Health Financia	u of Form CMS-2540-10				
	required by law (42 USC 1395g; 42 CFR 413.) since the beginning of the cost reporting p				FORM APPROVED OMB NO. 0938-0463
					Expires: 12/31/2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315413 Period: W COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY Provider CCN: 315413 Point W From 01/01/2021 P D 12/31/2021 P PART I - COST REPORT STATUS V S S					
PART I - COST F	REPORT STATUS				
Provi der	 [X] Electronically prepared cost rep 	Date: 5/23/20	22 Time: 8:57 am		
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report ent	ter the numbe	r of times the provide	r resubmitted thi	s cost report
	3.01 [] No Medicare Utilization. Enter '	'Y" for yes o	r leave blank for no.		
Contractor	4.[1]Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN	
	Settled without audit	8.[N] Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:	·		
	(4) Reopened	10.[0]1f]	ine 4, column 1 is "4"	: Enter number of	times reopened
	(5) Amended		r Vendor Code		
	5. Date Received:	12.[F] Medi	care Utilization. Ente no utilization.		'L" for low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PEACE CARE AT ST. ANNS (315413) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 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	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1	Janet N	/lerly Liranzo	ř	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	Janet Merly Liranzo			2
3	Signatory Title	ADMI NI STRATOR			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	-34, 310	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	-34, 310	0	0	100. 00

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

	Financial Systems PEAC D NURSING FACILITY AND SKILLED NURSING FACILITY HEAL X INDENTIFICATION DATA	<u>E CARE AT ST.</u> _TH CARE	Provider No		Period: From 01/01/ To 12/31/	/2021	u of Form Workshee Part I Date/Tin 5/23/202	et S-2 ne Prep	pared:
	1.00	2.00		3.00					
. 00	Skilled Nursing Facility and Skilled Nursing Facili Street: 198 OLD BERGEN ROAD PO Box City: JERSEY CITY State:	:	Zip Code:0	7305					1.00 2.00
	5	ode: 35614	Urban/Rura						3. 00 3. 00
		Compoi	nent Name	Provi der CCN	Date Certified		ent Syste 0, or N) XVIII	m (P, XIX	
			1.00	2.00	3.00			6.00	
. 00 . 00 . 00 . 00 . 00 . 00 0. 00	SNF and SNF-Based Component Identification: SNF Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FQHC SNF-Based CMHC SNF-Based OLTC	PEACE CARE	AT ST. ANNS	S 315413	10/15/1997	N	P	0	4.00 5.00 6.00 7.00 8.00 9.00 10.00
2.00	SNF-Based HOSPICE								11.00
3.00	SNF-Based CORF				From:		To:		13.00
					1.00	1	2.00		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (See Enstructions)				01/01/2	021 1	12/31/2		14.00 15.00
						-	Y/N 1.00		
6. 00	Type of Freestanding Skilled Nursing Facility Is this a distinct part skilled nursing facility th section 483.5?	at meets the	requi rement	s set forth	in 42 CFR		N	_	16.00
7.00	Is this a composite distinct part skilled nursing f 42 CFR section 483.5?	acility that	meets the r	equirements	set forth	in	Ν		17.00
	Are there any costs included in Worksheet A that re organizations as defined in CMS Pub. 15–1, chapter Miscellaneous Cost Reporting Information						Y		18.00
9. 01	If this is a low Medicare utilization cost report, If line 19 is yes, does this cost report meet your utilization cost report, indicate with a "Y", for y Depreciation - Enter the amount of depreciation rep	contractor's es, or "N" fo	criteria fo or no.	or filing a l	ow Medicar		N N		19.00 19.01
0. 00 1. 00	Straight Line Declining Balance					LITIES		04, 965 0 0	21.00
	Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance as of	the end of t	the period.				90	0 04, 965 0	•
	Were there any disposal of capital assets during th Was accelerated depreciation claimed on any assets (Y/N)		0.	• •	porting per	i od?	Y N		25.00 26.00
7.00	Did you cease to participate in the Medicare progra applies? (Y/N)	m at end of 1	the period t	o which this	s cost repo	rt	Ν		27.00
8. 00	Was there a substantial decrease in health insuranc reports? (Y/N)	e proportion	of allowabl	e cost from	•		N		28.00
	If this facility contains a public or non-public pr of the lower of the costs or charges enter "Y" for exemption.				ion from th	1.00 ne app	lication	0ther 3.00	
9. 00	Skilled Nursing Facility Nursing Facility ICF/IID					N	N N N	N	29.00 30.00 31.00 32.00 33.00
1.00 2.00 3.00 4.00 5.00	SNF-Based HHA SNF-Based RHC SNF-Based FQHC SNF-Based CMHC						N		34.00 35.00
1.00 2.00 3.00 4.00 5.00	SNF-Based RHC SNF-Based FQHC				Y/N 1.00)	35.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	SNF-Based RHC SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state regardless of the level of care given for Titles V Are you legally-required to carry malpractice insur	& XIX patient ance? (Y/N)	ts? (Y/N)		1.00		N 2.00)	35.00 36.00 37.00 38.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00	SNF-Based RHC SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state regardless of the level of care given for Titles V	& XIX patient ance? (Y/N) policy? If th	ts? (Y/N)		1.00 Y				•

							2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.:	315413	Peri od:	Worksheet S-2	2
COMPLE	X INDENTIFICATION DATA				From 01/01/2021 To 12/31/2021	Part Date/Time Pre	marod
					10 12/31/2021	5/23/2022 8:5	
						1.00	
	Are malpractice premiums and paid losse					N	42.00
	center? Enter Y or N. If yes, check box	and submit supporting s	schedule listin	g cost c	enters and		
	amounts.						
	Are there any home office costs as defi					N	43.00
	If line 43 is yes, enter the home offic	ce chain number and enter	the name and a	ddress 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

MPLI	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Pro	ovider N		Period: From 01/01/2021 To 12/31/2021		epared
					Y/N	5/23/2022 8: Date	<u>57 am</u>
					1.00	2.00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column 1,	"Y" for	Yes or "N"			_
00	Provider Organization and Operation Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.
			_	Y/N 1.00	Date 2.00	V/I 3.00	_
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date 3, "V" for voluntary or "I" for involuntary.			N	2.00	3.00	2.
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 offices, d to the provider or it I, or members of the bo	drug ts pard	Y			3.
				Y/N	Туре	Date	
				1.00	2.00	3.00	_
00	Financial Data and Reports Column 1: Were the financial statements prep Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If Are the cost report total expenses and total	" for Audited, "C" for te copy or enter date no, see instructions. revenues different fro	om	Y	С		4.
	those on the filed financial statements? If reconciliation.	column 1 is "Y", submit 	t		Y/N	Legal Oper.	
					1.00	2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch- legal operator of the program? (Y/N)	ool? (Y/N) Column 2: I	s the pr	rovider the	N	N	6
							_
00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s	ng the cost reporting p	ons.		N N		7. 8.
	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri	ng the cost reporting p	ons.			<u>Y/N</u> 1.00	
00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb	ng the cost reporting p ee instructions. d debts? (Y/N) see inst	ons. beriod fo	or Nursing	N		8
00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived	bns. beriod fo tructions ange duri d? If "Y"	or Nursing s. ng this cos ', see instr	N t reporting uctions.	1.00 Y	9. 10.
00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived	bns. beriod fo tructions ange duri d? If "Y"	or Nursing s. ng this cos ', see instr see instru	N t reporting uctions. ctions.	1.00 Y N N	
00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period?	bns. beriod fo tructions ange duri d? If "Y"	or Nursing s. ng this cos ', see instr see instru Pa	N t reporting uctions. ctions. irt A	1.00 Y N N Part B	8 9 10 11
00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived	bns. beriod fo tructions ange duri d? If "Y"	or Nursing s. ng this cos ', see instr see instru	N t reporting uctions. ctions.	1.00 Y N N	9. 10. 11.
00 00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description	bns. beriod fo tructions ange duri d? If "Y"	or Nursing s. ng this cos ', see instru See instru Pa Y/N 1.00	N t reporting uctions. ctions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00	8. 9. 10. 11. 12.
000000000000000000000000000000000000000	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description	bns. beriod fo tructions ange duri d? If "Y"	or Nursing s. ng this cos ', see instru see instru Pa Y/N	N t reporting uctions. ctions. irt A Date	1.00 Y N N Part B Y/N	8. 9. 10. 11. 12.
0 0 00 00 00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	bns. beriod fo tructions ange duri d? If "Y"	or Nursing s. ng this cos ', see instru See instru Pa Y/N 1.00	N t reporting uctions. ctions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00	8 9. 10. 11. 12. 13.
	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba- If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an- Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	bns. beriod fo tructions ange duri d? If "Y"	or Nursing S. ng this cos Y, see instru Pa Y/N 1.00 Y	N t reporting uctions. ctions. int A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	8. 9. 10. 11.
00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	bns. beriod fo tructions ange duri d? If "Y"	or Nursing S. ng this cos 7, see instru See instru Pa Y/N 1.00 Y	N t reporting uctions. ctions. int A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	8. 9,10. 11. 12. 13. 14.
	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Is the provider seeking reimbursement for ba- If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	bns. beriod fo tructions ange duri d? If "Y"	or Nursing S. ng this cos 7, see instru See instru Pa Y/N 1.00 Y N	N t reporting uctions. ctions. int A Date 2.00	1.00 Y N Part B Y/N 3.00 Y N	8 9 10 11 12 13 13 14 15

Health Financial Systems	PEACE CARE AT	ST. ANNS		In Lieu	u of Form CMS-2	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY	/ HEALTH CARE	Provi der M		Period:	Worksheet S-2	
COMPLEX REIMBURSEMENT QUESTIONNAIRE				rom 01/01/2021 o 12/31/2021	Part II Date/Time Pre	narod
			1	0 12/31/2021	5/23/2022 8:5	
		1. C	0	2. (00	
Cost Report Preparer Contact Information						
19.00 Enter the first name, last name and the title/	position SL	LAVKA		PARTI LOVA		19.00
held by the cost report preparer in columns 1,	2, and 3,					
respecti vel y.						
20.00 Enter the employer/company name of the cost re	port HE	EALTH CARE RES	OURCES			20.00
preparer.						
21.00 Enter the telephone number and email address o		09-987-1440		SLAVKA. PARTI LOV	/A@HCRNJ. NET	21.00
report preparer in columns 1 and 2, respective	ly.					

Heal th	Financial Systems	PEACE CARE AT	ST. ANNS	In Lie	u of Form CMS-:	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der No.: 315413	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/23/2022 8:5	pared:
		Part B Date 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.)	05/04/2022				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.					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.					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.					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:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
			3.00			
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		REPARER			19.00
20.00	Enter the employer/company name of the cost i	report				20.00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

	Financial Systems ED NURSING FACILITY AND SKILLED NURSIN EX STATISTICAL DATA	NG FACILITY HEALTH CARE	T ST. ANNS Provi der	F	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I	pared:
				l np	oatient Days/Vis	sits	
	Component	Number of Beds	Bed Days Avai LabLe	Title V	Title XVIII	Title XIX	
	7	1.00	2.00	3.00	4.00	5.00	
. 00	SKILLED NURSING FACILITY	120	43, 800	(.,		1.0
. 00 . 00	NURSING FACILITY	0	0	()	0	2.0 3.0
. 00	HOME HEALTH AGENCY COST	0	0	(0	0	4.0
. 00	Other Long Term Care	0	0				5.0
. 00	SNF-Based CMHC		_		_		6.0
. 00	HOSPICE	0	0	(0	7.0
. 00	Total (Sum of lines 1-7)	120 Inpatient D	43,800 avs/Visits	() 4, 556 Di scharges	22, 129	8.0
		inpatrent b	ay37 v1 31 t 3		Di Scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	7, 768	34, 453	(13 0	1.0 2.0
. 00		0	0	(0	3.0
00	HOME HEALTH AGENCY COST	0	0			0	4.0
00	Other Long Term Care	0	0				5.0
00	SNF-Based CMHC						6.0
00	HOSPICE	0	0	(0	
00	Total (Sum of lines 1-7)	7, 768 Di scha	34, 453 arges	Ave	age Length of	13 Stav	8.0
	Component	0ther 11.00	<u>Total</u> 12.00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
. 00	SKILLED NURSING FACILITY	74	218	0.00			1. C
. 00	NURSING FACILITY	0	0	0.00)	0.00	2. C
00	ICF/IID	0	0			0.00	3.0
. 00	HOME HEALTH AGENCY COST		0				4.0 5.0
. 00 . 00	Other Long Term Care SNF-Based CMHC	0	0				6.0
. 00	HOSPICE	0	0	0.00	0.00	0.00	
. 00	Total (Sum of lines 1-7)	74	218	0.00		1, 702. 23	8.0
		Average Length of Stay		Admi	sions		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
	-	16.00	17.00	18.00	19.00	20.00	
. 00	SKILLED NURSING FACILITY	158.04	0	196			1.0
00 00	NURSING FACILITY	0. 00 0. 00	0		0	0	2. (3. (
00	HOME HEALTH AGENCY COST	0.00			0	0	4. (
00	Other Long Term Care	0.00				0	5.
00	SNF-Based CMHC						6. (
00	HOSPICE	0.00	0				
00	Total (Sum of lines 1-7)	158.04 Admissions	O Full Time		13	9	8.0
				•			
	Component	Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
00	SKILLED NURSING FACILITY	218	125.30)		1. C
00	NURSING FACILITY	0	0.00				2.0
00		0	0.00				3.0
00	HOME HEALTH AGENCY COST Other Long Term Care	0	0.00 0.00				4.0
00 00	SNF-Based CMHC	0	0.00				5. (6. (
00	HOSPI CE	0	0.00	0.00)		7.0

Heal th	Financial Systems	PEACE CARE A	T ST. ANNS		In Lie	u of Form CMS-2	2540-10
SNF WA	IGE INDEX INFORMATION				Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/23/2022 8:5	pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
			Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARIES	1	1	1			
1.00	Total salaries (See Instructions)	6, 250, 223	0	6, 250, 22			1.00
2.00	Physician salaries-Part A	0	0		0 0.00		2.00
3.00	Physician salaries-Part B	0	0		0 0.00		3.00
4.00	Home office personnel	0	0		0 0.00		4.00
5.00	Sum of lines 2 through 4	0	0		0 0.00		5.00
6.00	Revised wages (line 1 minus line 5)	6, 250, 223	0	6, 250, 22			6.00
7.00	Other Long Term Care	0	0		0 0.00		7.00
8.00	HOME HEALTH AGENCY COST	0	0		0 0.00		
9.00	CMHC	0	0		0 0.00		
10.00	HOSPI CE	0	0		0 0.00		
11.00	Other excluded areas	0			0 0.00		
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0			0 0.00		
13.00	Total Adjusted Salaries (line 6 minus line	6, 250, 223	0	6, 250, 22	271, 876. 00	22.99	13.00
	12) OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	23, 056	0	23, 05	1, 065. 00	21.65	14.00
15.00	Contract Labor: Physician services-Part A	23,030		23,00	0 1,003.00		
16.00	Home office salaries & wage related costs	0			0 0.00		
10.00	WAGE-RELATED COSTS	0		1	0 0.00	0.00	10.00
17.00	Wage-related costs core (See Part IV)	1, 976, 310	0	1, 976, 31	0		17.00
18.00	Wage-related costs other (See Part IV)	0		.,	0		18.00
19.00	Wage related costs (excluded units)	0			0		19.00
20.00	Physician Part A - WRC	0			0		20.00
21.00	Physician Part B - WRC	0	c c		0		21.00
22.00	Total Adjusted Wage Related cost (see	1, 976, 310	c c	1, 976, 31	0		22.00
	instructions)						

Heal th	Financial Systems	PEACE CARE A	T ST. ANNS		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2021 To 12/31/2021		nared
					10 12/31/2021	5/23/2022 8:5	
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	1					
1.00	Employee Benefits	0	0		0.00		
2.00	Administrative & General	463, 384		463, 38			
3.00	Plant Operation, Maintenance & Repairs	229, 340	0	229, 34	0 11, 044. 00	20.77	3.00
4.00	Laundry & Linen Service	0	0		0 0.00	0.00	4.00
5.00	Housekeepi ng	691, 563	0	691, 56	3 40, 586. 00	17.04	5.00
6.00	Dietary	539, 025	0	539, 02	5 35, 429. 00	15. 21	6.00
7.00	Nursing Administration	418, 715	0	418, 71	5 11, 119. 00	37.66	7.00
8.00	Central Services and Supply	0	0		0.00	0.00	8.00
9.00	Pharmacy	0	0		0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	16, 369	0	16, 36	9 843.00	19.42	10.00
11.00	Soci al Servi ce	137, 829	0	137, 82	9 3, 610. 00	38.18	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
	Other General Service	178, 512	0	178, 51	2 9, 318.00	19.16	13.00
14.00	Total (sum lines 1 thru 13)	2, 674, 737	0	2, 674, 73	7 121, 654. 00	21.99	14.00
				•			•

Heal th	Financial Systems	PEACE CARE AT ST	Γ. ANNS	In Lie	u of Form CMS-2	2540-10
	AGE RELATED COSTS		Provi der No.: 315413	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Pre 5/23/2022 8:5	pared:
				,	Amount	
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					-
	Part A - Core List					-
1 00	RETIREMENT COST					1 4 00
1.00	401K Employer Contributions	.,			0	
2.00	Tax Shel tered Annui ty (TSA) Employer Contr				0	
3.00	Qualified and Non-Qualified Pension Plan C	ost			139, 469	•
4.00	Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External				0	4.00
5.00	401K/TSA Plan Administration fees	organization)			0	5.00
5.00 6.00	Legal /Accounting/Management Fees-Pension P	Lon			0	
7.00	Employee Managed Care Program Administration				0	
7.00	HEALTH AND INSURANCE COST	UT Fees			0	7.00
8.00	Heal th Insurance (Purchased or Self Funded)			943, 322	8.00
9.00	Prescription Drug Plan)			943, 322	1
10.00	Dental, Hearing and Vision Plan				0	
11.00	Life Insurance (If employee is owner or be	neficiary)			36, 846	
12.00	Accident Insurance (If employee is owner o				0	
13.00	Disability Insurance (If employee is owner				73, 571	
14.00	Long-Term Care Insurance (If employee is o				,0,0,1	•
15.00	Workers' Compensation Insurance				273, 350	
16.00	Retirement Health Care Cost (Only current	vear, not the extrao	rdinary accrual require	ed by FASB 106.	0	
	Non cumulative portion)	,,			-	
	TAXES					1
17.00	FICA-Employers Portion Only				513, 204	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				0	20.00
	OTHER					
21.00	Executive Deferred Compensation				0	21.00
	Day Care Cost and Allowances				0	
23.00	Tuition Reimbursement				-3, 452	
24.00	Total Wage Related cost (Sum of lines 1	23)			1, 976, 310	24.00
					Amount	
					Reported	
	Part B - Other than Core Related Cost				1.00	
25 00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00
25.00	UTHEN WAVE RELATED COSTS (SPECIFT)				0	25.00

Heal th	Financial Systems	PEACE CARE AT	ST ANNS		Inlie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES	1 2/102 0/112 /11			Peri od:	Worksheet S-3	
					From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	narod
					10 12/31/2021	5/23/2022 8:5	7 am
	Occupational Category	Amount	Fri nge	Adj usted		Average Hourly	
		Reported	Benefits	Salaries (col		Wage (col. 3 ÷	
				1 + col. 2)	Salary in col.	col. 4)	
		1.00	2.00	3.00	<u>3</u> 4. 00	5.00	
	Direct Salaries	1.00	2.00	3.00	4.00	5.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 417, 107	448, 086	1, 865, 19	3 19, 054. 00	97.89	1.00
2.00	Licensed Practical Nurses (LPNs)	702, 111	222, 006	924, 11	7 24, 420. 00	37.84	2.00
3.00	Certified Nursing Assistant/Nursing	1, 487, 993	470, 500	1, 958, 49	3 82, 047. 00	23.87	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 607, 211	1, 140, 592				4.00
5.00	Physical Therapists	428, 128	135, 373				5.00
6.00	Physical Therapy Assistants	0	0		0.00		
7.00	Physical Therapy Aides	645	204	84			7.00
8.00	Occupational Therapists	322, 766	102, 058				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	20, 604	6, 515 0				11.00 12.00
12.00 13.00	Respiratory Therapists Other Medical Staff	0	0		0 0.00 0 0.00		
13.00	Contract Labor	0	0		0 0.00	0.00	13.00
	Nursing Occupations						
14.00	Registered Nurses (RNs)	0			0.00	0,00	14.00
15.00	Licensed Practical Nurses (LPNs)	0			0.00		
16.00	Certified Nursing Assistant/Nursing	23, 056		23, 05	6 1, 065. 00	21.65	16.00
	Assi stants/Ai des						
17.00	Total Nursing (sum of lines 14 through 16)	23, 056		23, 05			
18.00	Physical Therapists	0			0.00		
19.00	Physical Therapy Assistants	0			0.00		
20.00	Physical Therapy Aides	0			0.00		
21.00	Occupational Therapists	0			0.00		21.00
22.00	Occupational Therapy Assistants	0			0 0.00		
23.00	Occupational Therapy Aides	0			0 0.00		
24.00 25.00	Speech Therapi sts	0			0 0.00 0 0.00		24.00 25.00
25.00 26.00	Respiratory Therapists Other Medical Staff	0			0.00		25.00
20.00		l d		I	U U. UU	I 0.00	∠0. 00

Health Financial Systems PE/ PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Period:	u of Form CMS Worksheet S-	
	From 01/01/2021 To 12/31/2021	Date/Time Pr	
	Group	5/23/2022 8: Days	
1.00	1.00 RUX	2.00	1.00
2.00	RUL		2.00
3.00	RVX	- 	3.00
4.00	RVL		4.00
5.00 6.00	RHX RHL		5.00 6.00
7.00	RMX		7.00
8.00	RML		8.00
9.00	RLX		9.00
10. 00 11. 00	RUC RUB		10.00
12.00	RUA		12.00
13.00	RVC		13.00
14.00	RVB		14.00
15.00	RVA		15.00
16.00 17.00	RHC RHB		16.00 17.00
18.00	RHA		18.00
19.00	RMC		19.00
20.00	RMB		20.00
21.00 22.00	RMA RLB		21.00
23.00	RLA		23.00
24.00	ES3		24.00
25. 00	ES2		25.00
26.00	ES1		26.00
27.00 28.00	HE2 HE1		27.00 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 39. 00	LD1 LC2		38.00 39.00
40.00	LC1		40.00
41. 00	LB2		41.00
42.00	LB1		42.00
43.00 44.00	CE2 CE1		43.00 44.00
45.00	CD2		45.00
46.00	CD1		46.00
47.00	CC2		47.00
48.00	CC1		48.00
49. 00 50. 00	CB2 CB1		49.00 50.00
51.00	CA2		51.00
52.00	CA1		52.00
53. 00	SE3		53.00
54.00 55.00	SE2 SE1		54.00 55.00
56.00	SSC		56.00
57.00	SSB		57.00
58.00	SSA		58.00
59.00	I B2		59.00
60. 00 61. 00	I B1 I A2		60.00 61.00
62.00	I A1		62.00
63. 00	BB2		63.00
64. 00	BB1		64.00
65. 00 66. 00	BA2 BA1		65.00 66.00
67.00	PE2		67.00
68. 00	PE1		68.00
69.00	PD2		69.00
70.00	PD1		70.00
71.00 72.00	PC2 PC1		71.00 72.00
73.00	PC1 PB2		72.00
74.00	PB1		74.00
75. 00	PA2		75.00

Health Financial Systems PEACE CARE AT ST	. ANNS		In Lie	u of Form CMS	6-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315413	Peri od:	Worksheet S	-7
			From 01/01/2021 To 12/31/2021		
			Group	Days	
			1.00	2.00	
76.00			PA1		76.00
99.00			AAA		99.00
100. 00 TOTAL		-			100.00
		Expenses	Percentage	Y/N	
		1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 A payments beginning 10/01/2003. Congress expected this increase expenses. For lines 101 through 106: Enter in column 1 the amou column 2 the percentage of total expenses for each category to line 1, column 3. Indicate in column 3 "Y" for yes or "N" for n with direct patient care and related expenses for each category (See instructions)	to be used nt of the total SNF o if the s	l for direct expense for d revenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)					101. 00 102. 00 103. 00 104. 00 105. 00 106. 00

ECLAS	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	PEACE CARE AT EXPENSES	Provi der	No.: 315413	Peri od:	Worksheet A	2540-10
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
		Calarian	Others	Tatal (asl		5/23/2022 8:5	7 am
	Cost Center Description	Sal ari es	Other	+ col. 2	1 Recl assi fi cati ons	Reclassified Trial Balance	
				+ COI. 2)	I ncrease/Decre		
					ase (Fr Wkst	col. 4)	
					A-6)	COI. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	· ·					
. 00	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 081, 497	1, 081, 4	97 0	1, 081, 497	1.00
. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0		0 0	0	2.00
. 00	00300 EMPLOYEE BENEFITS	0	2,012,400	2, 012, 4	00 0	2, 012, 400	3.00
. 00	00400 ADMINISTRATIVE & GENERAL	463, 384	2, 739, 979	3, 203, 3	63 0	3, 203, 363	4.00
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	229, 340	542, 549			771, 889	
. 00	00600 LAUNDRY & LINEN SERVICE	0	1, 880	1, 8		1, 880	
. 00	00700 HOUSEKEEPI NG	691, 563	156, 057			847, 620	•
. 00	00800 DI ETARY	539, 025	921, 139			1, 460, 164	
. 00	00900 NURSI NG ADMI NI STRATI ON	418, 715	1, 775	420, 4	90 0	420, 490	
0.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	
1.00		1(2(0	10 1/7	/F F	0 0	0	11.00
2.00	01200 MEDI CAL RECORDS & LI BRARY	16, 369	49, 167	65, 5		65, 536	
3.00	01300 SOCIAL SERVICE	137, 829	2, 438	140, 2		140, 267	13.00
4.00	01400 NURSING AND ALLIED HEALTH EDUCATION	170 510	0	202.2	0 0	0	
5.00	01500 RECREATION	178, 512	24, 816	203, 3	28 0	203, 328	15.00
0 00	INPATIENT ROUTINE SERVICE COST CENTERS	2 224 010	190, 097	2 414 1	15 0	2 414 115	200.00
0.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	3, 224, 018	190, 097	3, 414, 1	0 0	3, 414, 115 0	30.00
2.00	03200 I CF/I I D	0	0		0 0	0	32.00
3.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
3.00	ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	33.00
0. 00	04000 RADI OLOGY	0	23, 129	23, 1	29 0	23, 129	40.00
1.00	04100 LABORATORY	0	68, 447	68, 4		68, 447	
2.00	04200 I NTRAVENOUS THERAPY	0	00, 447	00,4	0 0	00, 447	42.00
3.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
4.00	04400 PHYSI CAL THERAPY	7, 685	429, 690	437, 3	75 0	437, 375	
5.00	04500 OCCUPATI ONAL THERAPY	332, 532	3, 679			336, 211	
6.00	04600 SPEECH PATHOLOGY	11, 251	0	11, 2		11, 251	46.00
7.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
8.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46, 040	46, 0	40 0	46, 040	48.00
9.00	04900 DRUGS CHARGED TO PATIENTS	0	209, 546	209, 5	46 0	209, 546	49.00
0. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
1.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	1 1					
0.00	06000 CLI NI C	0	0		0 0	0	60.00
1.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
2.00	06200 FQHC				_	_	62.00
3.00	06300 DAY CARE	0	0		0 0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						1
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	24, 392	24, 3		24, 392	
3.00	07300 CMHC	0	0		0 0	0	73.00
~ ~~	SPECIAL PURPOSE COST CENTERS	1	0	[0	0	
0.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	
1.00	08100 I NTEREST EXPENSE		0		0 0	0	
2.00 3.00	08200 UTI LI ZATI ON REVIEW - SNF 08300 HOSPI CE	0	0		0 0	0	82.00 83.00
3.00 9.00	SUBTOTALS (sum of lines 1-84)	6, 250, 223	0 8, 528, 717	14, 778, 9		14, 778, 940	
7.00	NONREI MBURSABLE COST CENTERS	0,200,223	0, 520, 717	14,770,9		14, 770, 740	1 0 7. 00
0. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.0
1.00	09100 BARBER AND BEAUTY SHOP		1, 205	1, 2			90.0
2.00	09200 PHYSICIANS PRIVATE OFFICES	0	1, 200	1, 2		1, 205	
3.00	09300 NONPAID WORKERS	0	0		0 0	0	
0.00			0			0	1
4 00							
4.00	09400 PATIENTS LAUNDRY 09500 DAYCARE	0	683, 323	683, 3	0 0 23 0	683, 323	

CLASSI FI CA	ial Systems TION AND ADJUSTMENT OF TRIAL BALANCE O	PEACE CARE /		der No.: 3154		_ieu of Form CMS-25 Worksheet A
					From 01/01/20	21
					To 12/31/20	21 Date/Time Prepa 5/23/2022 8:57
	Cost Center Description	Adjustments to	Net Expens	ses		0/20/2022 0.0/
		Expenses (Fr	For Alloca	ti on		
		Wkst A-8)	(col. 5 ·	+-		
			col. 6)			
CENEDA		6.00	7.00			
	L SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	-118, 894	962	, 603		
	CAP REL COSTS - MOVABLE EQUIPMENT	0,074		0		
	EMPLOYEE BENEFITS					
	ADMINISTRATIVE & GENERAL	-960, 855				
	PLANT OPERATION, MAINT. & REPAIRS	,00,000		, 889		
	LAUNDRY & LINEN SERVICE			, 880		
	HOUSEKEEPING	E 221		, 620		
		-5, 221				
1 1	NURSING ADMINISTRATION	C	420,	, 490		
	CENTRAL SERVICES & SUPPLY	C	2	0		
	PHARMACY	C		0		
	MEDICAL RECORDS & LIBRARY	C		, 536		
	SOCIAL SERVICE	C	140,	, 267		
	NURSING AND ALLIED HEALTH EDUCATION	C	1	0		· · · · · · · · · · · · · · · · · · ·
	RECREATION	C	203,	, 328		
I NPATI	ENT ROUTINE SERVICE COST CENTERS					
00 03000	SKILLED NURSING FACILITY	C	3, 414,	, 115		
00 03100	NURSING FACILITY	C		0		
00 03200	ICF/IID	C		o		
	OTHER LONG TERM CARE	0		o		
	ARY SERVICE COST CENTERS	-	•	-		
	RADI OLOGY	C	23	, 129		
	LABORATORY			, 447		
	INTRAVENOUS THERAPY			0		
	OXYGEN (INHALATION) THERAPY			0		
	PHYSI CAL THERAPY		127	, 375		
	OCCUPATIONAL THERAPY			, 211		
	SPEECH PATHOLOGY			, 251		
	ELECTROCARDI OLOGY		, II.			
				0		
	MEDICAL SUPPLIES CHARGED TO PATIENTS			, 040		
	DRUGS CHARGED TO PATIENTS	C		, 546		
	DENTAL CARE - TITLE XIX ONLY	C		0		
	SUPPORT SURFACES	C)	0		
	I ENT SERVICE COST CENTERS	-	1			
00 06000		C		0		
	RURAL HEALTH CLINIC	C	2	0		
00 06200						
	DAY CARE	C	Ŋ	0		
	REIMBURSABLE COST CENTERS		1			
	HOME HEALTH AGENCY COST	C		0		
00 07100	AMBULANCE	C	24,	, 392		
00 07300	СМНС	C		0		
SPECI A	L PURPOSE COST CENTERS					
	MALPRACTICE PREMIUMS & PAID LOSSES	C		0		
	INTEREST EXPENSE	0		0		
	UTILIZATION REVIEW - SNF		b	o		
	HOSPICE			0		
	SUBTOTALS (sum of lines 1-84)	-1, 084, 970	13, 693,	970		
	MBURSABLE COST CENTERS	1,004,970	1 13,073,	, , , 0		
	GIFT, FLOWER, COFFEE SHOPS & CANTEEN			0		
			1	205		
	BARBER AND BEAUTY SHOP		1,	, 205		
	PHYSICIANS PRIVATE OFFICES		1	0		
	NONPAID WORKERS	C	2	0		
	PATIENTS LAUNDRY	C	2	0		
00 09500		C		, 323		
	TOTAL	-1,084,970	14, 378,			1

Health Financial Systems	PEACE CARE AT ST.	ANNS		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS	Provi		No.: 315413	Period: From 01/01/2021	Worksheet A-6	
					Date/Time Pre 5/23/2022 8:5	
			Increases			
	Cost Cente	ŕ	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
TOTALS						
	Total Reclassifications (Sur of columns 4 and 5 must equal sum of columns 8 and 9)			0	0	100. 00

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

Health Financial Systems	PEACE CARE AT ST.	ANNS		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315413	Period: From 01/01/2021	Worksheet A-0	5
					Date/Time Pre 5/23/2022 8:5	
			Decreases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
TOTALS						
100.00				0	(100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS Provider No.: 315413 Period: From 01/01/2021 To 12/31/2021 Workshee Date/Tim 5/23/202 Description Beginning Balances Provider No.: 315413 Period: From 01/01/2021 To 12/31/2021 Workshee Date/Tim 5/23/202 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 2,997,898 0 0 0 0 1.00 Land 0 23,611,959 1,714,314 0 1,714,314 0 1,714,314 4.00 Building improvements 0	CMS-2	540-10
Description Beginning Balances Purchases Donation Total Disposal s Retirement 1.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 0	A-7	
Description Beginning Balances Purchases Donation Total Disposal s Retirement ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00 1.00 Land 0 0 0 0 0 0 2.00 Land Improvements 0 0 0 21,800 0 1.714,314 0 1.714,314 0 1.714,314 0 1.714,314 0 1,67 0 0 0 0 0 0 0		
Bal ances Bal ances Retiremed 1.00 2.00 3.00 4.00 5.00 ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 2,997,898 0 0 0 2.00 Land Improvements 2,997,898 0 0 0 3.00 Buil dings and Fixtures 23,611,959 1,714,314 0 1,714,314 4.00 Buil ding Improvements 0 0 0 0 0 5.00 Fixed Equipment 4,273,066 0 0 0 0 0 0 6.00 Reconciling Items 30,882,923 1,736,114 0 1,736,114 1,67 9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1,736,114 1,67 0 Total (line 7 minus line 8) 30,882,923 1,736,114 0		
ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00 2.00 Land 0 0 0 0 2.00 Land Improvements 0 21,800 0 0 0 3.00 Buildings and Fixtures 23,611,959 1,714,314 0 1,714,314 0 4.00 Building Improvements 0 0 0 0 0 5.00 Fixed Equipment 4,273,066 0 0 0 0 6.00 Movable Equipment 4,273,066 0 0 0 0 9.00 Subtotal (sum of lines 1-6) 30,882,923 1,736,114 0 1,736,114 1,67 9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 0 0 7.00 Bescription Ending Balance Fully 0 1,736,114 1,67 0 1.00 Land Ending Balance Fully <		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 0 0 0 0 0 0 0 21,800 0 21,800 0 21,800 0 21,800 0 21,800 0 21,800 0 21,800 0 21,800 0 21,800 0	ts	
1.00 Land 2,997,898 0 0 0 2.00 Land Improvements 0 21,800 0 21,800 3.00 Buildings and Fixtures 23,611,959 1,714,314 0 1,714,314 4.00 Building Improvements 0 0 0 0 5.00 Fixed Equipment 0 0 0 0 6.00 Movable Equipment 4,273,066 0 0 0 7.00 Subtotal (sum of Lines 1-6) 30,882,923 1,736,114 0 1,736,114 1,67 9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 Description Ending Balance Fully Depreciated Assets 6.00 7.00 1.00 Land Land CAPITAL ASSET BALANCES 2,997,898 0 0 0 2.00 Land Improvements 21,800 0 0 0 0		
2.00 Land Improvements 0 21,800 0 21,800 3.00 Buildings and Fixtures 23,611,959 1,714,314 0 1,714,314 4.00 Building Improvements 0 0 0 0 0 5.00 Fixed Equipment 0 0 0 0 0 6.00 Movable Equipment 4,273,066 0 0 0 1,67 7.00 Subtotal (sum of lines 1-6) 30,882,923 1,736,114 0 1,736,114 1,67 9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 Description Ending Balance Fully Depreciated Assets 6.00 7.00 1.00 Land ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 2,997,898 0 0 0 2.00 Land Improvements 21,800 0 0 0 0		
3.00 Buildings and Fixtures 23,611,959 1,714,314 0 1,714,314 4.00 Building Improvements 0 0 0 0 5.00 Fixed Equipment 0 0 0 0 6.00 Movable Equipment 4,273,066 0 0 0 1,67 7.00 Subtotal (sum of lines 1-6) 30,882,923 1,736,114 0 1,736,114 1,67 8.00 Reconciling Items 0 0 0 0 0 0 9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 Description Ending Balance Fully Depreciated Assets 6.00 7.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2,997,898 0 0 0 2.00 Land Improvements 21,800 0 0 0	0	1.00
4.00 Building Improvements 0 0 0 0 5.00 Fixed Equipment 0 0 0 0 0 6.00 Movable Equipment 4,273,066 0 0 0 1,67 7.00 Subtotal (sum of lines 1-6) 30,882,923 1,736,114 0 1,736,114 1,67 8.00 Reconciling Items 0 0 0 0 0 0 9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 Description Ending Balance Fully Depreciated Assets 0 0 0 0 1.00 Land Color 7.00 21,800 0 0 1,736,00 0 0 0 1,736,114 1,67	0	2.00
5.00 Fixed Equipment 0 0 0 0 6.00 Movable Equipment 4, 273, 066 0 0 0 1, 67 7.00 Subtotal (sum of lines 1-6) 30, 882, 923 1, 736, 114 0 1, 736, 114 1, 67 8.00 Reconciling Items 0 0 0 0 0 0 9.00 Total (line 7 minus line 8) 30, 882, 923 1, 736, 114 0 1, 736, 114 1, 67 Description Ending Balance Fully Depreciated Assets 6.00 7.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 2, 997, 898 0 0 0 0 1.00 Land Improvements 21, 800 0 0 0	0	3.00
6.00 Movable Equipment 4,273,066 0 0 1,67 7.00 Subtotal (sum of lines 1-6) 30,882,923 1,736,114 0 1,736,114 1,67 8.00 Reconciling Items 0 0 0 0 0 0 9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 Description Ending Balance Fully Depreciated Assets 6.00 7.00 1,736,114 1,67 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 2,997,898 0 0 2.00 0	0	4.00
7.00 Subtotal (sum of lines 1-6) 30,882,923 1,736,114 0 1,736,114 1,67 8.00 Reconciling Items 0 0 0 0 0 0 9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 Description Ending Balance Fully Depreciated Assets 6.00 7.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Land 2,997,898 0 0 0 2.00 Land Improvements 21,800 0 0 0 0	0	5.00
8.00 Reconciling Items 0 1, 67 0 1, 736, 114 1, 67 Description Ending Balance Fully Depreciated Assets 6.00 7.00 7.00 20 2.00 Land 2, 997, 898 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 0 21, 800 21, 800 21, 800 <td>439</td> <td>6.00</td>	439	6.00
9.00 Total (line 7 minus line 8) 30,882,923 1,736,114 0 1,736,114 1,67 Description Ending Balance Fully Depreciated Assets Fully 1 <	439	7.00
Description Ending Balance Fully Depreciated Assets 6.00 7.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land Land 2,997,898 0 21,800	0	8.00
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Depreciated Assets 1.00 Land 2,997,898 0 2.00 Land Improvements 21,800 0	439	9.00
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 Land 2,997,898 0 2.00 Land Improvements 21,800 0		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2,997,898 0 2.00 Land Improvements 21,800 0		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2,997,898 0 2.00 Land Improvements 21,800 0		
1.00 Land 2,997,898 0 2.00 Land Improvements 21,800 0		
2.00 Land Improvements 21,800 0		
		1.00
		2.00
3.00 Buildings and Fixtures 25, 326, 273 0		3.00
4.00 Building Improvements 0 0		4.00
5.00 Fixed Equipment 0 0		5.00
6.00 Movable Equipment 2, 593, 627 0		6.00
7.00 Subtotal (sum of lines 1-6) 30,939,598 0		7.00
8.00 Reconciling Items 0 0		8.00
9.00 Total (line 7 minus line 8) 30,939,598 0		9.00

	Financial Systems MENTS TO EXPENSES	PEACE CARE AT		No.: 315413	Peri od:	u of Form CMS-2 Worksheet A-8	
5051				10	From 01/01/2021 To 12/31/2021		
						5/23/2022 8:5	
					lassification on		
				10/From Whic	ch the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
		Adjustment	, and arre				
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds (chapter 2)	В		CAP REL COST FIXTURES	S – BLDGS &	1.00	1.
00	Trade, quantity, and time discounts (chapter		0			0.00	2.
	8)						
00	Refunds and rebates of expenses (chapter 8)		0			0.00	
00	Rental of provider space by suppliers (chapter 8)		0			0.00	4.
00	Telephone services (pay stations excluded)		0			0.00	5.
	(chapter 21)						
00	Television and radio service (chapter 21)		0			0.00	
00 00	Parking lot (chapter 21) Remuneration applicable to provider-based	A-8-2	0			0.00	7. 8.
00	physician adjustment	A-0-2	0				0
00	Home office cost (chapter 21)		0			0.00	9
00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
00	Nonallowable costs related to certain		0			0.00	11
. 00	Capital expenditures (chapter 24) Adjustment resulting from transactions with	A-8-1	-11, 573				12
. 00	related organizations (chapter 10)	A-0-1	-11, 575				'2
. 00	Laundry and linen service		0)		0.00	13
. 00	Revenue – Employee meals	В		DI ETARY		8.00	
. 00	Cost of meals - Guests		0			0.00	
. 00	Sale of medical supplies to other than patients		0			0.00	10
. 00	Sale of drugs to other than patients		0			0.00	17
00	Sale of medical records and abstracts		0			0.00	
. 00	Vending machines		0			0.00	
. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20
00	Interest expense on Medicare overpayments		0			0.00	21
	and borrowings to repay Medicare						
~~	overpayments						
. 00	Utilization reviewphysicians' compensation (chapter 21)		0	UTILIZATION	REVIEW - SNF	82.00	22
. 00	Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23
				FI XTURES			
. 00	Depreciationmovable equipment		0	CAP REL COST	S - MOVABLE	2.00	24
00	Other adjustment (specify)		0	EQUI PMENT		0.00	25
01	PCSA BAD DEBT PROVISION	А	-912,280	ADMI NI STRATI	VE & GENERAL	4.00	
02	PCSA NON OP REVENUE INVESTMENT INC	A		ADMI NI STRATI		4.00	
04	PCSA OTHER NON-OP FUNDRALSING COSTS	A		ADMI NI STRATI		4.00	
06	PCSA GOLF EVENT REV - PHYS FEE-PATHO	A	12, 490	CAP REL COST	S - BLDGS &	1.00	25
. 07	NON OP EXPENSES 50/50 RAFFLE EXPENSE	А	-9 426	FI XTURES ADMI NI STRATI	VE & GENFRAI	4.00	25
	NON OP EXPENSES - FUNDRALSING EXPENS	A		ADMI NI STRATI		4.00	
	MI SC I NCOME	В		ADMI NI STRATI		4.00	
0.00	Total (sum of lines 1 through 99) (Transfer		-1, 084, 970				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	PEACE CARE A	T ST. ANNS		In Lie	u of Form CMS	-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOM	E Provi der		Peri od:	Worksheet A-	8-1
OFFICE COSTS				From 01/01/2021 To 12/31/2021	Parts I-II Date/Time Pr	epared:
					5/23/2022 8:	
	Line No.		Center		e Items	_
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI					00	
CLAIMED HOME OFFICE COSTS:	KED AS A RESULT	UF TRANSACTIO	NS WITH RELAT	ED URGANIZATIONS	5 UK	
1.00	4.00	ADMI NI STRATI VE	& GENERAL	FINANCE COST		1.00
2.00		ADMI NI STRATI VE		HUMAN RESOURCES	S COST	2.00
3.00		ADMI NI STRATI VE		MARKETING COST		3.00
4.00	4.00	ADMI NI STRATI VE	& GENERAL	PEACE CARE ADM	I NI STRATI ON	4.00
5.00	4.00	ADMI NI STRATI VE	& GENERAL	ACCOUNTING COST	Т	5.00
6.00		ADMI NI STRATI VE	& GENERAL	DEVELOPMENT COS	ST	6.00
7.00	0.00					7.00
8.00	0.00					8.00
9.00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line 12.						
12.	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minus			
	Cost	Wkst. A, col.	col . 5)			
		5				
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANIZATIONS	5 OR	
1.00	7,452	7 450		0		1.00
2.00	87, 878			0		2.00
3.00	07,070			0		3.00
4.00	143, 888			0		4.00
5.00	143, 000			0		5.00
6.00	71, 072			0		6.00
7.00	0	0		0		7.00
8.00	0	0		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	491, 419	502, 992	-11, 57	'3		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						

Health Financial Systems	PEACE CARE A	T ST.	ANNS	In Lie	u of Form CMS-2	2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME		Provider No.: 315413	From 01/01/2021	Worksheet A-8 Parts I-II Date/Time Prep 5/23/2022 8:5	pared:
	Symbol (1)		Name	Percentage of Ownership		
	1.00		2.00	3.00		

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

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

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

1.00	F	PEACECARE	0.00	1.00
2.00	F	PEACECARE	0.00	2.00
3.00	В	PEACECARE	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.

Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

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

related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial

interest in provider.

	Rel ated Organi	zation(s) and/	or Home Office						
	Name	Percentage of	Type of Business						
		Ownershi p							
	4.00	5.00	6.00]					
PART II. INTERRELATIONSHIP TO RELATED ORGANI	ZATION(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	ST. JOSEPHS PEACECARE	0. 00 SNF	1.00
2.00	ST. JOSEPHS PEACECARE	0.00 SNF	2.00
3.00	PEACECARE	O. OOMANAGEMENT	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.

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	PEACE CARE AT		No.: 315413	Pe	eri od:	u of Form CMS-2 Worksheet B	2040-10
						om 01/01/2021	Part I Date/Time Pre 5/23/2022 8:5	
			CAPI TAL REL	ATED COSTS			10,20,2022 0.0	
	Cost Center Description	Net Expenses for Cost Allocation	BLDGS & FI XTURES	MOVABLE EQUI PMENT		EMPLOYEE BENEFI TS	Subtotal	
		(from Wkst A col. 7)						
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS				_			
1.00 2.00	00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUI PMENT	962, 603	962, 603		0			1.00 2.00
3.00	00300 EMPLOYEE BENEFITS	2, 012, 400	0		0	2, 012, 400		3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	2, 242, 508	163, 175		0	149, 197	2, 554, 880	
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	771, 889	36, 719		0	73, 841	882, 449	5.00
5.00	00600 LAUNDRY & LINEN SERVICE	1, 880	34, 108		0	37	36, 025	
7.00	00700 HOUSEKEEPI NG	847, 620	9, 339		0	222, 627	1, 079, 586	
3.00	00800 DI ETARY	1, 454, 943	85, 238		0	173, 551	1, 713, 732	
9.00	00900 NURSI NG ADMI NI STRATI ON	420, 490	0		0	134, 815	555, 305	
10.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0		0	0	0	
	01200 MEDICAL RECORDS & LIBRARY	65, 536	0		0	5, 270	70, 806	11.00 12.00
	01300 SOCIAL SERVICE	140, 267	1, 380		0	44, 377	186, 024	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	00,021	14.00
	01500 RECREATION	203, 328	62, 432		0	57, 476	323, 236	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 SKILLED NURSING FACILITY	3, 414, 115	527, 104		0	1, 038, 046	4, 979, 265	
	03100 NURSING FACILITY	0	0		0	0	0	31.00
		0	0		0	0	0	
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0	0	0	33.00
40.00	04000 RADIOLOGY	23, 129	0		0	0	23, 129	40.00
	04100 LABORATORY	68, 447	0		0	0	68, 447	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	
44.00	04400 PHYSI CAL THERAPY	437, 375	40, 412		0	2, 474	480, 261	44. OC
45.00	04500 OCCUPATI ONAL THERAPY	336, 211	0		0	107, 066	443, 277	45.00
46.00	04600 SPEECH PATHOLOGY	11, 251	0		0	3, 623	14, 874	
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	46,040	0		0	0	46,040	
	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	209, 546	0		0	0	209, 546 0	49.00 50.00
	05100 SUPPORT SURFACES	0	0		0	0	0	
	OUTPATIENT SERVICE COST CENTERS				0			
50.00	06000 CLINIC	0	0		0	0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0		0	0	0	61.00
	06200 FQHC				_	_	_	62.00
53.00	06300 DAY CARE	0	0		0	0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
	07100 AMBULANCE	24, 392	0		0	0	24, 392	
	07300 CMHC	21,072	0		0	0	0	
	SPECIAL PURPOSE COST CENTERS				-	-		
30. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES							80.00
	08100 INTEREST EXPENSE							81.00
	08200 UTILIZATION REVIEW - SNF							82.00
	08300 HOSPI CE	0	0		0	0	0	
39.00	SUBTOTALS (sum of lines 1-84)	13, 693, 970	959, 907		0	2,012,400	13, 691, 274	89.00
00 00	NONREI MBURSABLE COST CENTERS 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	[0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	1, 205	2, 696		0	0	3, 901	91.00
	09200 PHYSI CLANS PRI VATE OFFI CES	0	2,070		õ	0	0	
	09300 NONPAI D WORKERS	0	0		0	0	0	
	09400 PATIENTS LAUNDRY	0	0		0	0	0	
		683, 323	0		0	0	683, 323	
98.00	Cross Foot Adjustments	0	0		0	0	0	
99.00	Negative Cost Centers	0	0		0	0	0	
100.00	D TOTAL	14, 378, 498	962, 603		0	2, 012, 400	14, 378, 498	100 -

2 00 00200 CAP ELE COSTS - MOVABLE EQUIPMENT 2 3.00 00300 PHUAYE BERNETIS 2,554,860 4.00 00400 ADMI INSTRATIVE & GENERAL 2,554,860 0.00 00000 LAUNOPK & LINEN SERVICE 7,784 47,790 0.00 00000 DETAM ENERSERFER 31,410 1,073,131 0.00 00000 DETAM SERVICE 7,784 47,790 0.00 00000 DETAM SERVICE 33,280 13,140 1,070 0.00 0000 DETAM SERVICE 33,280 01,171,22 2,361,112 0.00 0000 O 0000 0000 0000 00000 11.00 01300 SOCIAL SERVICE ASEVICE 40,197 1,941 0,2,53 01,33 0.100 OSCIOOLINESING ANA ALLED HALTH FUCATION 69,946 87,942 015,098 0 0 0 0 0.100 OSCIOOLINESING ANA ALLED HALTH FUCATION 69,946 87,942 0 0 0 0 0 0 0 0 0 0 0 0	Heal th	Financial Systems	PEACE CARE AT	ST. ANNS		In Lie	u of Form CMS-	2540-10
LANDINY A BCREAD PLANT WENT LANDINY A WENT DELATIONY A WENT DELATIONY A WENT	COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	rom 01/01/2021	Part I Date/Time Pre	
ENERGY ENERGY I 00 001000 (AP REL COSTS BLDSS & FLYURES 1 2.00 00200 (AP REL COSTS MOVABLE COLISANDY 2 0.00100 (AP REL COSTS MOVABLE COLISANDY 3 1.00100 (00200 (AP REL COSTS MOVABLE COLISANDY 3 1.0010 (00200 (AP REL COSTS A MOVABLE COLISANDY 1.073, 131 5 0.0010 (00500 (PLATT OPEATTOR, MAINT & REPAIRS 7, 784 7.90, 47, 799 6 0.0010 (00500 (PLATT OPEATTOR, MAINT & REPAIRS 7, 784 7.93, 40, 0 1.7, 226, 000 6 0.001000 (0157 (FLATTAL SPRICE S A SUPPLY 0 0 0 10 10 0.001000 (CHTAL, SPRICE S A SUPPLY 0 0 0 0 11 11 9.92 0 0 10 10 12.000 (1200 (CHTAL, SPRICE S A SUPPLY 0 0 0 0 11 10 11 10 11 10 11 11 10 11 10 11 11 11 11 11 11 11 11 11 11 11 11 11 <td< th=""><th></th><th>Cost Center Description</th><th></th><th>OPERATION, MAINT. &</th><th></th><th></th><th></th><th></th></td<>		Cost Center Description		OPERATION, MAINT. &				
1.00 OTOD CAP FEL COSTS - BLIDS & FLXTURES 1. 1. 0.00 OSAGO FUPLOYTE REFET TS 3. 3. 3. 3. 0.00 OSAGO FUPLOYTE REFET TS 3. 3. 3. 3. 0.00 OSAGO FUPLOYTE REFET TS 3. 3. 3. 3. 0.00 OSAGO FUPLOYTE REFET TS GUENAL MARKED TA SCHULC 3. 4. 0.00 OSAGO FUPLOYTE REFET TS GUENAL MARKED TA SCHULC 3. 4. 0.00 OSAGO FUELOSTAR FUEL STATION 10. 1. 0. 1. 2. 3. 1. 9. 0. 1. 2. 3. 1. 1. 2. 3. 1. 1. 2. 3. 1. <th></th> <th></th> <th>4.00</th> <th>5.00</th> <th>6.00</th> <th>7.00</th> <th>8.00</th> <th></th>			4.00	5.00	6.00	7.00	8.00	
2.00 00200 CAP EEL COSTS - MOVABLE FOULPUENT 2. 3.00 00300 UPLYOTE BITRATI VE & GENRAL 2.554,980 4.00 00400 ADMI MISTRATI VE & GENRAL 2.554,980 6.00 00500 ELANDERY & LINEN SERVICE 7.784 47.7990 9.00 00400 ADMI MISTRATI VE & GENRAL 2.554,980 5. 9.00 00400 FLANG FEARTININ 13.146 1.326,006 9.00 00400 FLANG FEARTININ 10.9992 0 0 9.00 00900 MIRSING AM INSTRATION 119.9992 0 0 0 11.00 01100 PHARABACY 0 </td <td></td> <td></td> <td>-1</td> <td></td> <td>1</td> <td>1</td> <td></td> <td></td>			-1		1	1		
10.00 01000 CENTROL SERVICES & SUPPLY 0 <	2.00 3.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS 00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG 00800 DI ETARY	190, 682 7, 784 233, 280 370, 308	47, 990 13, 140	91, 799 C	1, 326, 006		
14 0.0 0 <td>10. 00 11. 00 12. 00</td> <td>01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY</td> <td>0 0 15, 300</td> <td>0 0 0 0 1 941</td> <td></td> <td></td> <td>0 0 0</td> <td>10.00 11.00 12.00</td>	10. 00 11. 00 12. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY	0 0 15, 300	0 0 0 0 1 941			0 0 0	10.00 11.00 12.00
30.00 03000 (SK1LLED NURSING FACILITY 1,075,93 741,636 91,799 971,752 2,361,112 30.31 31.00 03100 (NURSING FACILITY 0 0 0 0 31.32 32.00 03200 (ICF/ID 0 0 0 0 33.33 33.00 03300 (PHE) LONG TERM CARE 0 0 0 0 0 ANCILLARY SERVICE COST CENTERS	14.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 RECREATION	0	0	C	0	0	14.00
31.00 ORSTON NUESTING FACILITY O <th< td=""><td>20.00</td><td></td><td>1 075 022</td><td>741 (2)</td><td>01 700</td><td>071 750</td><td>2 2/1 112</td><td>1 20 00</td></th<>	20.00		1 075 022	741 (2)	01 700	071 750	2 2/1 112	1 20 00
32.00 03200 1CF/IID 0 0 0 0 33. 33.00 03300 01410 LANG TEAM CARE 0 0 0 0 33. 40.00 04000 RADIOLOGY 4,998 0						-		
ARCILLARY SERVICE COST CENTERS Image: Control of the service of the ser			0	-		-		
40.00 04000 RADIOLOGY 4,998 0	33.00		0	0	0 0	0	0	33.00
11.00 04100 LABORATORY 14,790 0 <td>10.00</td> <td></td> <td>1 000</td> <td></td> <td></td> <td></td> <td>0</td> <td>1 10 00</td>	10.00		1 000				0	1 10 00
42.00 04200 INTRAVENOUS THERAPY 0<					1			
44.00 0400 PHYSICAL THERAPY 103,776 56,859 0 74,502 0 44. 45.00 04500 0CCUPATIONAL THERAPY 95,785 0 0 0 0 45. 46.00 04600 SPEECH PATHOLOGY 3,214 0 0 0 45. 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 45. 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 9,948 0 0 0 44. 49.00 04900 PRUSS CHARGED TO PATIENTS 45,279 0 0 0 0 45. 00.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 51. 00.00 SOLOO SUPORT SURFACES 0 0 0 0 0 62. 63. 00.00 ORAL HEALTH ALLEN LLINIC 0 0 0 0 0 63. 0100 OTACO 0 0 0 0 0 0 70. 0100<				0		0		
45.00 04500 OCCUPATIONAL THERAPY 95,785 0			0	0	C	0	0	43.00
46.00 06400 SPEECH PATHOLOGY 3, 214 0 0 0 0 0 47.00 47.00 04000 ECETROCARDIOLOGY 0 0 0 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 948 0 0 0 48.00 49.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 45, 279 0								
47.00 04700 LECTROCABDIOLOGY 0 0 0 0 0 47. 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 9,948 0 0 0 0 47. 49.00 04900 DRUSC CHARGED TO PATIENTS 45,279 0 0 0 49. 50.00 DSODO SUPPARTS SURFACES 0 0 0 0 0 0 55. 00 DOIDOSUPPORT SURFACES 0 0 0 0 0 0 55. 00 DOGOSUPPORT SURFACES 0 0 0 0 0 66. 62. 66.00 66.00 66.00 62. 63. 62. 63. 60.00 60.00 60.00 63. 63				0		0		
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 9,948 0 0 0 0 48. 49.00 04900 DRUGS CHARGED TO PATIENTS 45,279 0 0 0 48. 50.00 SOGO DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 55. 001701 DENTS SUPPORT SURFACES 0 0 0 0 0 0 0 60.				0		0		
49.00 04900 DRUGS CHARGED TO PATIENTS 45, 279 0 <td></td> <td></td> <td>S S</td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>			S S	0		0		
51.00 OSTOD SUPPORT Support <thsupport< th=""> <thsupport< th=""> <thsuppo< td=""><td></td><td></td><td></td><td>0</td><td>) C</td><td>0</td><td></td><td></td></thsuppo<></thsupport<></thsupport<>				0) C	0		
OUTPATIENT SERVICE COST CENTERS O <t< td=""><td></td><td></td><td>-</td><td>0</td><td>C</td><td>0</td><td></td><td></td></t<>			-	0	C	0		
60.00 06000 CLINIC 0	51.00		0	0	C	0	0	51.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61. 62.00 06200 FOHC 0 0 0 0 62. 63.00 06300 DAY CARE 0 0 0 0 63. 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 70. 70.00 OTOOO HOME HEALTH AGENCY COST 0 0 0 0 0 70. 73.00 O7300 CMHC 5, 271 0 0 0 73. 973.00 ORHOC 0 0 0 0 73. 73. 90.00 080000 MALPRACTICE PREMIUMS & PAID LOSSES 80. 81. 80. 81. 81.00 80.00 83. 80.00 83.00 83.00 80.00 1.069,338 91,799 1.321,037 2.361,112 82. 83.00 08300 HOSPICE 0 0 0 0 0 90. 90.00 SUBTOTALS (sum of Lines 1-84) 2,406,383 1,069,338 91,7	60.00		0	0		0	0	60.00
62.00 06200 FOHC 0 0 0 0 0 62.0 63.00 06300 DAY CARE 0 0 0 0 0 63.0 63.0 0 0 0 0 0 63.0 0			-					
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY OST 0 0 0 0 0 0 70.00 71.00 O7100 AMBULANCE 5, 271 0 0 0 0 0 0 70.71.00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>62.00</td>								62.00
70.00 07000 HOME HEALTH AGENCY COST 0 <td>63.00</td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td>63.00</td>	63.00		0	0	C	0	0	63.00
71.00 07100 AMBULANCE 5, 271 0 0 0 0 71. 73.00 07300 CMHC 0 0 0 0 0 0 73. SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80. 81.00 08100 INTEREST EXPENSE 81. 82.00 08200 UTI LI ZATI ON REVIEW - SNF 81. 83.00 08300 HOSPI CE 0 0 0 83. 89.00 SUBTOTALS (sum of Lines 1-84) 2,406,383 1,069,338 91,799 1,321,037 2,361,112 89. NONREL IMBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90. 91.00 90.00 0 0 0 0 90. 91.00 90.00 0 0 0 0 0 91. 92.00 92.00 93.00 93.00 90.00 0 0 0 90. 0 0	70.00						0	70.00
73.00 07300 CMHC 0 <t< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td></t<>				0				
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80. 81.00 08100 I NTEREST EXPENSE 81. 82.00 08200 UTI LI ZATI ON REVIEW - SNF 82. 83.00 08300 HOSPI CE 0 0 0 83. 89.00 SUBTOTALS (sum of lines 1-84) 2,406,383 1,069,338 91,799 1,321,037 2,361,112 89. 90.00 O9000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90. 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90. 91.00 09100 BARBER AND BEAUTY SHOP 843 3,793 0 4,969 91. 92.00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 92. 93.00 09300 NONPAI D WORKERS 0 0 0 0 93. 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94. 95.00 09500 DAYCARE 147,654				0		0		
81.00 08100 INTEREST EXPENSE 81. 82.00 08200 UTI LI ZATI ON REVIEW - SNF 0 0 0 0 82. 83.00 08300 HOSPI CE 0 0 0 0 0 83. 89.00 SUBTOTALS (sum of lines 1-84) 2,406,383 1,069,338 91,799 1,321,037 2,361,112 89. NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COFFEE SHOPS & CANTEEN 0 0 0 0 90. 90.00 090100 BARBER AND BEAUTY SHOP 843 3,793 0 4,969 0 91. 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92. 93.00 09300 NONPAI D WORKERS 0 0 0 0 93. 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94. 95.00 09500 DAYCARE 147,654 0 0 0 95. 99.00 Negati ve Cost Centers 0 0 0			· · · · ·					
82.00 08200 UTI LI ZATI ON REVIEW - SNF 82. 82. 83.00 08300 HOSPICE 0 0 0 0 83. 89.00 SUBTOTALS (sum of Lines 1-84) 2,406,383 1,069,338 91,799 1,321,037 2,361,112 89. NONREL IMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90. 91.00 0 0 90. 91.00 0 0 90. 91.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 91.00 93.00 00,000 0 92. 93.00 09300 NONPAID WORKERS 0 0 0 93. 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94.00 940.00 940.00 94.00 940.00								80.00
83.00 08300 HOSPICE 0 0 0 0 0 83. 89.00 SUBTOTALS (sum of lines 1-84) 2,406,383 1,069,338 91,799 1,321,037 2,361,112 89. 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90. 91.00 9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90. 91.00 9100 BARBER AND BEAUTY SHOP 843 3,793 0 4,969 0 91. 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92. 93.00 09300 NONPAI D WORKERS 0 0 0 0 92. 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94. 95.00 OS DAYCARE 147,654 0 0 0 94. 98.00 Cross Foot Adjustments 0 0 0 0 98. 99.00								81.00
B9.00 SUBTOTALS (sum of lines 1-84) 2,406,383 1,069,338 91,799 1,321,037 2,361,112 89. NONREI MBURSABLE COST CENTERS 0 0 0 0 0 90. 90.00 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90. 91.00 9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90. 91.00 9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90. 91.00 91.00 94.09 0 91. 92.00 92.00 09100 BARBER AND BEAUTY SHOP 843 3,793 0 4,969 0 91. 92. 93.00 00300 NONPAI D WORKERS 0 0 0 0 92. 93.00 94.00			0	0			0	82.00
NONREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90. 91.00 09100 BARBER AND BEAUTY SHOP 843 3,793 0 4,969 0 91. 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92. 93.00 09300 NONPAI D WORKERS 0 0 0 0 93. 94.00 09400 PATI ENTS LAUNDRY 0 0 0 93. 95.00 09500 DAYCARE 147, 654 0 0 0 94. 98.00 Cross Foot Adjustments 0 0 0 98. 0 0 0 98. 99.00 Negati ve Cost Centers 0 0 0 0 99. 99. 90. 0 0 99.			2 406 383	1 069 338	91 799	1 321 037		1
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90. 90. 91. 00 09100 BARBER AND BEAUTY SHOP 843 3,793 0 4,969 0 91. 92. 00 00 0 0 0 91. 92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92. 93.00 09300 NONPAID WORKERS 0 0 0 0 0 93. 94. 94.00	07.00	NONREI MBURSABLE COST CENTERS	2, 100, 000	1,007,000	, ,,,,,,	1, 021, 007	2,001,112	07.00
92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92. 93.00 09300 NONPAI D WORKERS 0 0 0 0 93.00 93.00 09300 NONPAI D WORKERS 0 0 0 0 93.00 93.00 00 94.00 0 0 0 0 93.00 94.00 0 94.00 0 0 0 0 94.00 94.00 94.00 0 0 0 0 94.00 95.00 95.00 96.00 0 0 0 0 0 97.00 99.00 Negative Cost Centers 0 0 0 0 0 0 97.00		09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0		
93.00 09300 NONPAID WORKERS 0 0 0 93. 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94. 95.00 09500 DAYCARE 147,654 0 0 0 95. 98.00 Cross Foot Adjustments 0 0 0 0 98. 99.00 Negative Cost Centers 0 0 0 0 99.			843	3, 793	C	4, 969		
94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 94.00 94.00 95.00 97.00 DAYCARE 147,654 0 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 0 98.00 0 99.00 Negative Cost Centers 0 0 0 0 99.00 0 0 0 0 99.00			0	0		0		
95.00 09500 DAYCARE 147,654 0 0 0 95. 98.00 Cross Foot Adjustments 0 0 0 0 98. 99.00 Negative Cost Centers 0 0 0 0 99.			0	0				
98.00 Cross Foot Adjustments 0 0 0 0 98. 99.00 Negative Cost Centers 0 0 0 0 99.			147.654	0		0		
99.00 Negative Cost Centers 0 0 0 0 0 99.			0	0		0		
100. 00 TOTAL 2, 554, 880 1, 073, 131 91, 799 1, 326, 006 2, 361, 112 100.			0	0	C	0		
	100.00	DI I TOTAL	2, 554, 880	1, 073, 131	91, 799	1, 326, 006	2, 361, 112	100. 00

	Financial Systems	PEACE CARE AT					eu of Form CMS-2	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315413		: 1/01/2021 2/31/2021	Worksheet B Part I Date/Time Pre 5/23/2022 8:5	pared: 7 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	RE	EDI CAL CORDS & I BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS	,						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES							1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT							2.00
3.00	00300 EMPLOYEE BENEFITS							3.00
4.00	00400 ADMI NI STRATI VE & GENERAL							4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS							5.00
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG							6.00 7.00
7.00 8.00	00800 DI ETARY							8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	675, 297						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	075,277	0					10.00
11.00	01100 PHARMACY	0	0		0			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	86, 106		12.00
13.00	01300 SOCIAL SERVICE	0	0		0	0	230, 705	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
15.00	01500 RECREATI ON	0	0		0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	TT						
30.00	03000 SKILLED NURSING FACILITY	675, 297	0		0	86, 106	230, 705	30.00
31.00	03100 NURSING FACILITY	0	0		0	0	0	31.00
32.00	03200 I CF/I I D	0	0		0	0		32.00
33.00	O3300 OTHER LONG TERM CARE	0	0		0	0	0	33.00
40, 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0		0	0	0	40.00
40.00	04100 LABORATORY	0	0		0	0		40.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0	0	0	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	0	0		0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
40.00	OUTPATI ENT SERVICE COST CENTERS	0	0		0	0	0	40.00
60.00 61.00	06100 RURAL HEALTH CLINIC	0	0		0	0		60.00 61.00
62.00	06200 FQHC	0	0		0	0	0	62.00
	06300 DAY CARE	0	0		0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS			1		-		
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
	07100 AMBULANCE	0	0		0	0	0	71.00
73.00	07300 CMHC	0	0		0	0	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 83.00	08200 UTI LI ZATI ON REVI EW - SNF	0	0		0	0	0	82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	675, 297	0		0 0	86, 106	0 230, 705	83.00 89.00
69.00	NONREIMBURSABLE COST CENTERS	075, 297	0		U	80, 100	230, 705	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0	0		91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	0	94.00
95.00	09500 DAYCARE	0	0		0	0	0	95.00
98.00	Cross Foot Adjustments	0	0					98.00
99.00	Negative Cost Centers	0	0		0	0	0	
100.00	D TOTAL	675, 297	0		0	86, 106	230, 705	100.00

Heal th	Financial Systems	PEACE CARE A	AT ST. ANNS		In Lie	u of Form CMS-	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315413	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/23/2022 8:5	pared: 7 am
			OTHER GENERAL SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	RECREATI ON	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
4 00	GENERAL SERVICE COST CENTERS	1	1	1			1 1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00 9.00							8.00
9.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY						9.00 10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 RECREATION	0	596, 022				15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		50(000	11 000 (0	7	11 000 (07	1 00 00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0				11, 809, 627 0	30.00 31.00
31.00	03200 I CF/I I D				0 0 0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE			1	0 0	0	33.00
	ANCI LLARY SERVICE COST CENTERS		-	1	-1 -		
40.00	04000 RADI OLOGY	0	0	28, 12	27 0	28, 127	40.00
41.00	04100 LABORATORY	0	-			83, 237	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0		0 0	715 209	
44.00	04400 PHISICAL THERAPY			715, 39 539, 06		715, 398 539, 062	1
46.00	04600 SPEECH PATHOLOGY		0			18, 088	1
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	55, 98	88 0	55, 988	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0			254, 825	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	-		0 0	0	50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVI CE COST CENTERS	0	0	1	0 0	0	51.00
60.00	06000 CLINIC	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0			0 0	0	61.00
62.00	06200 FQHC						62.00
63.00	06300 DAY CARE	0	0		0 0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS	0	0		0 0		1 70 00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE		0		0 0	0	70.00 71.00
73.00	07300 CMHC				0 0	29,003	1
/01/00	SPECIAL PURPOSE COST CENTERS				<u> </u>		1 / 01 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF	-	_			_	82.00
83.00	08300 HOSPICE	0	-	10 504 01	0 0 5 0	0	1
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	596, 022	13, 534, 01	5 0	13, 534, 015	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP			1		13, 506	1
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	1
95.00	09500 DAYCARE	0	0	830, 97	0	830, 977	
98.00 99.00	Cross Foot Adjustments Negative Cost Centers					0	1
100.00	5	0	596, 022	14, 378, 49	0 08 0		
	1 1		0,0,022	1	-1 0	, ., ., ., .,	

	Financial Systems	PEACE CARE A				u of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315413	Period: From 01/01/2021 To 12/31/2021		
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDGS & FI XTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		Related Costs 0	1.00	2.00	2A	3.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	0		0 0	0	2.00 3.00
3.00 4.00	00400 ADMI NI STRATI VE & GENERAL	0	163, 175		0 163, 175		
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	36, 719		0 36, 719		1
6.00	00600 LAUNDRY & LINEN SERVICE	0	34, 108		0 34, 108	0	6.00
7.00	00700 HOUSEKEEPI NG	0	9, 339		0 9, 339	0	7.00
8.00	00800 DI ETARY	0	85, 238		0 85, 238		
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0			0	
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0			0	1
13.00	01300 SOCIAL SERVICE	0	1, 380		0 1, 380		
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
15.00	01500 RECREATION	0	62, 432		0 62, 432	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1		1	1	1	
30.00	03000 SKI LLED NURSI NG FACI LI TY	0	527, 104		0 527, 104	0	
31.00	03100 NURSING FACILITY	0	0		0 0		
32.00 33.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0	0		0 0 0 0		
33.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		0 0	0	33.00
40.00	04000 RADI OLOGY	0	0		0 0	0	40.00
41.00	04100 LABORATORY	0	0		0 0		1
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
44.00	04400 PHYSI CAL THERAPY	0	40, 412		0 40, 412		
45.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0 0	0	
46.00 47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	-1	-	1	-	-	
60.00	06000 CLINIC	0	0		0 0		1
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0	0	61.00 62.00
63.00	06300 DAY CARE	0	0		0 0	0	
	OTHER REIMBURSABLE COST CENTERS			1	-1 -	-	
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	0		0 0		
73.00	07300 CMHC	0	0		0 0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS			1			
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	0	1
89.00	SUBTOTALS (sum of lines 1-84)	0	959, 907		0 959, 907	0	89.00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	2, 696		0 2,696		
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0			0	1
93.00 94.00	09400 PATIENTS LAUNDRY	0	0			0	
95.00	09500 DAYCARE	0	0		0 0	0	
98.00	Cross Foot Adjustments				0		98.00
99.00	Negative Cost Centers		0		0 0	0	
100.00	TOTAL	0	962, 603	I	0 962, 603	0	100. 00

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/23/2022 8:5	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICI	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1.00 2.00 3.00 4.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	163, 175					1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION	12, 179 497 14, 899 23, 651 7, 664	48, 898 2, 187 599 5, 465 0	36, 79	2 0 24, 837 0 2, 943 0 0		1
10. 00 11. 00 12. 00 13. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0 0 977 2, 567	0 0 0 88		0 0 0 0 0 0 0 48	0 0 0 0	10.00 11.00 12.00 13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 RECREATION INPATIENT ROUTINE SERVICE COST CENTERS	0 4, 461	0 4, 003		0 0 0 2, 156		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	68, 716 0 0	33, 792 0 0 0		2 18, 202 0 0 0 0 0 0 0 0	117, 297 0 0 0	31.00 32.00
40.00	ANCI LLARY SERVI CE COST CENTERS	319	0		0 0	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	945 0	C C		0 0 0 0	0	41.00 42.00
43.00 44.00 45.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY	0 6, 628 6, 118	0 2, 591 0		0 0 0 1, 395 0 0	0 0 0	44.00
46.00 47.00 48.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	205 0 635	C		0 0 0 0 0 0	0 0 0	47.00
49.00 50.00 51.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	2, 892 0 0	0 0 0		0 0 0 0 0 0	0	49.00 50.00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	000	C		0 0 0 0	0	61.00
62.00 63.00	06200 FQHC 06300 DAY CARE OTHER REIMBURSABLE COST CENTERS	0	C		0 0	0	62.00 63.00
	07100 AMBULANCE 07300 CMHC	0 337 0	C C C		0 0 0 0 0 0	0	71.00
80. 00 81. 00 82. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						80.00 81.00 82.00
83. 00 89. 00	08300 HOSPI CE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS	0 153, 690	0 48, 725	36, 79	0 0 2 24, 744	0 117, 297	
90.00 91.00 92.00 93.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0 54 0 0	0 173 0 0		0 0 0 93 0 0 0 0	0 0 0 0	91.00 92.00 93.00
94.00 95.00 98.00 99.00	09400 PATIENTS LAUNDRY 09500 DAYCARE Cross Foot Adjustments Negative Cost Centers	0 9, 431	0			0 0 0 0	95.00 98.00
100.00		163, 175	48, 898	36, 79	2 24,837		

ALLOCAT	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315413		riod: om 01/01/2021 12/31/2021	Worksheet B Part II Date/Time Pre 5/23/2022 8:5	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY		MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS							
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	7,664	0					1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
	01100 PHARMACY	0	0		0			11.00
	01200 MEDICAL RECORDS & LIBRARY	0	0		0	977		12.00
	01300 SOCIAL SERVICE	0	0		0	0	4, 083	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
H	01500 RECREATION	0	0		0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1		I				
	03000 SKI LLED NURSI NG FACI LI TY	7,664	0		0	977	4, 083	30.00
	03100 NURSING FACILITY 03200 ICF/IID	0	0		0 0	0	0	31.00 32.00
	03300 OTHER LONG TERM CARE	0	0		0	0	0	32.00 33.00
H	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0				0	00.00
E E	04000 RADI OLOGY	0	0		0	0	0	40.00
41.00	04100 LABORATORY	0	0		0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43.00
	04400 PHYSI CAL THERAPY	0	0		0	0	0	44.00
	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0	0	0	45.00 46.00
	04700 ELECTROCARDI OLOGY	0	0		0	0	0	40.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS		0	1	0	0	0	(0.00
	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0	0	0	60.00 61.00
	06200 FQHC	0	0		0	0	0	62.00
	06300 DAY CARE	0	0		0	0	0	63.00
Ī	OTHER REIMBURSABLE COST CENTERS							
	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
	07100 AMBULANCE	0	0		0	0	0	71.00
	07300 CMHC	0	0		0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS	1						<u>00 00</u>
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00 81.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE							81.00
80. 00 81. 00 82. 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	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 7,664	0		0	0 977	0 4, 083	81. 00 82. 00
80.00 81.00 82.00 83.00 89.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	7,664	0		0	977	4, 083	81. 00 82. 00 83. 00 89. 00
80. 00 81. 00 82. 00 83. 00 89. 00 90. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	-	0		0	· · · · · · · · · · · · · · · · · · ·	4, 083	81.00 82.00 83.00 89.00 90.00
80. 00 81. 00 82. 00 83. 00 89. 00 90. 00 91. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	7,664	0		0 0 0	977	4, 083 0 0	81.00 82.00 83.00 89.00 90.00 91.00
80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	7,664	0		0	977	4, 083 0 0 0	81.00 82.00 83.00 89.00 90.00 91.00 92.00
80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	7,664	0		0 0 0	977	4, 083 0 0 0 0 0 0	81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00
80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	7,664	0		0 0 0 0	977 0 0 0 0 0	4, 083 0 0 0	81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00
80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	7,664	0		0 0 0 0 0 0	977 0 0 0 0 0	4, 083 0 0 0 0 0 0 0 0 0	81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00
80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00 95.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 DAYCARE	7,664	0		0 0 0 0 0 0 0	977 0 0 0 0 0	4, 083 0 0 0 0 0 0 0 0	81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00 95.00

Heal th	Financial Systems	PEACE CARE A	AT ST. ANNS		In Lie	u of Form CMS-2	2540-10
	TION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/23/2022 8:5	pared: 7 am
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVI CE RECREATI ON	Subtotal	Post Step-Down Adjustments	Total	-
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY						1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00 11.00 12.00 13.00 14.00 15.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE 01400 NURSI NG AND ALLI ED HEALTH EDUCATI ON 01500 RECREATI ON	0					9.00 10.00 11.00 12.00 13.00 14.00 15.00
20.00			72 052	007 (7		887, 679	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0			9 0 0 0	887,679	30.00 31.00
	03200 CF/I D	0			0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0			0 0	0	33.00
00.00	ANCI LLARY SERVICE COST CENTERS		۰ ۱		<u> </u>	<u> </u>	00.00
40.00	04000 RADI OLOGY	0	0	31	9 0	319	40.00
41.00	04100 LABORATORY	0		94		945	
	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY		0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	51, 02	-	51, 026	44.00
	04400 PHISICAL THERAPY	0	0				
45.00		0	0	6, 11		6, 118	1
46.00	04600 SPEECH PATHOLOGY	0	0	20		205	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	63		635	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	0	2, 89		2, 892	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	-		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC						62.00
63.00	06300 DAY CARE	0	0		0 0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	0	33	7 0	337	71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	73, 052	950, 15	6 0	950, 156	89.00
	NONREI MBURSABLE COST CENTERS						1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	3, 01	6 0	3, 016	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		o o	0	
93.00	09300 NONPAID WORKERS	0	0		o o	0	93.00
	09400 PATIENTS LAUNDRY	0	0		0 0	0	1
	09500 DAYCARE	0	n	9, 43	1 0	9, 431	
98.00	Cross Foot Adjustments	0	0	., 10	o n	0	1
99.00	Negative Cost Centers	0	0		o n	0	1
100.00		0	73, 052	962, 60	3 0		
			, 0, 002	,02,00	-, 9	,02,000	1.00.00

	Financial Systems LLOCATION - STATISTICAL BASIS	PEACE CARE A			Period:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
				'	12/31/2021	5/23/2022 8:5	
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
		FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
		1.00	2.00	SALARIES) 3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS - BLDGS & FIXTURES	90, 706					1.0
00 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	90, 706	6, 250, 223			2.0
00	00400 ADMINISTRATIVE & GENERAL	15, 376	-	463, 384		11, 823, 618	
00	00500 PLANT OPERATION, MAINT. & REPAIRS	3, 460		229, 340		882, 449	
00	00600 LAUNDRY & LINEN SERVICE	3, 214		116		36, 025	1
00 00	00700 HOUSEKEEPI NG 00800 DI ETARY	880 8, 032		691, 447 539, 025		1, 079, 586	
00	00900 NURSI NG ADMI NI STRATI ON	0,032	0,032	418, 715		1, 713, 732 555, 305	
	01000 CENTRAL SERVICES & SUPPLY	0	0	(0 0	0	1
	01100 PHARMACY	0	0	C	0 0	0	
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	130	0 130	16, 369		70, 806	
	01400 NURSING AND ALLIED HEALTH EDUCATION	130		137, 829		186, 024	1
	01500 RECREATION	5, 883		178, 512	, v	323, 236	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 SKI LLED NURSI NG FACI LI TY	49,669		3, 224, 018		4, 979, 265	
	03100 NURSING FACILITY 03200 ICF/IID				, o	0	31.0
	03300 OTHER LONG TERM CARE	0	-		-	0	
	ANCI LLARY SERVI CE COST CENTERS	1	1	Π	Т	1	
	04000 RADI OLOGY	0	0	0		23, 129	
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0				68, 447 0	41. 42.
	04300 OXYGEN (INHALATION) THERAPY	0	0			0	43.
l. 00	04400 PHYSI CAL THERAPY	3, 808	3, 808	7, 685	5 0	480, 261	44.
	04500 OCCUPATI ONAL THERAPY	0	0	332, 532		443, 277	
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0		11, 251		14, 874	1
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	46, 040	
	04900 DRUGS CHARGED TO PATIENTS	0	0	C	0 0	209, 546	49.
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0 0	0	
. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	51.
). 00	06000 CLINIC	0	0	0	0 0	0	60.
	06100 RURAL HEALTH CLINIC	0	0	C		0	61.
	06200 FQHC	_	_			_	62.
3.00	06300 DAY CARE OTHER REIMBURSABLE COST CENTERS	0	0	(0 0	0	63.
). 00	07000 HOME HEALTH AGENCY COST	0	0	0	0 0	0	70.
	07100 AMBULANCE	0	0	C		24, 392	
3.00	07300 CMHC	0	0	(00	0	73.
). 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	1	1		1		80.
	08100 INTEREST EXPENSE						80.
	08200 UTILIZATION REVIEW - SNF						82.
	08300 HOSPI CE	0	-	(0 0	0	
9.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	90, 452	90, 452	6, 250, 223	3 -2, 554, 880	11, 136, 394	89.
). 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0	0	90.
	09100 BARBER AND BEAUTY SHOP	254	254	0	-	3, 901	
	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0 0	0	
	09300 NONPALD WORKERS	0	0		0	0	
	09400 PATIENTS LAUNDRY 09500 DAYCARE					0 683, 323	
3. 00	Cross Foot Adjustments					000, 020	98.
9.00	Negative Cost Centers						99.
02.00	Cost to be allocated (per Wkst. B,	962, 603	0	2, 012, 400	D	2, 554, 880	102.
03.00	Part I) Unit cost multiplier (Wkst. B, Part I)	10. 612341	0. 000000	0. 321973	3	0. 216083	103
)3.00)4.00	Cost to be allocated (per Wkst. B,	10.012341	0.00000	0.3219/3		163, 175	
. 20	Part II)						
05.00	Unit cost multiplier (Wkst. B, Part			0.00000	D	0. 013801	105.0

Heal th	Financial Systems	PEACE CARE A	T ST. ANNS		In Lie	u of Form CMS-:	2540-10
	LOCATION - STATISTICAL BASIS				eriod: rom 01/01/2021	Worksheet B-1	
					0 12/31/2021	Date/Time Pre	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/23/2022 8:5 NURSI NG	/ am
		OPERATI ON,	LINEN SERVICE		(MEALS SERVED)		
		MAINT. & REPAIRS	(POUNDS OF LAUNDRY)			(DI RECT	
		(SQUARE FEET)				NURSI NG)	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
	DO100 CAP REL COSTS - BLDGS & FIXTURES						1.00
	DO200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3.00 4.00
	DO500 PLANT OPERATION, MAINT. & REPAIRS	71, 870					5.00
	DO600 LAUNDRY & LINEN SERVICE	3, 214					6.00
	00700 HOUSEKEEPI NG 00800 DI ETARY	880 8, 032		67, 776 8, 032			7.00
	DO900 NURSI NG ADMI NI STRATI ON	0,032		0,032	03, 337	126, 586	9.00
	01000 CENTRAL SERVICES & SUPPLY	0	C	0	0	0	10.00
	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0		0	0	0	11.00
	D1300 SOCIAL SERVICE	130		130	0	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
	01500 RECREATION NPATIENT ROUTINE SERVICE COST CENTERS	5, 883	0	5, 883	0	0	15.00
	D3000 SKILLED NURSING FACILITY	49, 669	34, 453	49, 669	103, 359	126, 586	30.00
31.00	D3100 NURSING FACILITY	0	C	-	0	0	31.00
		0				0	32.00 33.00
	03300 OTHER LONG TERM CARE	0		<u>ı</u> 0	0	0	33.00
40.00	D4000 RADI OLOGY	0	C	0	0	0	
	D4100 LABORATORY	0	0	0	0	0	41.00
	D4200 I NTRAVENOUS THERAPY D4300 OXYGEN (I NHALATI ON) THERAPY				0	0	42.00 43.00
44.00	04400 PHYSI CAL THERAPY	3, 808	0	3, 808	0	0	44.00
	04500 OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY				0	0	46.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
	D5000 DENTAL CARE - TITLE XIX ONLY D5100 SUPPORT SURFACES				-	0	50.00 51.00
	DUTPATIENT SERVICE COST CENTERS						01100
		0				0	60.00
	D6100 RURAL HEALTH CLINIC D6200 FQHC	0	C	0	0	0	61.00 62.00
	D6300 DAY CARE	0	C	0	0	0	
	OTHER REIMBURSABLE COST CENTERS	0	0		0	0	70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE				0	0	70.00 71.00
	07300 CMHC	0	0	0		0	
	SPECIAL PURPOSE COST CENTERS	1	[1			
	D8000 MALPRACTICE PREMIUMS & PAID LOSSES D8100 INTEREST EXPENSE						80.00 81.00
	D8200 UTI LI ZATI ON REVIEW - SNF						82.00
	D8300 HOSPI CE	0	0	0	0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	71, 616	34, 453	67, 522	103, 359	126, 586	89.00
	D9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	0	0	0	90.00
	D9100 BARBER AND BEAUTY SHOP	254	0	254	0	0	
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS				0	0	
	09400 PATIENTS LAUNDRY	0	0	0	0	0	
	09500 DAYCARE	0	0	0	0	0	
98.00 99.00	Cross Foot Adjustments Negative Cost Centers						98.00 99.00
102.00	Cost to be allocated (per Wkst. B,	1, 073, 131	91, 799	1, 326, 006	2, 361, 112	675, 297	
	Part I)						
103.00 104.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	14. 931557 48, 898				5. 334689	103.00 104.00
104.00	Part II)	40,090	30, 792	24,037	117,297	7,004	104.00
105.00	Unit cost multiplier (Wkst. B, Part	0. 680367	1.067890	0. 366457	1. 134850	0. 060544	105.00
	11)	I	I	I	I		I

Health Financial Systems	PEACE CARE AT	ST. ANNS		In Lie	eu of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS				Period:	Worksheet B-1	
				rom 01/01/2021 o 12/31/2021	Date/Time Pre	pared:
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	5/23/2022 8:5 NURSI NG AND	7 am
cost center bescription	SERVICES &	(COSTED	RECORDS &	SUCIAL SERVICE	ALLI ED HEALTH	
	SUPPLY	REQUI S)	LI BRARY	(TIME SPENT)	EDUCATI ON	
	(COSTED		(TIME SPENT)		(ASSI GNED	
	REQUI S) 10.00	11.00	12.00	13.00	TIME) 14.00	
GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00 00300 EMPLOYEE BENEFITS 4. 00 00400 ADMINISTRATIVE & GENERAL						3.00
4. 00 00400 ADMI NI STRATI VE & GENERAL 5. 00 00500 PLANT OPERATI ON, MAI NT. & REPAI RS						4.00 5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7.00 00700 HOUSEKEEPI NG						7.00
8. 00 00800 DI ETARY						8.00
9.00 00900 NURSI NG ADMI NI STRATI ON						9.00
10. 00 01000 CENTRAL SERVI CES & SUPPLY 11. 00 01100 PHARMACY	255, 586	0				10.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	0	34, 453			12.00
13.00 01300 SOCI AL SERVI CE	0	0	C			13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0 0	0	14.00
15. 00 01500 RECREATION	0	0	C	0 0	0	15.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 SKI LLED NURSI NG FACI LI TY	0	0	34, 453	34, 453	0	30.00
31. 00 03100 NURSING FACILITY	0	0				31.00
32. 00 03200 I CF/I I D	0	0				32.00
33.00 03300 OTHER LONG TERM CARE	0	0	C	0	0	33.00
ANCI LLARY SERVI CE COST CENTERS						
40. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY	0	0			0	40.00
41.00 04100 LABORATORT 42.00 04200 INTRAVENOUS THERAPY	0	0			0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0	0	C	0 0	0	43.00
44.00 04400 PHYSI CAL THERAPY	0	0	C	0 0	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	C	0	0	45.00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	0	0			0	46.00 47.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	46,040	0			0	47.00
49.00 04900 DRUGS CHARGED TO PATIENTS	209, 546	0	C	0	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0				
51.00 05100 SUPPORT SURFACES	0	0	C	0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS	0		0	0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0	0				
62.00 06200 FQHC	-			-		62.00
63. 00 06300 DAY CARE	0	0	C	0 0	0	63.00
OTHER REIMBURSABLE COST CENTERS	0	0		0		70.00
70.00 07000 HOME HEALTH AGENCY COST 71.00 07100 AMBULANCE	0	0			0	70.00 71.00
73. 00 07300 CMHC	0	0		0 0	0	
SPECIAL PURPOSE COST CENTERS						
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 08100 INTEREST EXPENSE 82.00 08200 UTI LI ZATI ON REVIEW - SNF						81.00
82. 00 08200 UTI LI ZATI ON REVIEW - SNF 83. 00 08300 HOSPI CE	0	0	0	0	0	82.00 83.00
89.00 SUBTOTALS (sum of lines 1-84)	255, 586	0	34, 453	34, 453		
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0		
91. 00 09100 BARBER AND BEAUTY SHOP 92. 00 09200 PHYSI CLANS PRI VATE OFFICES	0	0		0	0	
93. 00 09300 NONPALD WORKERS	0	0			0	
94. 00 09400 PATIENTS LAUNDRY	o	0		0	0	1
95. 00 09500 DAYCARE	0	0	c c	0	0	
98.00 Cross Foot Adjustments						98.00
99.00 Negative Cost Centers		0	04 104	220 705	_	99.00
102.00 Cost to be allocated (per Wkst. B, Part I)	0	0	86, 106	230, 705	0	102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	2. 499231	6. 696224	0. 000000	103.00
104.00 Cost to be allocated (per Wkst. B,	0	0	977			104.00
Part II)	0.000000	0 000000	0 00005-	0 440500	0.000000	105 00
105.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 028357	0. 118509	0.00000	105.00
	i I		I	ļ.	I	I

	Financial Systems	PEACE CARE AT		No . 215412		eu of Form CMS	
CUST A	LLOCATION - STATISTICAL BASIS		Provi der	No.: 315413	Period: From 01/01/2021	Worksheet B-	
					To 12/31/2021	Date/Time Pro	
		OTHER GENERAL	I			0,20,2022 01	
	Cast Contor Description	SERVI CE RECREATI ON					
	Cost Center Description	(CENSUS)					
		15.00					
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00
4.00 4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
5.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
3.00							8.00
0.00 0.00	00900 NURSI NG ADMI NI STRATI ON						9.00
	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY						10.00
	01200 MEDICAL RECORDS & LIBRARY						12.00
	01300 SOCIAL SERVICE						13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION						14.00
15.00	01500 RECREATION	34, 453					15.00
0 00	INPATIENT ROUTINE SERVICE COST CENTERS	24 452					
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	34, 453 0					30.00
	03200 I CF/I I D	0					32.00
	03300 OTHER LONG TERM CARE	0					33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0					40.00
	04100 LABORATORY	0					41.00
	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	0					42.00
	04400 PHYSI CAL THERAPY	0					43.00
	04500 OCCUPATI ONAL THERAPY	o					45.00
	04600 SPEECH PATHOLOGY	0					46.00
	04700 ELECTROCARDI OLOGY	0					47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					48.00
	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0					49.00
	05100 SUPPORT SURFACES	0					51.00
	OUTPATIENT SERVICE COST CENTERS	L -1					
	06000 CLI NI C	0					60.00
	06100 RURAL HEALTH CLINIC	0					61.00
	06200 FQHC						62.00
63.00	06300 DAY CARE OTHER REIMBURSABLE COST CENTERS	0					63.00
70.00	07000 HOME HEALTH AGENCY COST	0					70.00
	07100 AMBULANCE	0					71.00
73.00	07300 CMHC	0					73.00
~~ ~~	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW – SNF						82.00
B3. 00	08300 HOSPI CE	0					83.00
89.00	SUBTOTALS (sum of lines 1-84)	34, 453					89.00
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0					90.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0					91.00
	09200 PHYSICIANS PRIVATE OFFICES	0					92.00
	09400 PATIENTS LAUNDRY	0					94.00
5.00	09500 DAYCARE	0					95.00
8.00	Cross Foot Adjustments						98.00
9.00	Negative Cost Centers	F0/ 00-					99.00
02.00		596, 022					102.00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	17. 299568					103.00
103.00		73, 052					103.00
20	Part II)						
105.00		2. 120338					105.00
	11)						

Health Financial Systems	PEACE CARE AT ST.	ANNS		In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT	T COST CENTERS	Provi der	No.: 315413	Peri od:	Worksheet C	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
				10 12/31/2021	5/23/2022 8:5	
Cost Center Description			Total (from	Total Charges	Ratio (col. 1	
			Wkst. B, Pt I	1	di vi ded by	
			col. 18)		col. 2	
			1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS						
40. 00 04000 RADI OLOGY			28, 12		0.000000	1
41. 00 04100 LABORATORY			83, 23	37 0	0.00000	
42.00 04200 I NTRAVENOUS THERAPY				0 0	0.000000	•
43.00 04300 OXYGEN (INHALATION) THERAPY				0 0	0.00000	
44. 00 04400 PHYSI CAL THERAPY			715, 39			
45.00 04500 OCCUPATIONAL THERAPY			539, 00			
46.00 04600 SPEECH PATHOLOGY			18, 08	64, 033		
47.00 04700 ELECTROCARDI OLOGY				0 0	0.00000	1
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			55, 98		0.00000	1
49. 00 04900 DRUGS CHARGED TO PATIENTS			254, 82	162, 605		
50.00 05000 DENTAL CARE - TITLE XIX ONLY				0 0	0.00000	1
51.00 05100 SUPPORT SURFACES				0 0	0. 000000	51.00
OUTPATI ENT SERVI CE COST CENTERS 60. 00 06000 CLI NI C			1	0 0	0,000000	60.00
61. 00 06100 RURAL HEALTH CLINIC				0 0	0. 000000	61.00
62. 00 06200 FOHC						62.00
63. 00 06300 DAY CARE				0	0. 000000	
71. 00 07100 AMBULANCE			29,60		0. 000000	
100.00 Total			1, 724, 38			100.00
			1,724,30	1, 047, 140	I	1100.00

Health Financial Systems	PEACE CARE A				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315413	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/23/2022 8:5	
		Title	XVIII (1)	Skilled Nursing		
				Facility		
		Health Care Pi	rogram Charge	es Health Care	Program Cost	
Cost Center Description	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					
	Column 3)					
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TENT COST					-
ANCI LLARY SERVI CE COST CENTERS	1	-	1	-1 -	-	
40. 00 04000 RADI OLOGY	0. 000000			0 0	0	
41.00 04100 LABORATORY	0. 000000			0 0	0	
42.00 04200 I NTRAVENOUS THERAPY	0. 000000			0 0	0	
43.00 04300 0XYGEN (INHALATION) THERAPY	0. 000000			0 0	0	101.00
44. 00 04400 PHYSI CAL THERAPY	0. 850922			0 415, 308		1 1 1 00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 691310			0 347, 553		
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	0. 282479			0 8, 823		
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			0 0		
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 567141	158, 537		0 248, 450	-	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0 246, 430		50.00
51. 00 05100 SUPPORT SURFACES	0.000000			0 0	C	
OUTPATIENT SERVICE COST CENTERS	0.00000	0		0 0	0	51.00
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60,00
61. 00 06100 RURAL HEALTH CLINIC	0.00000			0		61.00
62. 00 06200 FQHC						62.00
63. 00 06300 DAY CARE	0. 000000	0		0 0	C	
71. 00 07100 AMBULANCE (2)	0. 000000					1
100.00 Total (Sum of Lines 40 - 71)	0.00000	1, 180, 584		0 1, 020, 134	-	100.00
(1) For title V and XIX use columns 1 2 and 4 on		1 1, 100, 004	I	1,020,104		1.00.00

(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 Financial Systems	PEACE CARE A	T ST. ANNS		In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/23/2022 8:5	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3,	line 49)	1. 567141	1.00
2.00 Program vacci ne charges (From your reco					0	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	viders, transfe	er this amoun	t to Worksheet	0	3.00
E, Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
	(From Wkst. B,			Cost (From	& Allied	
		(From Wkst. B,			Heal th Costs	
	18		Costs to Tota		for Pass	
		14)	Costs - Part (Col. 2 / Col		Through (Col. 3 x Col. 4)	
					3 X COI. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
ANCI LLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	28, 127	0			0	40.00
41. 00 04100 LABORATORY	83, 237	0	0.00000		0	41.00
42.00 04200 I NTRAVENOUS THERAPY	0	0	0.00000		0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0.00000		0	43.00
44. 00 04400 PHYSI CAL THERAPY	715, 398	0	0.00000			44.00
45.00 04500 OCCUPATI ONAL THERAPY	539, 062	0	0.00000			45.00
46.00 04600 SPEECH PATHOLOGY	18, 088	0	0.00000			46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0.00000		0	47.00
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	55, 988	0	0.0000		0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	254, 825	0	0.00000			49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000		0	50.00
51.00 05100 SUPPORT SURFACES	1 404 725	0	0.00000		0	51.00
100.00 Total (Sum of lines 40 - 52)	1, 694, 725	0	1	1, 020, 134	0	100. 00

COMPUT	Financial Systems PEACE (ATION OF INPATIENT ROUTINE COSTS	CARE AT ST. ANNS Provider No.: 315413	Period: From 01/01/2021	Worksheet D-1 Parts I-II	2540-10
			To 12/31/2021	Date/Time Pre 5/23/2022 8:5	pared: 7 am
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
1.00	Inpatient days including private room days			34, 453	
2.00	Private room days			0	2.00
3.00	Inpatient days including private room days applicable			4, 556	3.00
4.00	Medically necessary private room days applicable to t	he Program		0	4.00
5.00	Total general inpatient routine service cost			11, 809, 627	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges			13, 130, 126	
7.00	General inpatient routine service cost/charge ratio	(Line 5 divided by line 6)		0.899430	7.00
8.00	Enter private room charges from your records			0	8.00
9.00	Average private room per diem charge (Private room ch. 2)	arges line 8 divided by private	room days, line	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-privasemi-private room days)	ate room charges line 10, divide	d by	0.00	11.00
12.00	Average per diem private room charge differential (Li	ne 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 tim			0	14.00
15.00	General inpatient routine service cost net of private PROGRAM INPATIENT ROUTINE SERVICE COSTS	room cost differential (Line 5	minus line 14)	11, 809, 627	15.00
16.00	Adjusted general inpatient service cost per diem (Lin	e 15 divided by line 1)		342.77	16.00
17.00	Program routine service cost (Line 3 times line 16)	3		1, 561, 660	17.00
18.00	Medically necessary private room cost applicable to p	rogram (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost	(Line 17 plus line 18)		1, 561, 660	19.00
20. 00	Capital related cost allocated to inpatient routine so line 30 for SNF; line 31 for NF, or line 32 for ICF/I		t II column 18,	887, 679	20.00
21.00	Per diem capital related costs (Line 20 divided by I			25.76	21.00
22.00	Program capital related cost (Line 3 times line 21)			117, 363	22.0
23.00	Inpatient routine service cost (Line 19 minus line 2	2)		1, 444, 297	
24.00	Aggregate charges to beneficiaries for excess costs	(From provider records)		0	24.0
25.00	Total program routine service costs for comparison to	the cost limitation (Line 23 mi	nus line 24)	1, 444, 297	25.00
	Enter the per diem limitation (1)				26.00
	Inpatient routine service cost limitation (Line 3 tim				27.00
28.00	Reimbursable inpatient routine service costs (Line 22 (Transfer to Worksheet E, Part II, line 4) (See instru		line 27)		28.00

	1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COS	TS FOR PPS PASS-THROUGH	
1.00 Total SNF inpatient days	34, 453	1.00
2.00 Program inpatient days (see instructions)	4, 556	2.00
3.00 Total nursing & allied health costs. (see instructions) (Do n	ot complete for titles V or XIX) 0	3.00
4.00 Nursing & allied health ratio. (line 2 divided by line 1)	0. 132238	4.00
5.00 Program nursing & allied health costs for pass-through. (lin	e 3 times line 4) 0	5.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315413	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Pre	
		Title XVIII	Skilled Nursing	5/23/2022 8: 5 PPS	7 am
			Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMB	URSEMENT			
1.00	Inpatient PPS amount (See Instructions)			3, 608, 864	1.00
2.00	Nursing and Allied Health Education Activities (pass through	n payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			3, 608, 864	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			411, 439	5.00
6.00	Allowable bad debts (From your records)	· • · · · • • • · · · · · · · · · · · ·		225, 061	
7.00	Allowable Bad debts for dual eligible beneficiaries (See ins	structions)		88, 048	
B. 00	Adjusted reimbursable bad debts. (See instructions)			146, 290	
9.00	Recovery of bad debts - for statistical records only			0	
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			3, 343, 715	
12.00 13.00	Interim payments (See instructions)			3, 378, 025	
	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			-	14.00
14.50 14.55	Demonstration payment adjustment amount before sequestration	I		0	14.50 14.55
14. 55	Demonstration payment adjustment amount after sequestration			0	14.55
14.75	Sequestration for non-claims based amounts (see instructions	s)		0	
14.99	Sequestration amount (see instructions)				
16.00	Balance due provider/program (see Instructions) Protested amounts (Nonallowable cost report items in accorda	peo with CMS Dub 15 2 c	action 11E 2)	-34, 310 0	16.00
10.00	PART B - ANCI LLARY SERVICE COMPUTATION OF REIMBURSEMENT LESS			0	10.00
17.00	Ancillary services Part B	ER OF COST OR CHARGES - T	ITEL AVITE UNLT	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	17.00
19.00	Total reasonable costs (Sum of Lines 17 and 18)			0	19.00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	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 ins	structions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)			Ő	24.02
25.00	Subtotal (Sum of Lines 21 and 24, minus Lines 22 and 23)			Ő	25.00
26.00	Interim payments (See instructions)			0	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50	Demonstration payment adjustment amount before sequestration	1		0	28.50
28.55	Demonstration payment adjustment amount after sequestration			Ő	28.55
28.99	Sequestration amount (see instructions)			0	28.99
29.00	Balance due provider/program (see instructions)			0	29.00
	Protested amounts (Nonallowable cost report items) in accord			Ő	30.00

	Financial Systems PEACE CARE AT			u of Form CMS	-2540-
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY	Provider No.: 315413	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part II Date/Time Pr 5/23/2022 8:	
		Title XIX	Skilled Nursing	Cost	
			Facility		
				1 00	-
	CONDUTATION OF NET COST OF COVEDED SEDVICES			1.00	-
. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient ancillary services (see Instructions)				0 1.
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. 11, 11	no E)			0 2.
. 00	Outpatient services	ne s)			0 2.
. 00	Inpatient routine services (see instructions)				0 4.
5. 00	Utilization reviewphysicians' compensation (from provider r	ocords)			0 4.
. 00 . 00	Cost of covered services (Sum of Lines 1 - 5)				0 6.
. 00 . 00	Differential in charges between semiprivate accommodations an	d less than semi-nrivate	accommodations		0 7.
. 00 3. 00	SUBTOTAL (Line 6 minus line 7)	a ress than sempirvate			0 8.
. 00 . 00	Primary payor amounts				0 9.
0.00	Total Reasonable Cost (Line 8 minus line 9)				0 10.
0.00	REASONABLE CHARGES				10.
1.00	Inpatient ancillary service charges				0 11.
	Outpati ent servi ce charges				0 12.
3.00	Inpatient routine service charges				0 13
	Differential in charges between semiprivate accommodations an	d less than semiprivate	accommodations		0 14
	Total reasonable charges	- · · · · · · · · · · · · · · · · · · ·			0 15.
	CUSTOMARY CHARGES				_
6.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis		0 16.
7.00	Amounts that would have been realized from patients liable fo	r payment for services o	n a charge basis		0 17.
	had such payment been made in accordance with 42 CFR 413.13(e)	-		
8.00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.00000	0 18.
9.00	Total customary charges (see instructions)				0 19.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Cost of covered services (see Instructions)				0 20.
	Deducti bl es				0 21.
	Subtotal (Line 20 minus line 21)				0 22.
	Coinsurance				0 23.
	Subtotal (Line 22 minus line 23)				0 24.
	Allowable bad debts (from your records)				0 25.
6.00	Subtotal (sum of lines 24 and 25)				0 26.
7.00	Unrefunded charges to beneficiaries for excess costs erroneou	sly collected based on c	orrection of		0 27.
0 00	cost limit				
8.00	Recovery of excess depreciation resulting from provider termi utilization	nation or a decrease in	program		0 28.
9.00	Other Adjustments (see instructions) Specify				0 29.
	Amounts applicable to prior cost reporting periods resulting	from disposition of door	ociablo accote (0 29.
0.00	if minus, enter amount in parentheses)		ecianie assets (0 30.
1.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus line	s 27 and 28)			0 31.
	Interim payments	5 Z7 and 20j			0 31.
3.00	Balance due provider/program (Line 31 minus line 32) (indicat	e overnavments in parent	heses) (see		0 32.
	124.4.00 and provider program (Erne or minus rine oz) (Indicat	s storpaymonts in parent			~I 33.

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315413	Period: From 01/01/2027 To 12/31/2027		parec
		Ti tl	e XVIII	Skilled Nursing Facility		
		I npati en	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero List separately each retroactive lump sum adjustment		3, 273, 8	00	0	
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	08/03/2021	80, 9	67	0	3.
02		09/30/2021	23, 2		0	
03				0	0	
04 05				0	0	
55	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53				0	0	
54				0	0	
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		104, 2	25	0	3
~	- 3.98)		0.070.0	25		
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)		3, 378, 0	25	0	4
	TO BE COMPLETED BY CONTRACTOR		1	1	1	
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
	Program to Provider		1		1	
)1	TENTATI VE TO PROVIDER			0	0	
)2)3				0	0	
13	Provider to Program		l		0	1 2
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
2				0	0	
99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	5
0	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER			0	0	6
)2	PROVIDER TO PROGRAM		34, 3	10	0	
00	Total Medicare program liability (see instructions)		3, 343, 7		0	
				actor Name	Contractor	
					Number	
				1.00	2.00	

 8.00
 Name of Contractor

 (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.

0 Temporal 0 Notes r 0 Other r 0 Less: a receival Invento 0 Prepaid 0 Other r 0 Due fro 0 Due for 0 Buildin 0 Less: A 00 Major m 00 Less: A 00 Minor e 00 TotAL F 00 TotAL F 00 TotAL C	accounting records, complete the "General Fund" column			From 01/01/2021 To 12/31/2021	Date/Time Pre	pare
CURRENT0Cash or0Notes r0Account0Other r0Less: areceivalreceival0Invento0Derepaic0Other c0Due fro0TOTAL C0FIXED A00Land00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Maj or m00Less: A00Minor e00Other f00TOTAL F00Other f01TOTAL F00Other f01TOTAL F00Other f01TOTAL F01OTHER A00Notes f00Other c00Other c00TOTAL C00Other c00Other f00Notes f00Other c00Other f00Notes f00Other f00Notes f00Other f00Other f00Notes f00Other f00Other f00Other f00Other f00Other f00Other f00Other f00Other f		General Fund	Speci fi c	Endowment Fund	5/23/2022 8:5 Plant Fund	/ am
CURRENT0Cash or0Notes r0Account0Other r0Less: areceivalreceival0Invento0Derepaic0Other c0Due fro0TOTAL C0FIXED A00Land00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Maj or m00Less: A00Minor e00Other f00TOTAL F00Other f01TOTAL F00Other f01TOTAL F00Other f01TOTAL F01OTHER A00Notes f00Other c00Other c00TOTAL C00Other c00Other f00Notes f00Other c00Other f00Notes f00Other f00Notes f00Other f00Other f00Notes f00Other f00Other f00Other f00Other f00Other f00Other f00Other f00Other f		1.00	Purpose Fund 2.00	3.00	4.00	
0 Cash or 0 Temporal 0 Notes r 0 Other r 0 Less: a receival Other r 0 Other r 0 Prepaic 0 Due from 0 Due from 0 Due from 0 Due from 00 Due from 00 Land 01 Less: A 02 Less: A 03 Less: A 04 Less: A 05 Less: A 06 Less: A 07 Less: A 08 Less: A 09 Mi nor e 00 ToTAL F 00 ToTAL F 00 Other f 01 ToTAL F 01 ToTAL F 01 ToTAL C 02 ToTAL C 03 ToTAL C 04 Liabili 05 Deferrer 06 ToTAL C						
0 Temporal 0 Notes r 0 Other r 0 Less: a receival Invento 0 Prepaid 0 Other r 0 Due fro 0 Due for 0 Buildin 0 Less: A 00 Major m 00 Less: A 00 Minor e 00 TotAL F 00 TotAL F 00 TotAL C	n on hand and in banks	2, 652, 995		0 0	0	1 1.
0Account0Account0Uther0Less: areceivareceiva0Invento0Other0Other0Due0Fixed0Land00Land00Land00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Less: A00Minor00Other00TOTAL00Other00TOTAL00Other00TOTAL00Other01Notes02Account03Current00Other00TOTAL O00Deferrent00Other00Notes00Notes00TOTAL O00TOTAL O00Notes00Notes00TOTAL C00TOTAL C00TOTAL C00TOTAL C00Notes00TOTAL C00TOTAL C <t< td=""><td>porary investments</td><td>16, 606, 113</td><td></td><td>0 0</td><td>0</td><td></td></t<>	porary investments	16, 606, 113		0 0	0	
0 Other r 0 Less: a receiva receiva 0 Invento 0 Prepaid 0 Other c 0 Other c 0 Other c 0 TOTAL C 0 FIXED A 00 Land 00 Land in 00 Less: A 00 Minor e 00 Other f 00 Investm 00 Other a 00 TOTAL F 00 Other a 00 Other a 00 TOTAL C 00 Other a 00 TOTAL A Liabili Currenta 00 Other a 00 Other a 00 TOTAL C <	es recei vabl e	0		0 0	0	
0 Less: a 0 Invento 0 Prepaid 0 Other 0 Other 0 Due 0 Due 0 TOTAL 0 FIXED 00 Land 00 Land 00 Less: A 00 Automoto 00 Less: A 00 Major 00 Less: A 00 Major 00 Less: A 00 Major 00 Uther 00 TOTAL 00 TOTAL 01 TOTAL 02 TOTAL 03 TOTAL 04 Current 05 Salarie 06 Deferrence 07 TOTAL 08 Care	bunts receivable	3, 042, 460		0 0	0	
receiva rec	er receivables s: allowances for uncollectible notes and accounts	66, 766 -1, 086, 223			0	
0Prepaid Other <br< td=""><td></td><td>.,000,220</td><td></td><td></td><td></td><td></td></br<>		.,000,220				
0 Other c 00 Due from 00 Land in 00 Land in 00 Land in 00 Land in 00 Less: A 00 Minor e 00 Other f 00 Investm 00 Other f 00 Other f </td <td>5</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>	5	0		0 0	0	
00 Due frc 00 TOTAL 0 FIXED A FIXED A 00 Land im 00 Land im 00 Less: A 00 Minor e 00 Minor e 00 Other f 00 Investm 00 TOTAL F 00 Other a 00 Other f 00 TOTAL C 00 Other a 00 Other a 00 TOTAL C 00 TOTAL C 00 TOTAL C 00 Notes & 00 Deferrer 00 Notes C 00 Other c	paid expenses er current assets	256, 588 50, 745			0	
OD TOTAL C FIXED A 00 Land 00 Land in 00 Land in 00 Buildin 00 Buildin 00 Less A 00 Less A 00 Less A 00 Less: A 00 Less: A 00 Less: A 00 Automoto 00 Less: A 00 Major m 00 Less: A 00 Minor e 00 Others: A 00 Minor e 00 Other f 00 Total F 01 Other f 00 Total F 01 Other f 00 Total F 00 Total F 00 Total C 00 Total C 00 Total C 00 Total C 00 Total C <t< td=""><td>from other funds</td><td>161, 895</td><td></td><td>0 0</td><td>0</td><td></td></t<>	from other funds	161, 895		0 0	0	
00Land00Land im00Less : A00Buildir00Less AC00Less AC00Major m00Less: A00Minor G00Other f00Other	AL CURRENT ASSETS (Sum of lines 1 - 10)	21, 751, 339		0 0	0	
00 Land in 00 Less: A 00 Minor e 00 Minor e 00 Minor e 00 Other f 00 ToTAL F 00 ToTAL C 00 ToTAL C </td <td>D ASSETS</td> <td>L</td> <td></td> <td></td> <td></td> <td></td>	D ASSETS	L				
00 Less: A 00 Buildin 00 Less A 00 Less A 00 Less: A 00 Fixed e 00 Less: A 00 Itess: A 00 Other f	d d improvements	2, 997, 898 21, 800		0 0 0 0	0	
00 Buildin 00 Less AC 00 Less AC 00 Less AC 00 Fixed e 00 Less: A 00 Major m 00 Less: A 00 Minor e 00 Other f 00 TOTAL F 01 TOTAL F 01 Other f 00 Other f	s: Accumulated depreciation	-817		0 0	0	
00 Less Ac 00 Less Ac 00 Less: A 00 Less: A 00 Less: A 00 Automotion 00 Less: A 00 Automotion 00 Less: A 00 Mai or m 00 Less: A 00 Minor e 00 Other f 00 TOTAL F 00 TOTAL F 00 TOTAL A Liabili CURRENT 00 Deposit 01 TOTAL A Liabili CURRENT 00 Notes & 00 Deferrer 00 Notes & 00 TOTAL C 00 Other c 00 TOTAL C 00 Notes f 00 Other f 00 Notes f 00 Other f 00 TOTAL L 00 Other f 00 Other f 00 <td< td=""><td>•</td><td>25, 326, 273</td><td></td><td>0 0</td><td>0</td><td></td></td<>	•	25, 326, 273		0 0	0	
00 Less: A 00 Fixed e 00 Less: A 00 Less: A 00 Less: A 00 Maj or m 00 Less: A 00 Maj or m 00 Less: A 00 Minor e 00 Other f 00 TOTAL F 00 TOTAL A 00 TOTAL O 00 TOTAL C 00 TOTAL C 00 TOTAL O 00 Notes 8 00 Deferre 00 Other c 00 TOTAL L	s Accumulated depreciation	-16, 607, 285		0 0	0	16
00Fixed e00Less: A00Automotion00Less: A00Major m00Less: A00Minor e00Other f00TOTAL F00OTHER A00TOTAL F01Due frc00Due frc00TOTAL A1LiabiliCURRENT00Salarie00Payroll00Other a00Other a00TOTAL ALiabiliCURRENT00Account00Deferred00Other a00Other b00Other c00Other c00Unsecur00Loans f00Other l00TOTAL L00CAPITAL00General00Specifi00Donor c	sehold improvements	0		0 0	0	
00 Less: A 00 Automotion 00 Less: A 00 Major m 00 Less: A 00 Minor e 00 Minor e 00 Minor e 00 Other f 00 TOTAL F 01 TOTAL F 01 Investm 00 Other a 00 TOTAL A Li abili Li 00 Notes & 00 Other c 00 Recount 00 Contac o 00 Deferrer 00 Other c 00 Other f 00 Other f 00 Other c 00 Other f 00 Notes f 00 Other f 00 Other f 00 Other f 00 Other f <td>s: Accumulated Amortization</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>18</td>	s: Accumulated Amortization	0		0 0	0	18
00 Automob 00 Less: A 00 Major 01 Less: A 02 Less: A 03 Minor 04 Minor 05 Minor 06 Minor 07 TAL 08 Investm 09 TOTAL 00 Investm 00 Other 00 TOTAL 00 TOTAL 00 TOTAL 00 TOTAL 01 CURRENT 00 Account 00 Contes & 00 Other c 00 Other f 00 Other f 00 Other c 00 Other f	s: Accumulated depreciation	0		0 0	0	20
00 Maj or m 00 Less: A 00 Mi nor e 00 Mi nor e 00 Other f 00 Other f 01 TOTAL F 01 OTHER A 00 Investm 00 Deposit 00 Other a 00 Other a 00 Other a 00 Other a 01 TOTAL A 1 Liabili CURRENT O 00 Account 00 Account a 00 Other a 00 Notes 8 00 Other a 00 Notes 8 00 Other a 00 Notes 9 00 Notes 9 00 Other 1 00 Other 1 <t< td=""><td>pmobiles and trucks</td><td>0</td><td></td><td>0 0</td><td>0</td><td>2</td></t<>	pmobiles and trucks	0		0 0	0	2
00 Less: A 00 Minor e 00 Minor e 00 Other f 00 TOTAL F 01 TOTAL F 01 Investm 00 Deposit 00 Other f 00 Investm 00 Deposit 00 Other a 00 Other f 00 Other f 00 TOTAL A Li abili CURRENT 00 Salarie 00 Deferre 00 Acceler 00 Other c 00 Other c 00 Other f 00 Notes f 00 Notes p 00 Notes f 00 Other I 00 General <td>s: Accumulated depreciation</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>22</td>	s: Accumulated depreciation	0		0 0	0	22
00 Mi nor e 00 Mi nor e 00 Other f 00 Other f 00 Other f 00 Other f 00 Investm 00 Deposit 00 Due frc 00 Other a 00 TOTAL P 00 TOTAL O 00 TOTAL C 00 TOTAL O 00 TOTAL O 00 CORENT 00 Sal ari e 00 Payrol I 00 Notes 8 00 Deferre 00 Other c 00 TOTAL C 00 Other c 00 Other c 00 Notes p 00 Unsecur 00 Other I 00 TOTAL L 00 General 00 Specifi 00 Donor c	or movable equipment	2, 949, 924		0 0	0	
00 Minor e 00 Other f 00 OTHER A 00 Investm 00 Deposit 00 Due frc 00 Other a 00 Other a 00 TOTAL G 00 TOTAL O 00 TOTAL O 00 TOTAL A Li abili Li 00 CURRENT 00 Account 00 Deferre 00 Deterre 00 Other c 00 Other c 00 Other c 00 Notes P 00 Unsecur 00 Other I 00 General 00 Specifi 00 Donor c	s: Accumulated depreciation pr equipment – Depreciable	-2, 544, 165		0 0	0	
00 0ther f 00 TOTAL F 01 TOTAL F 01 Investm 00 Investm 00 Deposit 00 Other a 00 Other a 00 TOTAL A 1 Liabili 1 CURRENT 00 Account 00 Salarie 00 Payroll 00 Notes & 00 Other c 00 Other c 00 Other c 00 Other c 00 Notes p 00 Unsecu 00 Unsecu 00 Other l 00 General 00 Specifi 00 Donor c	pr equipment nondepreciable	0		0 0	0	
OTHER A 00 1 nvestm 00 00 01 02 03 04 1 04 05 06 07 07 07 08 09 100 11 00 11 00 11 00 11 01 02 11 02 11 03 14 14 14 14 14 14 14 14 14 15 15 16 17 17 16 17 16 17 16 16 17 17 16 <td>er fixed assets</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>27</td>	er fixed assets	0		0 0	0	27
00 Investm 00 Deposit 00 Due froz 00 Other a 00 TOTAL 0 00 TOTAL A Li abili CURRENT 00 Salarie 00 Payroll 00 Notes & 00 Other c 00 Deferre 00 Other c 00 Other c 00 Other c 00 Other c 00 Unsecur 00 Unsecur 00 Other l 00 TOTAL L 00 General 00 Specifi 00 Donor c	AL FIXED ASSETS (Sum of lines 12 - 27)	12, 143, 628		0 0	0	28
00 Deposit 00 Due from 00 Other a 00 TOTAL 0 00 TOTAL 0 1 abili CURRENT O 00 Salarie 00 Payrol I 00 Notes 8 00 Deferre 00 Acceler 00 Due to 00 Other c 00 Notes 0 00 Notes 0 00 Notes 0 00 Notes 0 00 Unsecur 00 Unsecur 00 Other 1 00 OTHER (00 TOTAL L 00 General 00 Specifi 00 Donor c		0		0 0	0	29
00 Due frc 00 Other a 00 TOTAL A 11 abili a 11 CURRENT Account 00 Salarie B 00 Payrol Acceler 00 Other C 00 Deferre Acceler 00 Acceler C 00 Other C 00 Mortgag 00 Notes 00 Notes 00 Usescur 00 Other 00 Other 00 Other 00 TOTAL 00 TOTAL 00 General 00 Specifi 00 Donor	osits on leases	0		0 0	0	
00 TOTAL C 00 TOTAL A Liabili CURRENT 00 Account 00 Salarie 00 Payroll 00 Notes & 00 Deferrence 00 Deferrence 00 Other c 00 TOTAL C 00 TOTAL C 00 Notes p 00 Notes p 00 Notes p 00 Unsecur 00 Uther l 00 Other l 00 Other l 00 TOTAL L 00 TOTAL L 00 General 00 Specifi 00 Donor c	from owners/officers	-60, 653		0 0	0	3
00 TOTAL A Li abili CURRENT 00 Account 00 Sal arie 00 Payroll 00 Notes 8 00 Deferre 00 Due to 00 Other c 00 Other c 00 Other c 00 Notes p 00 Notes p 00 Notes p 00 Notes p 00 Unsecur 00 Other I 00 Other I	er assets	175, 679		0 0	0	
Li abi li CURRENT OU Account OU Sal ari e OP Payrol I OU Notes & OD Deferre OD Accel er OD Due to OD Other o OTOTAL C LONG TE OU Mortgag ON Notes p OU Unsecur OL LOAG TE OU OTHER (OU TOTAL L OU TOTAL L OU TOTAL L OU TOTAL L OU General OD Speci fi OD Donor c	AL OTHER ASSETS (Sum of lines 29 - 32) AL ASSETS (Sum of lines 11, 28, and 33)	115, 026 34, 009, 993		0 0 0 0	0	
00 Account 00 Salarie 00 Payrol I 00 Notes & 00 Deferre 00 Accel er 00 Due to 00 Other co 00 TOTAL Co LONG TE Mortgag 00 Notes p 00 Unsecur 00 Other I 00 OTHER (00 TOTAL L 00 TOTAL L 00 TOTAL L 00 General 00 Specifi 00 Donor c	pilities and Fund Balances	01,007,770		0	0	ľ
00 Salarie 00 Payrol I 00 Notes & 00 Deferre 00 Accel er 00 Other co 00 Other co 00 TOTAL Co LONG TE O 00 Mortgag 00 Unsecur 00 Other I 00 Other I 00 OTHER (00 TOTAL L CAPITAL 00 General 00 Specifi 00 Donor co	RENT LIABILITIES					
00 Payrol I 00 Notes 8 00 Deferre 00 Acceler 00 Due to 00 Other c 100 TOTAL C 100 Mortgag 00 Notes p 00 Unsecur 00 Other I 00 O	punts payable	45, 160		0 0 0 0	0	
00 Notes 8 00 Deferrent 00 Acceler 00 Due to 00 Other of 00 Other of 00 TOTAL O 00 Mortgag 00 Notes p 00 Unsecur 00 Other I 00	aries, wages, and fees payable roll taxes payable	1, 259, 207 38, 462			0	
00 Accel er 00 Due to 00 Other c 00 TOTAL C LONG TE Do 00 Mortaga 00 Notes p 00 Unsecur 00 Loans f 00 Other I 00 OTHER (00 TOTAL L CAPITAL CAPITAL 00 General 00 Specifi 00 Donor c	es & loans payable (Short term)	305, 830		0 0	0	
00 Due to 00 Other of 107AL O LONG TE 00 Mortgag 00 Notes p 00 Unsecur 00 Loans f 00 Other I 00 OTHER (00 TOTAL L CAPITAL 00 General 00 Specifi 00 Donor of	erred income	0		0 0	0	-
00 Other c 107AL C LONG TE 00 Mortgag 00 Notes p 00 Unsecur 00 Loans f 00 Other I 00 Other I 00 OTHER (00 TOTAL L CAPITAL 00 General 00 Specifi 00 Donor c	elerated payments	0			0	40
00 TOTAL C LONG TE 00 Mortgag 00 Notes p 00 Unsecur 00 Loans f 00 Other I 00 OTHER (00 TOTAL L CAPITAL 00 General 00 Specifi 00 Donor c	to other funds er current liabilities	1, 808, 481		0 0	0	
00 Mortgag 00 Notes p 00 Unsecur 00 Loans f 00 Other I 00 OTHER (00 TOTAL L 00 TOTAL L CAPITAL 00 General 00 Specifi 00 Donor c	AL CURRENT LIABILITIES (Sum of lines 35 - 42)	3, 457, 140		0 0	0	
00 Notes p 00 Unsecur 00 Loans f 00 Other I 00 OTHER (00 TOTAL L CAPITAL 00 General 00 Specifi 00 Donor c	G TERM LIABILITIES					
00 Unsecur 00 Loans f 00 Other I 00 OTHER (00 TOTAL L CAPITAL 00 General 00 Specifi 00 Donor c	tgage payable	9, 106, 204		0 0	0	
00 Loans f 00 Other I 00 OTHER (00 TOTAL L 00 TOTAL L <u>CAPI TAL</u> 00 General 00 Speci fi 00 Donor c	ecured Loans	0			0	
00 Other I 00 OTHER (00 TOTAL L 00 TOTAL L <u>CAPI TAL</u> 00 General 00 Speci fi 00 Donor c	ns from owners:	0		0 0	0	
00 TOTAL L 00 TOTAL L <u>CAPITAL</u> 00 General 00 Specifi 00 Donor c	er long term liabilities	0		0 0	0	
00 TOTAL L CAPITAL 00 General 00 Specifi 00 Donor c	ER (SPECIFY)	0		0 0	0	
CAPITAL 00 General 00 Specifi 00 Donorc	AL LONG TERM LIABILITIES (Sum of lines 44 - 49 AL LIABILITIES (Sum of lines 43 and 50)	9, 106, 204 12, 563, 344		0 0	0	50 51
00 General 00 Specifi 00 Donorc	TAL ACCOUNTS	12, 303, 344		0 0	0	
00 Donor c	eral fund balance	21, 446, 649				52
	cific purpose fund			0		53
	or created - endowment fund balance - restricted or created - endowment fund balance - unrestricted			0		54 55
	erning body created - endowment fund balance			0		56
	nt fund balance - invested in plant				0	
	nt fund balance - reserve for plant improvement,				0	58
						59
00 TOTAL F 00 TOTAL L	acement, and expansion AL FUND BALANCES (Sum of lines 52 thru 58)	21, 446, 649			0	1 54

STATEM	Financial Systems ENT OF CHANGES IN FUND BALANCES	PEACE CARE AT		No.: 315413	Pe	riod:	eu of Form Workshee		2540-10
STATE	LINE OF GIANGES THE FOND BALANCES			10 515415		om 01/01/2021		e Pre	
		General	Fund	Speci al	Pur	pose Fund	Endowment		
		1.00	0.00	2.00		4.00	5.00		
1.00	Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		20, 784, 288 595, 209			(2.00
3.00	Total (sum of line 1 and line 2)		21, 379, 475			(D		3.00
4.00	Additions (credit adjustments)								4.00
5.00	ADDI TI ONS	122, 840			0			0	5.00
6.00	ROUNDING	1			0			0	6.00
7.00		0			0			0	7.00
8.00		0			0			0	8.00
9.00		0			0			0	9.00
10.00	Total additions (sum of line 5 - 9)		122, 841			(10.00
11.00	Subtotal (line 3 plus line 10)		21, 502, 316			(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	OTHER DEDUCTIONS	55, 667			0			0	15.00
16.00		0			0			0	16.00
17.00		0			0			0	17.00
18.00	Total deductions (sum of lines 13 - 17)		55, 667			(18.00
19.00	Fund balance at end of period per balance		21, 446, 649			(19.00
	sheet (Line 11 - line 18)								
			DI 1						
		Endowment Fund	PLANT	Fund					
1.00	Fund balances at beginning of period	6.00	7.00	Fund 8. 00	0				1.00
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	6.00			0				1.00 2.00
	Net income (loss) (from Wkst. G-3, line 31)	6.00			0				
2.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00			-				2.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 31)	6.00			-				2.00 3.00
2.00 3.00 4.00	Net income (loss) (from WKst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	6.00			-				2.00 3.00 4.00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS	6.00			-				2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00 7.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS	6.00			-				2.00 3.00 4.00 5.00 6.00 7.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS	6.00			-				2.00 3.00 4.00 5.00 6.00 7.00 8.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING	6.00			-				2.00 3.00 4.00 5.00 6.00 7.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9)	6.00			0				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00			0				$\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9)	6.00			0				$\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00			0				$\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00 \end{array}$
$\begin{array}{c} 2 & 00 \\ 3 & 00 \\ 4 & 00 \\ 5 & 00 \\ 6 & 00 \\ 7 & 00 \\ 8 & 00 \\ 9 & 00 \\ 10 & 00 \\ 11 & 00 \\ 11 & 00 \\ 12 & 00 \\ 13 & 00 \\ 14 & 00 \end{array}$	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00			0				$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0				$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS	6.00 0 0 0			0				$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0				$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$

Heal th	Financial Systems	PEACE CARE AT ST.	ANNS			In Lie	u of Form CMS-2	2540-10		
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315413		riod: om 01/01/2021 12/31/2021	Worksheet G-2 Parts I-II Date/Time Prep 5/23/2022 8:5			
	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			13, 130, 1	26		13, 130, 126	1.00		
2.00	NURSING FACILITY				0		0	2.00		
3.00	ICF/IID				0		0	3.00		
4.00	OTHER LONG TERM CARE			682, 6			682, 606	4.00		
5.00	Total general inpatient care services (Sum of	lines 1 - 4)		13, 812, 7	32		13, 812, 732	5.00		
	All Other Care Services			T .						
6.00	ANCI LLARY SERVI CES			1, 847, 1	39	0	1, 847, 139	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		
	RURAL HEALTH CLINIC					0	0	10.00		
	FQHC					0	0	10. 10		
11.00	СМНС					0	0	11.00		
	HOSPI CE				0	0	0	12.00		
	ROUTINE CHARGES / BED HOLD			800, 3		0	800, 380	13.00		
14.00	Total Patient Revenues (Sum of Lines 5 - 13) Worksheet G-3, Line 1)	(Transfer column 3	to	16, 460, 2	51	0	16, 460, 251	14.00		
	Cost Center Description									
						1.00	2.00			
	PART II - OPERATING EXPENSES									
1.00	Operating Expenses (Per Worksheet A, Col. 3, I	Line 100)					15, 463, 468	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		
	Total Deductions (Sum of lines 9 - 13)						0	14.00		
15.00	Total Operating Expenses (Sum of lines 1 and 8	8, minus line 14)					15, 463, 468	15.00		
		,				'				

Heal th	Financial Systems	PEACE CARE AT ST.	ANNS	In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		3	Provider No.: 315413	Peri od:	Worksheet G-3	
				From 01/01/2021	Date/Time Pre	
	To 12/31/2021					
					5/23/2022 8:5	
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part	I, col. 3, line 1	4)		16, 460, 251	1.00
2.00	Less: contractual allowances and discounts on	patients accounts			2, 690, 698	2.00
3.00	Net patient revenues (Line 1 minus line 2)				13, 769, 553	3.00
4.00	Less: total operating expenses (From Workshee	t G-2, Part II, li	ne 15)		15, 463, 468	4.00
5.00	Net income from service to patients (Line 3 m				-1, 693, 915	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				403, 362	6.00
7.00	Income from investments				2, 817, 540	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 di scounts				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 gues	ts			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical sup		n patients		0	16.00
17.00	Revenue from sale of drugs to other than pati				0	17.00
18.00	Revenue from sale of medical records and abst	racts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	0	19.00			
20.00	Revenue from gifts, flower, coffee shops, can	teen			300	20.00
21.00	Rental of vending machines	5, 221	21.00			
22.00	Rental of skilled nursing space	0	22.00			
23.00	Governmental appropriations				0	23.00
24.00	NON PATIENT REVENUE				-1, 112, 482	24.00
24.50	COVI D-19 PHE Funding				175, 183	24.50
25.00	Total other income (Sum of lines 6 - 24)				2, 289, 124	25.00
26.00	Total (Line 5 plus line 25)				595, 209	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
	Net income (or loss) for the period (Line 26	minus line 30)			595, 209	31.00