	0 44.00
45.00	OCCUPATIONAL THERAPY	205,298	0	0.000000	97,037	0 45.00
46.00	SPEECH PATHOLOGY	17,893	0	0.000000	14,411	0 46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0 47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0 48.00
49.00	DRUGS CHARGED TO PATIENTS	109,892	0	0.000000	0	0 49.00
51.00	SUPPORT SURFACES	0	0	0.000000	0	0 51.00
100.00	Total (Sum of lines 40 - 52)	707,550	0		304,844	0 100.00


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COMPUTATION OF INPATIENT ROUTINE COSTS

Worksheet D-1
Part I
PPS

Title XVIII Skilled Nursing Facility

PART I CALCULATION OF INPATIENT ROUTINE COSTS		1.00	
INPATIENT DAYS			
1.00	Inpatient days including private room days	31,511	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	374	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	9,538,756	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	8,581,930	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	1.111493	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	9,538,756	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	302.71	16.00
17.00	Program routine service cost (Line 3 times line 16)	113,214	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	113,214	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	479,202	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	15.21	21.00
22.00	Program capital related cost (Line 3 times line 21)	5,689	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	107,525	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	107,525	25.00
26.00	Enter the per diem limitation (1)		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 lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
		1.00	
1.00	Total SNF inpatient days	31,511	1.00
2.00	Program inpatient days (see instructions)	374	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)	0.011869	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII

Worksheet E
Part I
PPS


Title XVIII Skilled Nursing Facility

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

		1.00	
1.00	Inpatient PPS amount (See Instructions)	238,047	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)	0	2.00
3.00	Subtotal (Sum of lines 1 and 2)	238,047	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	51,204	5.00
6.00	Allowable bad debts (From your records)	65,372	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	65,372	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	42,492	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)	229,335	11.00
12.00	Interim payments (See instructions)	208,645	12.00
13.00	Tentative 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)	850	14.75
14.99	Sequestration amount (see instructions)	3,737	14.99
15.00	Balance due provider/program (see Instructions)	16,103	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00

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

17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	1,068	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	1,068	19.00
20.00	Medicare Part B ancillary charges (See instructions)	898	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	898	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 instructions)	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)	898	25.00
26.00	Interim payments (See instructions)	880	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	18	28.99
29.00	Balance due provider/program (see instructions)	0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

NEW COMMUNITY ECF	Period: From: 01/01/2024 To: 12/31/2024	Run Date Time: 4/25/2025 10:09 am MCRIF32 Version: 10.23.179.0	
Provider CCN: 315393			


ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Worksheet E-1

Title XVIII Skilled Nursing Facility PPS

	DESCRIPTION	Inpatient Part A		Part 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		183,106		880	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/06/2024	25,539		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		0		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 - 3.98)		25,539		0	3.99
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 26 for Part B)		208,645		880	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		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 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		16,103		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		224,748		880	7.00
Contractor Name		Contractor Number				
1.00		2.00				
8.00						8.00

(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.


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

Worksheet G

PPS

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
Assets					
CURRENT ASSETS					
1.00	Cash on hand and in banks	379,294	0	0	1.00
2.00	Temporary investments	0	0	0	2.00
3.00	Notes receivable	0	0	0	3.00
4.00	Accounts receivable	1,378,653	0	0	4.00
5.00	Other receivables	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-383,000	0	0	6.00
7.00	Inventory	10,628	0	0	7.00
8.00	Prepaid expenses	68,783	0	0	8.00
9.00	Other current assets	0	0	0	9.00
10.00	Due from other funds	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1,454,358	0	0	11.00
FIXED ASSETS					
12.00	Land	0	0	0	12.00
13.00	Land improvements	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	14.00
15.00	Buildings	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	16.00
17.00	Leasehold improvements	470,860	0	0	17.00
18.00	Less: Accumulated Amortization	-464,371	0	0	18.00
19.00	Fixed equipment	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	22.00
23.00	Major movable equipment	1,430,563	0	0	23.00
24.00	Less: Accumulated depreciation	-1,297,672	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	26.00
27.00	Other fixed assets	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	139,380	0	0	28.00
OTHER ASSETS					
29.00	Investments	0	0	0	29.00
30.00	Deposits on leases	0	0	0	30.00
31.00	Due from owners/officers	1,051,835	0	0	31.00
32.00	Other assets	1,115,836	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	2,167,671	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	3,761,409	0	0	34.00
Liabilities and Fund Balances					
CURRENT LIABILITIES					
35.00	Accounts payable	989,641	0	0	35.00
36.00	Salaries, wages, and fees payable	993,939	0	0	36.00
37.00	Payroll taxes payable	27,094	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	38.00
39.00	Deferred income	5	0	0	39.00
40.00	Accelerated payments	0			40.00
41.00	Due to other funds	0	0	0	41.00
42.00	Other current liabilities	10,266,565	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	12,277,244	0	0	43.00
LONG TERM LIABILITIES					
44.00	Mortgage payable	0	0	0	44.00
45.00	Notes payable	0	0	0	45.00
46.00	Unsecured loans	0	0	0	46.00
47.00	Loans from owners:	0	0	0	47.00
48.00	Other long term liabilities	166,099	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	166,099	0	0	50.00

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

Worksheet G

PPS

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	12,443,343	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-8,681,934				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-8,681,934	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	3,761,409	0	0	0	60.00

() = contra amount

NEW COMMUNITY ECF	Period:	Run Date Time:	4/25/2025 10:09 am
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STATEMENT OF CHANGES IN FUND BALANCES

Worksheet G-1

PPS

	General Fund		Special Purpose Fund		Endowment Fund		Plant Fund		
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
1.00	Fund balances at beginning of period	-7,148,338		0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)	-1,533,596							2.00
3.00	Total (sum of line 1 and line 2)	-8,681,934		0		0		0	3.00
4.00	Additions (credit adjustments)								4.00
5.00		0	0		0		0		5.00
6.00		0	0		0		0		6.00
7.00		0	0		0		0		7.00
8.00		0	0		0		0		8.00
9.00		0	0		0		0		9.00
10.00	Total additions (sum of line 5 - 9)	0		0		0		0	10.00
11.00	Subtotal (line 3 plus line 10)	-8,681,934		0		0		0	11.00
12.00	Deductions (debit adjustments)								12.00
13.00		0	0		0		0		13.00
14.00		0	0		0		0		14.00
15.00		0	0		0		0		15.00
16.00		0	0		0		0		16.00
17.00		0	0		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	-8,681,934		0		0		0	19.00


NEW COMMUNITY ECF	Period:	Run Date Time:	4/25/2025 10:09 am
Provider CCN: 315393	From: 01/01/2024	MCRIF32	2540-10
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2
Part I
PPS

PART I - PATIENT REVENUES					
	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	8,581,930		8,581,930	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)	8,581,930		8,581,930	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	214,589	0	214,589	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	HOSPICE	0	0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD	213,864	0	213,864	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	9,010,383	0	9,010,383	14.00
PART II - OPERATING EXPENSES					
			1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			10,619,870	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			10,619,870	15.00

NEW COMMUNITY ECF	Period:	Run Date Time:	4/25/2025 10:09 am	
Provider CCN: 315393	From: 01/01/2024	MCRIF32	2540-10	
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-3

PPS

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	9,010,383	1.00
2.00	Less: contractual allowances and discounts on patients accounts	85,162	2.00
3.00	Net patient revenues (Line 1 minus line 2)	8,925,221	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	10,619,870	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1,694,649	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,730	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	9,523	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	143,449	24.00
24.01	MISC	6,351	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	161,053	25.00
26.00	Total (Line 5 plus line 25)	-1,533,596	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)	-1,533,596	31.00