Health Financia This report is	al Systems PEAC required by law (42 USC 1395g; 42 CFR 413	CE CARE AT ST. 20(b)). Failu	-		u of Form CMS-2540-10 FORM APPROVED
payments made s	since the beginning of the cost reporting p	eriod being d	eemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315413	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I, II & III Date/Time Prepared: 5/22/2023 1:22 pm
PART I - COST I	REPORT STATUS				
Provi der	1. [X] Electronically prepared cost rep	port		Date: 5/22/20	23 Time: 1:22 pm
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report ent	ter the numbe	r of times the provide	er 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			
use only	(1) As Submitted	7.[N]Firs	t Cost Report for this	Provider CCN	
	(2) Settled without audit		Cost Report for this		
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened		ine 4, column 1 is "4"		times reenand
	(5) Amended				trilles reopened
			r Vendor Code	4	
	5. Date Received:		care Utilization. Ente	er "F" for full, '	'L" for low, or "N"
		for	no utilization.		

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED 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 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1				I have read and agree with the above certification	1
				statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	
2	Signatory Printed Name				2
3	Signatory Title	ADMI NI STRATOR			3
4	Date				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	-55, 374	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	-55, 374	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 D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA	<u>PEACE CARE A</u> TY HEALTH CARE		ovider No.:		Period: From 01/01, To 12/31,	/2022	u of Form Workshee Part I Date/Tin 5/22/202	et S-2 me Prep	pared:
	1.00	2.00			3.00			0/22/20		- pm
00 00		PO Box: State: NJ CBSA Code: 356	Ziı	ss: c Code: 073 can/Rural :						1.00 2.00 3.00
.01		CBSA Code:	Component	Name	Provi der CCN	Date Certified		ent Syste O, or N)		3. 01
			1.00		2.00	3.00	V 4.00	XVIII 5.00	XI X 6.00	
00 00 00 00 00 00 00 00 00	SNF and SNF-Based Component Identification: SNF Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC	PEACE		ST. ANNS	315413	10/15/1997	N	P	0	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
	SNF-Based HOSPICE									12.00
3.00	SNF-Based CORF					From	.	To:		13.00
						1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (See Instructions)					01/01/2	022 1	12/31/ Y/N		14. 0 15. 0
								1.0		
b. 00	Type of Freestanding Skilled Nursing Facility Is this a distinct part skilled nursing facil section 483.5?		the requ	uirements	set forth	in 42 CFR		N		16. 0
. 00	Is this a composite distinct part skilled nur 42 CFR section 483.5?	sing facility	that mee	ts the req	uirements	set forth	in	N		17. 0
8. 00	Are there any costs included in Worksheet A t organizations as defined in CMS Pub. 15–1, ch Miscellaneous Cost Reporting Information							Y		18. 0
	If this is a low Medicare utilization cost re If line 19 is yes, does this cost report meet utilization cost report, indicate with a "Y",	your contract for yes, or "	or's cri <u>N" for n</u>	teria for o.	filing a	low Medicar		N N		19. 0 19. 0
. 00	Depreciation - Enter the amount of depreciati Straight Line Declining Balance	on reported in	<u>i this SN</u>	F TOR THE	method in	dicated on	Lines		19, 860 0	21. 0
3.00 4.00	Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance							9	0 19, 860 0	24.0
	Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a (Y/N)					porting per	i od?	YN		25. 0 26. 0
	Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in					·		N		27.0 28.0
3. 00	reports? (Y/N)							APart B	Other	20.0
	If this facility contains a public or non-pub of the lower of the costs or charges enter "Y exemption.							lication	3.00	
0.00 .00 2.00 3.00 4.00	Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FOHC						N	N	N	29.0 30.0 31.0 32.0 33.0 34.0
	SNF-Based CMHC SNF-Based OLTC					Y/N		N		35. 0 36. 0
	Is the skilled nursing facility located in a regardless of the level of care given for Tit	les V & XIX pa	tients?		er as a SN	1.00 F Y)	2.0	0	37.0
00	Are you legally-required to carry malpractice			olicy is		N				38. 0 39. 0
	Is the malpractice a "claims-made" or "occurr "claims-made" enter 1. If the policy is "occu			51109.10						
					Premiums 1.00	Paid Los 2.00	ses S	Self Insu 3.00		

Heal th	Financial Systems	PEACE CARE AT ST	ANNS		In Lie	u of Form CM	S-2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.:	315413	Peri od:	Worksheet S	-2
COMPLE	X INDENTIFICATION DATA				From 01/01/2022 To 12/31/2022	Part I Date/Time P	roparod
					10 12/31/2022	5/22/2023 1	
						Y/N	
						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	ig 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 org	ganization, enter the nam	e and address c	of the ho	ome office on the	lines	
	below.						
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

	X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Pro	ovider 1		Period: From 01/01/2022 To 12/31/2022		repared
	· · · · ·				Y/N	<u>5/22/2023 1:</u> Date	22 pm
					1.00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column 1,	"Y" for	Yes or "N"	for No. For all	the date	
00	Provider Organization and Operation Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.
				Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Program?	lf	1.00 N	2.00	3.00	2.
00	column 1 is yes, enter in column 2 the date			IN IN			2.
00	3, "V" for voluntary or "I" for involuntary. 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 l, or members of the bo	drug ts oard	Y			3.
				Y/N	Туре	Date	
	Cincucial Data and Demonts			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.		Y	С		4.
	those on the filed financial statements? If	column 1 is "Y", submit	t				
	reconciliation.				Y/N	Legal Oper.	
					1.00	2.00	
	Approved Educational Activities						_ ,
00	Column 1: Were costs claimed for Nursing Schulegal operator of the program? (Y/N)	OOI? (Y/N) COLUMN 2: I	is the p	provider the	Ν	N	6.
00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri		ons.		N		7.
	School and/or Allied Health Program? (Y/N) se		period f	for Nursing	Ν		8.
	School and/or Allied Health Program? (Y/N) s		period f	for Nursing	N	Y/N 1.00	8.
		ee instructions.	-		N		
00	Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb	ee instructions. d debts? (Y/N) see inst	tructior	ns.		1.00	9.
00	School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	d debts? (Y/N) see inst t collection policy cha	tructior ange dur	ns. ring this cos	t reporting	1.00 Y N	9.
00	Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb	d debts? (Y/N) see inst t collection policy cha	tructior ange dur	ns. ring this cos	t reporting	1.00 Y	9.
)0 00 00	School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	d debts? (Y/N) see inst collection policy cha d/or coinsurance waived	tructior ange dur d?lf"Y	ns. ring this cos (", see instru	t reporting uctions.	1.00 Y N N	8. 9. 10. 11. 12.
)0 00 00	School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived	tructior ange dur d?lf"Y	ns. ring this cos (", see instr ', see instru Pa	t reporting uctions. uctions.	1.00 Y N N Part B	9. 10. 11.
000000000000000000000000000000000000000	School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d debts? (Y/N) see inst collection policy cha d/or coinsurance waived	tructior ange dur d?lf"Y	ns. ring this cos (", see instru	t reporting uctions.	1.00 Y N N	9. 10. 11.
0 00 00	School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement 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	ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description	tructior ange dur d?lf"Y	ns. ring this cos (", see instru ', see instru Pa Y/N	t reporting uctions. ctions. art A Date	1.00 Y N N Part B Y/N	9.10.11.
0 00 00 00	School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement 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	d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description	tructior ange dur d?lf"Y	ns. ring this cos (", see instru ', see instru Pa Y/N 1.00	t reporting uctions. ctions. art A Date	1.00 Y N N Part B Y/N 3.00	9. 10. 11. 12. 13.
0 00 00 00 00	School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used 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",	d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	tructior ange dur d?lf"Y	ns. ring this cos (", see instru ', see instru Pa Y/N 1.00 N	t reporting uctions. ctions. art A Date	1.00 Y N N Part B Y/N 3.00	9. 10. 11. 12. 13.
	School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement 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	d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	tructior ange dur d?lf"Y	ns. ring this cos (", see instru ', see instru Pa Y/N 1.00 N	t reporting uctions. ctions. art A Date	1.00 Y N N Part B Y/N 3.00 N	9. 10. 11.
00 . 00 . 00	School and/or Allied Health Program? (Y/N) signal Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement 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	d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	tructior ange dur d?lf"Y	ring this cos (", see instru ', see instru Pa Y/N 1.00 N N	t reporting uctions. ctions. art A Date	1.00 Y N N Part B Y/N 3.00 N N	9. 10. 11. 12. 13. 14.

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		Period:	Worksheet S-2	
COMPLEX REIMBURSEMENT QUESTIONNAIRE				rom 01/01/2022 o 12/31/2022	Part II Date/Time Pre	narod
			1	- 12/31/2022	5/22/2023 1:2	
		1. (00	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	SOURCES			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-2	540-10
	D NURSING FÁCILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der No. : 315413	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prep 5/22/2023 1:22	
		Part B				
		Date 4.00				
	PS&R Data	4.00				
	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					13.00
14.00	prepare this cost report in cols. 2 and 4. (see Instructions.)					14.00
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
		F	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.		PREPARER			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 D NURSING FACILITY AND SKILLED NURSING X STATISTICAL DATA	PEACE CARE A			<u>In Lie</u> Period: From 01/01/2022 To 12/31/2022	Date/Time Prep 5/22/2023 1:22	pared
				l nj	patient Days/Vis	sits	
	Component	Number of Beds	Bed Days Avai LabLe	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
00 00 00 00 00 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	120 0 0 0	43, 800 0 0		0 4, 581 0 0 0	22, 527 0 0 0	1. (2. (3. (4. (5. (6. (
00	HOSPI CE	0	0		o c	0	7. (
00	Total (Sum of lines 1-7)	120	43, 800		0 4, 581	22, 527	8. (
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
00	SKILLED NURSING FACILITY	8, 544	35, 652		190		1.0
00 00	NURSING FACILITY	0	0		D	0	2. 3.
00	HOME HEALTH AGENCY COST	0	0			0	4.
00	Other Long Term Care	0	0				5.
00	SNF-Based CMHC						6.
00	HOSPICE	0	0		0 0 0 190	0	
00	Total (Sum of lines 1-7)	8, 544 Di scha	35, 652 arges	Ave	rage Length of		8.
	Component	Other		Title V	Title XVIII	Title XIX	
	Component	11.00	<u>Total</u> 12.00	13.00	14.00	15.00	
00	SKILLED NURSING FACILITY	33	230	0.0	0 24.11	3, 218. 14	1.
00 00 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	0	0 0	0.0	0	0. 00 0. 00	3. 4.
00 00	Other Long Term Care SNF-Based CMHC	0	0				5. 6.
00	HOSPICE	0	0	0.0	0.00	0.00	
00	Total (Sum of lines 1-7)	33	230				8.
		Average Length of Stay		Admi	ssi ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
00	SKILLED NURSING FACILITY	155. 01	0	12		87	1.
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	
00	SNF-Based CMHC						6.
00	HOSPICE	0.00	0		0 0		
00	Total (Sum of lines 1-7)	155.01 Admissions	O Full Time		8 17	87	8.
	Companyant	Tatal		Nonnaid	_		
	Component	Total	Employees on Payroll	Nonpaid Workers			
	1	21.00	22.00	23.00			
00	SKILLED NURSING FACILITY	232	125.20				1.
00	NURSING FACILITY	0	0.00 0.00				2. 3.
$\cap \cap$	HOME HEALTH AGENCY COST	0	0.00				3. 4.
			0.00		-1		
00	Other Long Term Care	0	0.00	0.0	C		5.
00 00 00 00 00		0	0.00 0.00 0.00	0.0	C		5. 6. 7.

	Financial Systems	PEACE CARE A		No . 215412	Period:	u of Form CMS-2	
SINF WA	GE INDEX INFORMATION				From 01/01/2022 To 12/31/2022	Worksheet S-3 Part II Date/Time Pre 5/22/2023 1:2	pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	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	I	1	-		
1.00	Total salaries (See Instructions)	6, 642, 448	0	6, 642, 44			
2.00	Physician salaries-Part A	0	0		0 0.00		
3.00	Physician salaries-Part B	0	0		0 0.00		
4.00	Home office personnel	0	0		0 0.00		
5.00	Sum of lines 2 through 4	0	0		0 0.00		
5.00	Revised wages (line 1 minus line 5)	6, 642, 448	0	6, 642, 44			6.0
7.00	Other Long Term Care	0	0		0 0.00		
8.00	HOME HEALTH AGENCY COST	0	0		0 0.00		
9.00	HOSPI CE	0			0 0.00 0 0.00		
10.00	Other excluded areas	0			0 0.00		
		0					
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, 642, 448	0	6, 642, 44	8 280, 868. 00	23.65	13.0
1 4 . 0.0	OTHER WAGES & RELATED COSTS	00/ 00/			F 057 00	(4.04	1 4 4 9
14.00	Contract Labor: Patient Related & Mgmt	326, 826	0	326, 82			
15.00	Contract Labor: Physician services-Part A				0 0.00		
16.00	Home office salaries & wage related costs WAGE-RELATED COSTS	0		1	0 0.00	0.00	16.0
17.00	Wage-related costs core (See Part IV)	2,093,285	0	2, 093, 28	15		17.0
18.00	Wage-related costs other (See Part IV)	2,093,203		2,075,20	0		18.0
19.00	Wage related costs (excluded units)	0			0		19.0
20.00	Physician Part A - WRC				0		20.0
20.00	Physician Part B - WRC				0		20.0
22.00	Total Adjusted Wage Related cost (see	2,093,285		2, 093, 28	5		22.0
22.00	instructions)	2,070,200		2,075,20			22.00

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 01/01/2022 To 12/31/2022		narod
					10 12/31/2022	5/22/2023 1:2	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	1			-		
1.00	Employee Benefits	0	0		0.00		
2.00	Administrative & General	489, 283		489, 283			
3.00	Plant Operation, Maintenance & Repairs	210, 904	0	210, 904	10, 686. 00	19.74	3.00
4.00	Laundry & Linen Service	0	0	(0.00	0.00	4.00
5.00	Housekeepi ng	761, 827	0	761, 82	7 37, 490. 00	20.32	5.00
6.00	Dietary	588, 128	0	588, 128	3 38, 221. 00	15.39	6.00
7.00	Nursing Administration	353, 129	0	353, 129	9 8, 615. 00	40.99	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	37, 735	0	37, 73	5 1, 896. 00	19.90	10.00
11.00	Soci al Servi ce	119, 749	0	119, 749	3, 648. 00	32.83	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	211, 606	0	211, 600	10, 983. 00	19.27	13.00
14.00	Total (sum lines 1 thru 13)	2, 772, 361	0	2, 772, 36	1 127, 446. 00	21.75	14.00
	···· (··· ··· ··· ··· ··· ··· ··· ···· ··· ····			, , , , _,	, , , , , , , , , , , , , , , , , , , ,		

lealth Financial Systems	PEACE CARE AT ST. ANNS		In Lie	u of Form CMS-2	2540-1
SNF WAGE RELATED COSTS	Provi d	er No.: 315413	Peri od: From 01/01/2022 To 12/31/2022		
				Amount	
				Reported	
				1.00	
PART IV - WAGE RELATED COSTS					
Part A - Core List RETIREMENT COST					
1.00 401K Employer Contributions				0	1.00
2.00 Tax Sheltered Annuity (TSA) Employe	r Contribution			0	2.00
3.00 Qualified and Non-Qualified Pension				130, 279	3.00
4.00 Prior Year Pension Service Cost	Plan Cost			130, 279	4.00
PLAN ADMINISTRATIVE COSTS (Paid to	External Organization)			0	4.00
5.00 401K/TSA Plan Administration fees				0	5.00
6.00 Legal /Accounting/Management Fees-Pe	nsion Plan			0	6.00
7.00 Employee Managed Care Program Admin				0	7.00
HEALTH AND INSURANCE COST				0	7.00
B. 00 Health Insurance (Purchased or Sel	Funded)			1, 035, 365	8.00
9.00 Prescription Drug Plan	(dilaca)			0	9.00
10.00 Dental, Hearing and Vision Plan				ō	10.00
11.00 Life Insurance (If employee is own	r or beneficiary)			46, 237	11.00
12.00 Accident Insurance (If employee is				0	12.00
13.00 Disability Insurance (If employee i				75, 511	13.00
14.00 Long-Term Care Insurance (If employ				0	14.00
15.00 Workers' Compensation Insurance				286, 755	15.00
16.00 Retirement Health Care Cost (Only (urrent year, not the extraordinary	accrual require	ed by FASB 106.	0	16.00
Non cumulative portion)			-		
TAXES					
17.00 FICA-Employers Portion Only				519, 138	
18.00 Medicare Taxes - Employers Portion	Onl y			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
22.00 Day Care Cost and Allowances				0	22.00
23.00 Tuition Reimbursement	1 00)			0	23.00
24.00 Total Wage Related cost (Sum of lin	es I - 23)			2, 093, 285	24.00
				Amount Reported	
				1.00	
Part B - Other than Core Related Co	27			1.00	
25. 00 OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00

Heal th	Financial Systems	PEACE CARE AT	ST. ANNS		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES		Provi der		Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Pre 5/22/2023 1:2	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)	. Related to Salary in col. 3		
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations				1		
1.00	Registered Nurses (RNs)	1, 242, 517	391, 564				1.00
2.00	Licensed Practical Nurses (LPNs)	543, 488	171, 274				2.00
3.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	1, 571, 136	495, 125	2, 066, 26	1 82, 113. 00	25.16	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3, 357, 141	1, 057, 963	4, 415, 10			4.00
5.00	Physical Therapists	507, 332	159, 880	667, 21	2 7, 238. 00	92.18	5.00
6.00	Physical Therapy Assistants	0	0		0 0.00		6.00
7.00	Physical Therapy Aides	0	0		0 0.00	0.00	7.00
8.00	Occupational Therapists	370, 036	116, 612	486, 64	8 6, 074. 00	80.12	8.00
9.00	Occupational Therapy Assistants	0	0		0 0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0		0 0.00	0.00	10.00
11.00	Speech Therapists	14, 841	4, 677	19, 51			
12.00	Respi ratory Therapi sts	0	0		0 0.00		12.00
13.00	Other Medical Staff	0	0		0 0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations	1 1			1	1	
14.00	Registered Nurses (RNs)	272, 964		272, 96			14.00
15.00	Licensed Practical Nurses (LPNs)	375		37			15.00
16.00	Certified Nursing Assistant/Nursing	53, 487		53, 48	7 1, 344. 00	39.80	16.00
47.00	Assi stants/Ai des	00/ 00/				(4.04	17.00
17.00	Total Nursing (sum of lines 14 through 16)	326, 826		326, 82			
18.00	Physical Therapists	0			0 0.00		
19.00	Physical Therapy Assistants	0			0 0.00		
20.00	Physical Therapy Aides	0			0 0.00 0 0.00		20. 00 21. 00
21.00 22.00	Occupational Therapists Occupational Therapy Assistants	0			0.00		21.00
22.00	Occupational Therapy Assistants	0			0 0.00		
23.00 24.00	Speech Therapi sts	0			0 0.00		
24.00	Respiratory Therapists	0			0 0.00		
25.00	Other Medical Staff	0			0 0.00		26.00
20.00	jotner mearear starr	, Ч		I	0.00	0.00	20.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PEACE CARE AT	ST. ANNS Provider No.: 315	413 Period:	eu of Form CMS Worksheet S	
			From 01/01/2022 To 12/31/2022	Date/Time P	
			Group	5/22/2023 1: Days	:22 pm
1.00			1.00 RUX	2.00	1.0
2.00			RUL		2.0
3. 00			RVX		3.0
4.00			RVL		4.0
5. 00			RHX RHL		5.0 6.0
7.00			RMX		7.0
3. 00			RML		8.0
9.00			RLX		9.0
10. 00 11. 00			RUC RUB		10.0
12.00			RUA		12.0
3. 00			RVC		13.0
4.00			RVB		14.0
5.00			RVA RHC		15. 0 16. 0
7.00			RHB		17.0
18.00			RHA		18.0
9.00			RMC		19.0
20.00			RMB		20.0
1. 00 2. 00			RMA RLB		21.0 22.0
3. 00			RLA		23.0
4.00			ES3		24.0
5.00			ES2		25.0
6. 00 7. 00			ES1 HE2		26. 0 27. 0
8.00			HE1		28.0
9.00			HD2		29.0
0.00			HD1		30.0
1.00			HC2		31.0
2. 00 3. 00			HC1 HB2		32.0 33.0
4.00			HB1		34.0
5.00			LE2		35.0
6.00			LE1		36.0
7. 00 8. 00			LD2 LD1		37.0 38.0
9.00			LC2		39.0
0. 00			LC1		40.0
1.00			LB2		41.0
2. 00 3. 00			LB1 CE2		42.0 43.0
4.00			CE2 CE1		44.0
5. 00			CD2		45.0
6. 00			CD1		46.0
7. 00 8. 00			CC2 CC1		47.0 48.0
7. 00			CB2		48.0
0.00			CB1		50.0
1.00			CA2		51.0
2. 00 3. 00			CA1 SE3		52.0 53.0
4. 00			SE2		53.0
5. 00			SE1		55.0
5.00			SSC		56. C
7. 00			SSB SSA		57. C 58. C
9.00			I B2		58.0
0. 00			I B1		60.0
. 00			I A2		61.0
2. 00			I A1 BB2		62. C
4. 00			BB2 BB1		64.0
5. 00			BA2		65. C
b. 00			BA1		66. C
7.00			PE2		67.0
3. 00 9. 00			PE1 PD2		68. 0 69. 0
2. 00			PD1		70.0
1.00			PC2		71.0
2.00			PC1		72.0
3.00 4.00			PB2 PB1		73.0 74.0
5. 00			PBT PA2	1	74.0

Health Financial Systems PEACE CARE AT ST.	ANNS		In Lie	u of Form CMS	5-2540-10			
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315413	Peri od:	Worksheet S-	-7			
			From 01/01/2022 To 12/31/2022					
			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 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)								
101.00 Staffing 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			

CLASS	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315413	Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/22/2023 1:2	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1 1		1	- 1		
	00100 CAP REL COSTS - BLDGS & FIXTURES		1,091,683	1, 091, 6		1, 091, 683	
	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0	0.110.0	0 0	0	
00	00300 EMPLOYEE BENEFITS	400, 202	2, 119, 396			2, 119, 396	
00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	489, 283	3, 106, 735			3, 596, 018 960, 492	
	00600 LAUNDRY & LINEN SERVICE	210, 904	749, 588 1, 386			1, 386	
	00700 HOUSEKEEPING	761, 827	170, 973			932, 800	
	00800 DI ETARY	588, 128	945, 903			1, 534, 031	
	00900 NURSI NG ADMI NI STRATI ON	353, 129	603			353, 732	
	01000 CENTRAL SERVICES & SUPPLY	000, 127	000	000, /	0 0	0	
	01100 PHARMACY	0	0		0 0	0	
	01200 MEDI CAL RECORDS & LI BRARY	37, 735	63, 185	100, 93	20 0	100, 920	
	01300 SOCIAL SERVICE	119, 749	8, 224	127, 9	73 0	127, 973	
00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14
00	01500 RECREATION	211, 606	16, 443	228, 04	49 0	228, 049	15
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
	03000 SKILLED NURSING FACILITY	2, 977, 878	450, 307	3, 428, 18	35 0	3, 428, 185	30
	03100 NURSING FACILITY	0	0		0 0	0	
	03200 CF/I D	0	0		0 0	0	
	03300 OTHER LONG TERM CARE	0	0		0 0	0	33
	ANCI LLARY SERVICE COST CENTERS		47.505	47.5	25	47.505	1 10
	04000 RADI OLOGY	0	17, 595			17, 595	
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	45, 376	45, 3	76 0 0 0	45, 376	
	04200 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
	04400 PHYSI CAL THERAPY	507, 332	3, 781	511, 1	13 0	511, 113	
	04500 OCCUPATI ONAL THERAPY	370, 036	0, 701			370, 036	
	04600 SPEECH PATHOLOGY	14, 841	0			14, 841	
	04700 ELECTROCARDI OLOGY	0	0		0 0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,604	4,60	04 0	4, 604	48
00	04900 DRUGS CHARGED TO PATIENTS	0	227, 238	227, 23	38 0	227, 238	49
00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50
	05100 SUPPORT SURFACES	0	0		0 0	0	51
	OUTPATIENT SERVICE COST CENTERS					-	1
		0	0		0 0	0	
	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0	0	
	06300 DAY CARE	0	0		0 0	0	62
	OTHER REIMBURSABLE COST CENTERS	<u>Ч</u>	0		0 0	0	03
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70
	07100 AMBULANCE	0	36, 904			36, 904	
	07300 CMHC	0	0		0 0	0	
	SPECIAL PURPOSE COST CENTERS						
00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80
	08100 INTEREST EXPENSE		0		0 0	0	81
	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	
	08300 HOSPI CE	0	0		0 0	0	
00	SUBTOTALS (sum of lines 1-84)	6, 642, 448	9, 059, 924	15, 702, 3	72 0	15, 702, 372	89
	NONREI MBURSABLE COST CENTERS	1		1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
	09100 BARBER AND BEAUTY SHOP	0	446	4.	46 0		91
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	
	09300 NONPALD WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY 09500 DAYCARE		0 814, 902	814, 9		0 814, 902	
00 1							

CLASSI FI (ncial Systems CATION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES	Provi der	No.: 315413	Peri od:	u of Form CMS-25 Worksheet A
					From 01/01/2022	
					To 12/31/2022	Date/Time Prepa 5/22/2023 1:22
	Cost Center Description	Adjustments to				
			For Allocation	ו		
		Wkst A-8)	(col. 5 +-			
		(aa	col . 6)	4		
CENE		6.00	7.00			
	RAL SERVICE COST CENTERS	-365, 510	726, 173	3		
	O CAP REL COSTS - MOVABLE EQUIPMENT	-303, 310				
	O EMPLOYEE BENEFITS		2, 119, 396			
	O ADMINI STRATI VE & GENERAL	-1, 263, 387		1		
	O PLANT OPERATION, MAINT. & REPAIRS	(960, 492	1		
	0 LAUNDRY & LINEN SERVICE		1, 386			
	O HOUSEKEEPING		932, 800	1		
	0 DI ETARY	-2, 752		1		
	O NURSI NG ADMI NI STRATI ON	0				
	O CENTRAL SERVICES & SUPPLY	0				
00 0110	0 PHARMACY	0				
00 0120	O MEDICAL RECORDS & LIBRARY	0	100, 920			
00 0130	O SOCIAL SERVICE	0	127, 973	3		
00 0140	ONURSING AND ALLIED HEALTH EDUCATION	0				
00 0150	0 RECREATION	0	228, 049	2		
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
	O SKILLED NURSING FACILITY	C	3, 428, 185	5		
	O NURSING FACILITY	C	0 0			
00 0320	O I CF/IID	C	0 0			
	O OTHER LONG TERM CARE	C) (0		
	LLARY SERVICE COST CENTERS					
	0 RADI OLOGY	C		1		
	0 LABORATORY	C	45, 376	1		
	O I NTRAVENOUS THERAPY	C				
	O OXYGEN (INHALATION) THERAPY	C) (-		
	0 PHYSI CAL THERAPY	0	511, 113	1		
	0 OCCUPATIONAL THERAPY	0	370, 036			
	O SPEECH PATHOLOGY		14, 84			
	O ELECTROCARDI OLOGY					
	O MEDI CAL SUPPLIES CHARGED TO PATIENTS		4,604			
	O DRUGS CHARGED TO PATIENTS		227, 238			
	0 DENTAL CARE - TITLE XIX ONLY 0 SUPPORT SURFACES					
	ATIENT SERVICE COST CENTERS		<u>и</u> (<u>л</u>		
00 0600		0				
	O RURAL HEALTH CLINIC					
	O FQHC					
	0 DAY CARE	0				
	R REIMBURSABLE COST CENTERS			- 1		
	O HOME HEALTH AGENCY COST	0)		
	O AMBULANCE					
	ОСМНС	0				
	I AL PURPOSE COST CENTERS					
00 0800	O MALPRACTICE PREMIUMS & PAID LOSSES	C) ()		
	O INTEREST EXPENSE	C		D I		
00 0820	OUTILIZATION REVIEW - SNF	0) (D		
00 0830	O HOSPI CE	C) ()		
00	SUBTOTALS (sum of lines 1-84)	-1, 631, 649	14, 070, 723	3		
NONR	EIMBURSABLE COST CENTERS					
00 0900	O GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C) () 		
	O BARBER AND BEAUTY SHOP	0	446	5		
	O PHYSICIANS PRIVATE OFFICES	C		D		
	O NONPAID WORKERS	C) (D		
	O PATIENTS LAUNDRY	C) (D		
	0 DAYCARE	C	814, 902			
0. 00	TOTAL	-1, 631, 649	14, 886, 07	1		1

Health Financial Systems	PEACE CARE AT ST.			-	u of Form CMS-	
RECLASSI FI CATI ONS				Period: From 01/01/2022	Worksheet A-6)
					Date/Time Pre 5/22/2023 1:2	epared: 22 pm
			Increases			
	Cost Center		Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
TOTALS						
	Total Reclassificat of columns 4 and 5 equal sum of column 9)	must		O	C	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 01/01/2022	Worksheet A-	6
					Date/Time Pro 5/22/2023 1::	
	Decreases					
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
TOTALS						
100.00				0	(0 100. 00

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

Heal th	Financial Systems	PEACE CARE A	T ST. ANNS		In Lie	eu of Form CMS-2	2540-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315413	Peri od:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022		
				Acqui si ti on	S		
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE						
1.00	Land	2, 997, 898	0		0 0	0	1.00
2.00	Land Improvements	21, 800	7, 500		0 7,500	0	2.00
3.00	Buildings and Fixtures	25, 326, 273	496, 772		0 496, 772	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	2, 593, 627	66, 554		0 66, 554	0	6.00
7.00	Subtotal (sum of lines 1-6)	30, 939, 598	570, 826		0 570, 826		7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	30, 939, 598	570, 826		0 570, 826	0	9.00
	Description	Endi ng Bal ance	Fully				
	·	Ű	Depreciated				
			Assets				
		6.00	7.00]			
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	S					
1.00	Land	2, 997, 898	0				1.00
2.00	Land Improvements	29, 300	0				2.00
3.00	Buildings and Fixtures	25, 823, 045	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	2, 660, 181	0				6.00
7.00	Subtotal (sum of lines 1-6)	31, 510, 424	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	31, 510, 424	0				9.00

	Financial Systems MENTS TO EXPENSES	PEACE CARE A		No.: 315413	Period: From 01/01/2022	Worksheet A-8	
					To 12/31/2022	Date/Time Pre 5/22/2023 1:2	
					lassification on ch the Amount is	Worksheet A	
	Description (1)	(2) Basis For	Amount	Cost	t Center	Line No.	
		Adjustment 1.00	2.00		3.00	4.00	
. 00	Investment income on restricted funds	B		CAP REL COST		4.00	1.0
	(chapter 2)	_		FIXTURES			
00	Trade, quantity, and time discounts (chapter 8)		0			0.00	2.0
00	Refunds and rebates of expenses (chapter 8)		0			0.00	3. (
00	Rental of provider space by suppliers		0			0.00	4.
00	(chapter 8) Telephone services (pay stations excluded)		0			0.00	5.
00	(chapter 21) Television and radio service (chapter 21)		0			0.00	6.
00	Parking lot (chapter 21)		0			0.00	
00	Remuneration applicable to provider-based	A-8-2	0				8.
~~	physician adjustment		0			0.00	
00 . 00	Home office cost (chapter 21) Sale of scrap, waste, etc. (chapter 23)		0			0. 00 0. 00	
. 00	Nonallowable costs related to certain		0			0.00	
	Capital expenditures (chapter 24)		-				
2.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-16, 283				12.
. 00	Laundry and Linen service		0			0.00	
. 00 . 00	Revenue - Employee meals Cost of meals - Guests	В	-2, /52	DI ETARY		8.00 0.00	
. 00	Sale of medical supplies to other than		0			0.00	
	patients		-				
	Sale of drugs to other than patients		0			0.00	
. 00	Sale of medical records and abstracts		0			0.00	
. 00 . 00	Vending machines Income from imposition of interest, finance		0			0. 00 0. 00	
. 00	or penal ty charges (chapter 21)		0			0.00	20.
. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21.
. 00	overpayments Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	REVIEW - SNF	82.00	22.
. 00	(chapter 21) Depreciationbuildings and fixtures		0	CAP REL COST FIXTURES	S - BLDGS &	1.00	23.
. 00	Depreciationmovable equipment		0	CAP REL COST	S - MOVABLE	2.00	24.
00	INTEREST INCOME	В		ADMI NI STRATI		4.00	
01	PCSA BAD DEBT PROVISION	А		ADMI NI STRATI		4.00	
02	PCSA NON OP REVENUE INVESTMENT INC	A		ADMI NI STRATI		4.00	
04 07	PCSA OTHER NON-OP FUNDRAISING COSTS NON OP EXPENSES 50/50 RAFFLE EXPENSE	A A		ADMI NI STRATI ADMI NI STRATI		4.00 4.00	
	DI VI DEND I NCOME	В		CAP REL COST		1.00	
				FI XTURES			
D. 00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1, 631, 649				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	S-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provi der		Period: From 01/01/2022 To 12/31/2022	Worksheet A Parts I-II Date/Time P 5/22/2023 1	repared:
	Line No.	Cost (Center	Expense	e Items	
	1.00	2.		3.		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	OR	
1.00	4.00	ADMI NI STRATI VE	& GENERAL	FINANCE COST		1.00
2.00	4.00	ADMI NI STRATI VE	& GENERAL	HUMAN RESOURCES	S COST	2.00
3.00	4.00	ADMI NI STRATI VE	& GENERAL	MARKETING COST		3.00
4.00	4.00	ADMI NI STRATI VE	& GENERAL	PEACECARE ADMIN	VI STRATI ON	4.00
5.00	4.00	ADMI NI STRATI VE	& GENERAL	ACCOUNTING COST	Г	5.00
6.00	4.00	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 minu:			
	Cost	Wkst. A, col.	col . 5)			
		5				
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIP	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	OR	
CLAIMED HOME OFFICE COSTS:	5, 555	5, 555		0		1.00
2.00	5, 555 132, 888	5, 555 132, 888		0		2.00
3.00	132,888	132, 888		0		2.00
4.00	223, 569	223, 569		0		4.00
5.00	223, 569 188, 629	188, 629		0		4.00
6.00	77, 017	77, 017		0		6,00
7.00	77,017	77,017		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	627, 658	643, 941	-16, 28	13		10,00
6, line 100 to Worksheet A-8, column 3, line	027,030	043, 941	-10, 20			10.00
12.						
1	1	I	I	I		I

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	E F	Provider No.: 315413	From 01/01/2022	Worksheet A-8 Parts I-II Date/Time Prep 5/22/2023 1:22	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.

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

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

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

related organization.

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

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

	Rel ated Organi	zation(s) and/	or Home Office					
	Name	Percentage of	Type of Business					
		Ownershi p						
	4.00	5.00	6.00					
PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

1.00	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	eriod:	u of Form CMS-2 Worksheet B	2540-10
					Fr	rom 01/01/2022	Part I Date/Time Pre 5/22/2023 1:2	
			CAPI TAL REL	ATED COSTS			072272020 1.2	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDGS & FI XTURES	MOVABLE EQUI PMENT		EMPLOYEE BENEFI TS	Subtotal	
		col. 7)						
	GENERAL SERVICE COST CENTERS	0	1.00	2.00		3.00	3A	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	726, 173	726, 173					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0			0			2.00
3.00	00300 EMPLOYEE BENEFITS	2, 119, 396	0		0	2, 119, 396	0 (11 040	3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	2, 332, 631 960, 492	123, 097 27, 700		0 0	156, 115 67, 293	2, 611, 843 1, 055, 485	
6.00	00600 LAUNDRY & LINEN SERVICE	1, 386	25, 731		0	07, 273	27, 117	
7.00	00700 HOUSEKEEPI NG	932, 800	7,045		0	243, 075	1, 182, 920	
8.00	00800 DI ETARY	1, 531, 279	64, 302		0	187, 653	1, 783, 234	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	353, 732	0		0	112, 673	466, 405	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	0	
	01100 PHARMACY	0	0		0	12 040	0	11.00
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	100, 920	0 1, 041		0	12, 040 38, 208	112, 960 167, 222	
	01400 NURSING AND ALLIED HEALTH EDUCATION	127, 473	1, 041		0	30, 200	107, 222	14.00
15.00	01500 RECREATION	228, 049	47, 098		0	67, 517	342, 664	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·		•				
	03000 SKILLED NURSING FACILITY	3, 428, 185	397, 640		0	950, 146	4, 775, 971	
	03100 NURSING FACILITY	0	0		0	0	0	31.00
	03200 I CF/I I D	0	0		0	0	0	
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0	0	0	33.00
40.00	04000 RADI OLOGY	17, 595	0		0	0	17, 595	40.00
	04100 LABORATORY	45, 376	0		0	0	45, 376	
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	511, 113	30, 486		0	161, 874	703, 473	
	04500 OCCUPATIONAL THERAPY	370, 036	0		0	118, 067	488, 103	
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	14, 841	0		0	4, 735 0	19, 576 0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 604	0		0	0	4,604	
49.00	04900 DRUGS CHARGED TO PATIENTS	227, 238	0		0	0	227, 238	
	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
(0.00	OUTPATIENT SERVICE COST CENTERS				0			1 (0.00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	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	
	OTHER REIMBURSABLE COST CENTERS	1 1		1				
	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	
	07100 AMBULANCE	36, 904	0		0 0	0	36, 904	
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		U	0	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00
	08100 I NTEREST EXPENSE							81.00
	08200 UTILIZATION REVIEW - SNF							82.00
	08300 HOSPI CE	0	0		0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	14, 070, 723	724, 140		0	2, 119, 396	14, 068, 690	89.00
00 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	00 00
	09100 BARBER AND BEAUTY SHOP	446	2, 033		0	0	0 2, 479	
	09200 PHYSICIANS PRIVATE OFFICES	440	2,033		0	0	2,477	1
93.00	09300 NONPAI D WORKERS	0	0		0	Ő	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	0	
	09500 DAYCARE	814, 902	0		0	0	814, 902	
98.00	Cross Foot Adjustments	0	0		0	0	0	
00 00				1	0			1 00 00
99.00 100.00	Negative Cost Centers TOTAL	14, 886, 071	726, 173		0	2, 119, 396	14, 886, 071	

To To <thto< th=""> To To To<!--</th--><th>COST A</th><th>Financial Systems LLOCATION - GENERAL SERVICE COSTS</th><th>PEACE CARE AT</th><th></th><th></th><th>Period:</th><th>Worksheet B</th><th>2540-10</th></thto<>	COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	PEACE CARE AT			Period:	Worksheet B	2540-10
Cost Center Description AUXI N STRATU & GIN RR L PLANT (MIRT & StrATUS) (MIRT & StrATUS) (MIRT & StrATUS) PLANT (MIRT & StrATUS) (MIRT & StrATUS) PLANT (MIRT & StrATUS) PLANT (MIRT & StrATUS) 1.00 DOTOC AP REL COST CENTERS (MIRT) 4.00 5.00 6.00 7.00 8.00 1.00 DOTOC (AP REL COST & BLOGS & FLITURES (MIRT) 2.011 BIS (MIRT) 7.700 0.0112 1.700 UIX 0.0000 (ADMIR) STRATIVE & EDICS & FLITURES (MIRT) 2.011 BIS (MIRT) 7.720 00 1.400.307 0.0000 (ADMIR) STRATIVE & EDICS & FLITURES (MIRT) 2.011 BIS (MIRT) 1.7200 UIX 1.400.307 0.00000 (MIRT) STRATIVE & EDICS & STRATINE (MIRT) 2.011 BIS (MIRT) 1.7200 UIX 1.400.307 0.00000 (MIRT) STRATIVE & EDICS & STRATINE (MIRT) 2.011 BIS (MIRT) 1.400 OIX 0.0170 (MIRT) 1.400.307 0.00000 (MIRT) STRATIVE & EDICS & STRATINE (MIRT) 2.011 FIS (MIRT) 1.400 OIX 0.0170 (MIRT) 1.400.307 0.00000 (MIRT) STRATIVE & EDICS & SUPPLY 0 0 0 0 0 0.00000 (MIRT) STRATINE SERVICE COST CENTERS 1.400 OIX 0.125.888 0 1.25.888						rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre	pared: 2 pm
ENERGY SERVICE DOST CENTERS 0.00100 (AP REL COSTS - MOVABLE COLIPWENT 30 00200 (DIREST VALOR OF MONTON SERVICE 31 1, 280, 080 30 00200 (DIREST VALOR OF MONTON SERVICE 31 0, 20 00200 (DIREST VALOR OF MONTON 39 456 143, 564 0 1100 (DIRAMARXY 9, 00 00200 (DIREST VALOR OF MONTON 39 456 143, 564 0 1100 (DIRAMARXY 9, 00 00200 (DIREST VALOR OF MONTON 30 00200 (DIREST VALOR OF VALOR OF MONTON 30 00200 (DIREST VALOR OF VALOR OF VALOR OF VALOR OF VALOR OF VALOR OF VALOR 30 00200 (DIREST VALOR OF VAL		Cost Center Description		OPERATION, MAINT. &				
1.00 OC100 CAP REL COSTS - ELIDES A FIXTURES 2.611, 843 7.200 OC200 CAP REL COSTS - MOVABLE COUPMENT 3.00 OC300 CAPTCOLE BUNKT 175 A REPAIRS 2.611, 843 7.200 OC300 CAPTCOLE BUNKT 175 A REPAIRS 2.611, 843 7.200 OC300 CAPTCOLE BUNKT 175 A REPAIRS 2.611, 843 7.200 OC300 CAPTCOLE DENTERT 100, MAINT 7 & REPAIRS 2.611, 843 7.200 OC 00 OC 00 OC 00 OC 00 OC 00 OC 000 OF EARLY NO SERVICE 2.511, 715 15, 674 0 OC 00			4.00	5.00	6.00	7.00	8.00	
2.00 00200 (AP REL COSTS - MOVABLE FOILPMENT 4.00 00200 (APA OFERLOSTS - MOVABLE FOILPMENT 4.00 00400 AMAINISTRATIVE & GEREBAL 5.777 57,245 90,132 1.400,00500 (JANNOYS & LINESSENCE 5.777 57,245 90,132 1.400,000 00400 (JANNOYS & LINESSES & SUPPLY 0000 00400 (JANNOYS & LINESSES & SUPPLY 0000 01100 (JANNOYS & LINESSES & SUPPLY 00000 01100 (JANNOYS & LINESSES & SUPPLY 10000 (JANNOYS & LINESSES & SUPPLY 10000 (JANNOYS & LINESSES & SUPPLY 100000 (JANNOYS & LINESSES & SUPPLY 10000 (JANNOYS & LINESSES & SUPPLY 10000 (JANNOYS & LINESSES & LINESSES 10000 (JANNOYS & LINESSES 10000 (JAN			- I					
5.00 00500 PLANT OPERATION. MAINT & REPAIRS 224,598 1,280,083 90,132 7.00 00700 HOUSEKEEPING 527,745 15,674 0 1,450,309 7.00 00700 HOUSEKEEPING 221,715 15,674 0 1,450,309 7.00 00700 HOUSEKEEPING 231,715 15,674 0 0 7.00 00700 HOUSEKEEPING 231,715 15,674 0 0 7.00 0 0 0 7.00 0 0 0 7.00 0 0 0 0	2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	2, 611, 843					1.00 2.00 3.00 4.00
8.00 000000 ULETARY 379, 456 143, 059 0 171, 873 2, 477, 620 10.00 01000 CENTRAL SERVICES & SUPPLY 0 <td></td> <td>00500 PLANT OPERATION, MAINT. & REPAIRS</td> <td></td> <td></td> <td></td> <td>2</td> <td></td> <td>5.00 6.00</td>		00500 PLANT OPERATION, MAINT. & REPAIRS				2		5.00 6.00
9.00 00000 NURSI NG ADMI NI STRATION 99.247 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00							7.00
10.00 01000 CENTRAL SERVICES SUPPLY 0 <t< td=""><td>8.00</td><td>00800 DI ETARY</td><td>379, 456</td><td>143, 059</td><td>c</td><td>171, 873</td><td>2, 477, 622</td><td>8.00</td></t<>	8.00	00800 DI ETARY	379, 456	143, 059	c	171, 873	2, 477, 622	8.00
11.00 01100 PHARMACY 0 0 0 0 0 13.00 01300 SOCI AL SERVICE 35,583 2,315 0 2,782 0 14.00 01400 NRSING SAD ALLED HALTH EDUCATION 72,916 104,783 0 125,888 0 15.00 01500 RECREATION 72,916 104,783 0 125,888 0 01800 RECREATION 0	9.00	00900 NURSING ADMINISTRATION	99, 247	0	C	0 0	0	9.00
12.00 01200 MEDICAL RECORDS & LIBRARY 24.037 0 0 0 0 14.00 01400 NURSING AND ALLED HEALTH EDUCATION 0	10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	C	0 0	0	10.00
13. 00 O1300 SOCIAL SERVICE 35. 583 2.315 0 2.782 0 14. 00 O1400 NURSING AND ALLIED HEALTH EDUCATION 72. 916 104. 783 0 125. 888 0 15. 00 O1500 RECREATION 72. 916 104. 783 0 125. 888 0 10. 00 3000 SKI LLED NURSING FACIL ITY 1.016. 279 884.658 90. 132 1.062.845 2.477.622 1.013.00 30. 00 3300 OTHER LONG TERN CARE 0	11.00	01100 PHARMACY	0	0	C	0 0	0	11.00
14. 00 01400 NUEX NO ALLIED HEALTH EDUCATION 0			24, 037	0	C	0 0	0	12.00
15.00 01500 PC2.916 104.783 0 125.888 0 30.00 03000 SKILLED NURSING FACILITY 1,016,279 884,658 90,132 1,062,845 2,477,622 2 30.00 03000 SKILLED NURSING FACILITY 0 <td></td> <td></td> <td>35, 583</td> <td>2, 315</td> <td>C</td> <td>2, 782</td> <td>0</td> <td>13.00</td>			35, 583	2, 315	C	2, 782	0	13.00
INPATIENT ROUTINE SERVICE COST CENTERS Image of the service cost centers 11 00 03100 NURSI NG FACLLITY 1,016,279 884,658 90,132 1,062,862 2,477,622 21 00 03300 (IF/I ID 0				0		, u	-	14.00
30.00 03000 SK1LLED NURSING FACILITY 1,016,279 884,658 90,132 1,062,845 2,477,622 31.00 03200 INHESING FACILITY 0	15.00		72, 916	104, 783	C	125, 888	0	15.00
31.00 D3100 NURSING FACILITY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
32.00 03200 CF/LI D.ONG TERM CARE 0			1, 016, 279					
33.00 00 00 0 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
ANCILLARY SERVICE COST CENTERS Image: Cost Centers 40.00 04000 RADIOLOGY 3, 744 0			0					
40. 00 04000 RAD IOLGY 3, 744 0	33.00		0	0	ין נ		0	33.00
41.00 04100 LABORATORY 9,656 0 0 0 0 42.00 04200 INTRAVENOUS THERAPY 0 0 0 0 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 109,693 67,825 0 81,486 0	10 00		2 744	0			0	40.00
42.00 04200 INTRAVENOUS THERAPY 0<								
43.00 04300 CVYCEN (1NHALATION) THERAPY 0 0 0 0 44.00 04400 PHYSICAL THERAPY 149,693 67,825 0 81,486 0 45.00 04500 CCUPATIONAL THERAPY 103,864 0<				0				41.00
44.00 PHYSICAL THERAPY 149,693 67,825 0 81,486 0 45.00 04500 OCCUPATIONAL THERAPY 103,864 0 0 0 0 45.00 04600 SPEECH PATHOLOGY 4,166 0 0 0 0 0 0 47.00 04700 ELECTROCARDIOLOGY 4,166 0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>43.00</td></td<>			0	0				43.00
45.00 04500 OCCUPATIONAL THERAPY 103,864 0			149 693	-		, u		•
46.00 04600 SPECH PATHOLOGY 4,166 0 0 0 0 47.00 04700 ELECTROCARDIOLOGY 0								•
47.00 04700 ELECTROCARDIOLOGY 0<				0		0	0	•
49.00 04900 DRUGS CHARGED T0 PATIENTS 48,354 0	47.00	04700 ELECTROCARDI OLOGY		0	c c	0 0	0	47.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0	48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	980	0	c c	0 0	0	48.00
51.00 OSTOD SUPPORT SURFACES O <td>49.00</td> <td>04900 DRUGS CHARGED TO PATIENTS</td> <td>48, 354</td> <td>0</td> <td>c c</td> <td>0 0</td> <td>0</td> <td>49.00</td>	49.00	04900 DRUGS CHARGED TO PATIENTS	48, 354	0	c c	0 0	0	49.00
OUTPATI ENT SERVICE COST CENTERS O <	50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	0 0	0	50.00
60.00 06000 CLINIC 0	51.00	05100 SUPPORT SURFACES	0	0	C	0 0	0	51.00
61.00 06100 RURAL HEALTH CLINIC 0			- F		1	r		
62.00 06200 FQHC 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
63.00 D6300 DAY CARE O			0	0	C	0	0	
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY OST 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>62.00</td></td<>								62.00
70.00 07000 HOME HEALTH AGENCY COST 0	63.00		0	0	<u> </u>	0	0	63.00
71.00 07100 AMBULANCE 7,853 0	70 00						^	70.00
73.00 07300 CMHC 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>70.00</td></t<>								70.00
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81.00 08100 INTEREST EXPENSE 82.00 08100 INTEREST EXPENSE 82.00 08300 HOSPI CE 0 0 0 0 0 88.00 08300 HOSPI CE 0 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>-</td> <td></td> <td></td>				0		-		
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08000 INTEREST EXPENSE 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08200 UTILIZATION REVIEW - SNF 80.00 0 <t< td=""><td>, 5. 00</td><td></td><td><u> </u></td><td>0</td><td></td><td></td><td>0</td><td>, 5. 00</td></t<>	, 5. 00		<u> </u>	0			0	, 5. 00
81.00 08100 INTEREST EXPENSE 0 </td <td>80, 00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>80.00</td>	80, 00							80.00
82.00 08200 UTILIZATION REVIEW - SNF 0								81.00
83.00 08300 HOSPICE 0								82.00
89.00 SUBTOTALS (sum of lines 1-84) 2,437,911 1,275,559 90,132 1,444,874 2,477,622 8 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0			0	0	с	0	0	1
NOREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0			2, 437, 911	1, 275, 559	90, 132	1, 444, 874		
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>]</td>]
92.00 09200 PHYSICIANS PRIVATE OFFICES 0		09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0	0	90.00
93.00 09300 NONPAI D WORKERS 0 <td>91.00</td> <td>09100 BARBER AND BEAUTY SHOP</td> <td>528</td> <td>4, 524</td> <td> C</td> <td>5, 435</td> <td>0</td> <td>91.00</td>	91.00	09100 BARBER AND BEAUTY SHOP	528	4, 524	C	5, 435	0	91.00
94.00 09400 PATIENTS LAUNDRY 0 <td>92.00</td> <td>09200 PHYSICIANS PRIVATE OFFICES</td> <td>0</td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td>92.00</td>	92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	92.00
95.00 09500 DAYCARE 173,404 0			0	0	C	0 0	0	
98.00 Cross Foot Adjustments 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td>0 0</td> <td>0</td> <td></td>			0	0	C	0 0	0	
99.00 Negative Cost Centers 0 0 0 0 0			173, 404	0	C	0 0		
			0	0	C	0 0	-	
			0	0	C .	0		
	100.00	TOTAL	2, 611, 843	1, 280, 083	90, 132	1, 450, 309	2, 477, 622	100.00

	ALLOCATION - GENERAL SERVICE COSTS	PEACE CARE AT		No.: 315413		i od: om 01/01/2022 12/31/2022	u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/22/2023 1:23	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY		MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	2 pm
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS			1				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	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 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	565, 652 0	0					1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
11.00	01100 PHARMACY	0	0		0			11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0	136, 997		12.00
13.00	01300 SOCIAL SERVICE	0	0		0	0	207, 902	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
15.00		0	0		0	0	0	15.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS			1		4.9 4.9 7	007.000	
30.00		565, 652	0		0	136, 997	207, 902	30.00
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D	0	0		0 0	0	0	31.00 32.00
32.00		0	0		0	0	0	33.00
00.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>		1			0	00.00
40.00	04000 RADI OLOGY	0	0	1	0	0	0	40.00
41.00	04100 LABORATORY	0	0		0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0	0	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0		0	0	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0		0	0	0	46.00 47.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	47.00
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
	OUTPATIENT SERVICE COST CENTERS			1				
60.00		0	0		0	0	0	60.00
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		0	0	0	61.00 62.00
63.00		0	0		0	0	0	63.00
00.00	OTHER REIMBURSABLE COST CENTERS				0			00.00
70.00		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								80.00
81.00 82.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW - SNF							81.00 82.00
83.00		0	0		0	0	0	83.00
89.00		565, 652	0		0	136, 997	207, 902	89.00
	NONREI MBURSABLE COST CENTERS							
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
91.00		0	0		0	0	0	91.00
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0		0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		U	0	0	94.00
95.00 98.00	09500 DAYCARE Cross Foot Adjustments	0	0		U	0	0	95.00 98.00
98.00 99.00	Negative Cost Centers	0	0		0	0	0	98.00 99.00
100.00	5	565, 652	0		0	136, 997		
			0		-1	, . , ,		

Heal th	Financial Systems	PEACE CARE A	AT ST. ANNS		In Lie	u of Form CMS-2	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315413	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/22/2023 1:2	pared: 2 pm
			OTHER GENERAL				
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	SERVICE RECREATION	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS	1	1	1			1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00 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	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00							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 MEDI CAL RECORDS & LI BRARY						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	646, 251				15.00
	INPATIENT ROUTINE SERVICE COST CENTERS		1		_		
30.00	03000 SKI LLED NURSI NG FACI LI TY	0				11, 864, 309	30.00
31.00	03100 NURSING FACILITY 03200 ICF/IID	0			0 0	0	31.00
32.00 33.00	03200 OTHER LONG TERM CARE			1	0 0	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS		η 0	1	0 0	0	33.00
40.00	04000 RADI OLOGY	0	0	21, 33	39 0	21, 339	40.00
41.00	04100 LABORATORY	0	0			55, 032	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0)	0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	.,		1,002,477	44.00
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY		0			591, 967 23, 742	45.00 46.00
40.00	04700 ELECTROCARDI OLOGY			23,72	0 0	23, 742	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5, 58	-	5, 584	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0			275, 592	
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
(0.00	OUTPATIENT SERVICE COST CENTERS					0	1 (0, 00
60.00 61.00	06100 RURAL HEALTH CLINIC				0 0	0	60.00 61.00
62.00	06200 FQHC				0 0	0	62.00
63.00	06300 DAY CARE	0	0		0 0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0			57 0		71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
<u>00 00</u>	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			1			80.00
80.00	08100 INTEREST EXPENSE						80.00
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	646, 251	13, 884, 79	09 0	13, 884, 799	89.00
	NONREI MBURSABLE COST CENTERS		1	1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0	0	
	09100 BARBER AND BEAUTY SHOP	0	0	12, 96	0	12, 966	
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0		0 0	0	92.00 93.00
93.00 94.00	09300 NONPATE WORKERS					0	1
94.00 95.00	09500 DAYCARE			988, 30	6 0	988, 306	1
98.00	Cross Foot Adjustments	0	0	,,	0 0	0	1
99.00	Negative Cost Centers	0	0		0 0	0	99.00
100.00	TOTAL	0	646, 251	14, 886, 07	/1 0	14, 886, 071	100. 00

Heal th	Financial Systems	PEACE CARE AT	F ST. ANNS		In Lie	eu of Form CMS-	2540-10
	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315413	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II	pared:
			CAPI TAL REL	ATED COSTS		572272023 1.2	
	Cost Center Description	Directly Assigned New Capital	BLDGS & FIXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		Related Costs 0	1.00	2.00	2A	3.00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	20	0.00	
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	o	2.00 3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	0	123, 097		0 123, 097		
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	27, 700		0 27,700		1
6.00	00600 LAUNDRY & LINEN SERVICE	0	25, 731		0 25, 731		6.00
7.00	00700 HOUSEKEEPI NG	0	7, 045		0 7, 045	0	7.00
8.00	00800 DI ETARY	0	64, 302		0 64, 302		
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0		0 0	0	
	01200 MEDICAL RECORDS & LIBRARY	0	0			0	1
	01300 SOCIAL SERVICE	0	1, 041		0 1,041	-	
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	1
15.00	01500 RECREATI ON	0	47, 098		0 47, 098	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · ·		I.		1	
	03000 SKILLED NURSING FACILITY	0	397, 640		0 397, 640		
	03100 NURSING FACILITY 03200 ICF/IID	0	0			0	
	03300 OTHER LONG TERM CARE	0	0		0 0		
55.00	ANCI LLARY SERVICE COST CENTERS	0	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	0	41.00
	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	1
	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
	04400 PHYSI CAL THERAPY	0	30, 486		0 30, 486		
	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0			0	
	04700 ELECTROCARDI OLOGY	0	0			0	1
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1
	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0		
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
(0.00	OUTPATIENT SERVICE COST CENTERS				0		
	06100 RURAL HEALTH CLINIC	0	0				1
62.00	06200 FQHC	0	0		0		62.00
63.00	06300 DAY CARE	0	0		0 0	0	
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0		0 0		1
	07100 AMBULANCE	0	0		0 0		
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES					1	80.00
	08100 I NTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	724, 140		0 724, 140	0	89.00
00.00	NONREI MBURSABLE COST CENTERS				0		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0 2, 033		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	1
	09200 PHYSICIANS PRIVATE OFFICES	0	2,033		0 2,033	0	1
	09300 NONPAI D WORKERS	0	0		0 0	0	1
	09400 PATIENTS LAUNDRY	0	0		0 0	Ő	1
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	726, 173	I	0 726, 173	0	100. 00

Cost Center Description AUM INISTRATUE (2) (2) (2) (2) (2) (2) (2) (2) (2) (2)		Financial Systems	PEACE CARE AT				u of Form CMS-	2540-10
Cost Center Description PLANT (Control Part of the Service) PLANT (Cost Center Service) DUSERCEPING (Cost Center Service) <	ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	rom 01/01/2022	Date/Time Pre	
BEREMI. STRVIC COST CAVERS		Cost Center Description		OPERATION, MAINT. &				
1.00 00100 CAP REL COSTS - BLIDGS A FIXTURES 1.00 2.00 00200 CAP REL COSTS - WOXABLE COMMENT 2.00 3.00 00200 CAP REL COSTS - BLIDGS A FIXTURES 1.23,097 3.00 00200 CAMIN STRATURE & GREFALL 123,097 5.00 00000 FIXART DEPENTION, MAIN ITA REPAIRS 10.552 7.00 00700 DIFFEREPIN 6.01000 FIXART DEPENTION 0.00000 DIFFEREPINC 17.864 4.279 0 0.00000 DIFFEREPINC 17.864 4.279 0 0 0.00000 DIFFEREPINC 17.864 4.279 0 0 0 0.00000 DIFFEREPINC 17.864 4.279 0 0 0 0 0.00000 DIFFEREPINC 0 </th <th></th> <th>L</th> <th>4.00</th> <th>5.00</th> <th>6.00</th> <th>7.00</th> <th>8.00</th> <th></th>		L	4.00	5.00	6.00	7.00	8.00	
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 4.00 00400 APMINOVE BINENTIS 3.00 4.00 00400 APMINOVE BINENTIS 3.00 6.00 000000 LANID OPEATINOVE AL LINES SENTCE 2.72 6.00 000000 LANID OPEATINOVE 2.77 6.00 000000 LERENY 1.75 2.7,715 6.00 000000 LERENY 0.00 0.00 0.00 7.00 000000 LERENY 1.733 0 0.00 0.00 7.00 01000 LERENY 1.333 0 0 0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>1</td><td></td><td>1</td></t<>						1		1
10. 00 01000 CENTRAL SERVICES & SUPPLY 0 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 ADMINI STRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY	10, 585 272 11, 864 17, 884	1, 712 469 4, 279	27, 715 (19, 378		2.00 3.00 4.00 5.00 6.00 7.00 8.00
14.00 01400_NURSI NG AND ALLIED HEALTH EDUCATION 0 <t< td=""><td>10. 00 11. 00</td><td>01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY</td><td>0</td><td>0 0 0 0</td><td></td><td></td><td>0</td><td>10.00 11.00</td></t<>	10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0 0 0 0			0	10.00 11.00
30. 00 03000 SKILLED NURSING FACILITY 47, 897 26, 458 27, 715 14, 201 88, 761 30. 00 30. 00 03300 ICF, 11 D 0 0 0 0 0 31. 00 30. 00 03300 ICF, 11 D 0 0 0 0 0 33. 00 30. 00 03300 IFFR LORG TERM CARE 0 0 0 0 0 33. 00 40.00 04000 OHTHE LORG TERM CARE 0	14.00	01400 NURSI NG AND ALLIED HEALTH EDUCATION 01500 RECREATION	0	0		0 0	0	14.00
31.00 03100 NUES ING FACILITY 0 0 0 0 0 31.00 32.00 03300 OTHER LONG TERM CARE 0 0 0 0 32.00 40.00 03300 OTHER LONG TERM CARE 0 0 0 0 32.00 40.00 CANDELLARY SERVICE COST CENTERS 0 0 0 0 40.00 41.00 ALARY SERVICE COST CENTERS 0 0 0 0 40.00 42.00 D42000 IARDRATORY 45.00 0 0 0 42.00 43.00 04200 INTRAVENUS THERAPY 7,055 2,029 0 1,089 44.00 44.00 04400 PHYSICAL THERAPY 7,055 2,029 0 0 0 45.00 45.00 04500 OCUPATI ONLI THERAPY 7,055 2,029 0 0 0 45.00 46.00 04500 OCUPATI ONLI THERAPY 7,055 2,029 0 0 0 0 0 0 0 0 0 0 0	20 00		47 907	26 /59	27.71	14 201	00 761	20.00
32. 00 03200 (CF/11D 0 0 0 0 33. 00 30. 00 300 (PABE LOAG TERM CARE 0 <				-				1
ANCI LLARY SERVICE COST CENTERS Image: Cost Centers ANCI LLARY SERVICE COST CENTERS 0			0					1
40.00 04000 RADIOLOGY 176 0	33.00	03300 OTHER LONG TERM CARE	0	0	(0 0	0	33.00
41.00 04100 LABORATORY 455 0 0 0 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0 42.00 43.00 04300 OXYGEN (INHALATTON) THERAPY 7.055 2.029 0 1.089 0 42.00 0.00 00 0.00 0 0 0 0 43.00 0.00 00 0.00 0 0 0 0 0 44.00 0.00 00 0.00 0.00 0 0 0 45.00 0.00 0.00 0.00 0 0 0 0 0 0 0 45.00 0.00 0.00 0.00 0 0 0 0 0 0 47.00 0.00 0.00 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
42.00 Qod200 INTRAVENOUS THERAPY 0 0 0 0 42.00 43.00 Q4300 Q4400 PHYSI CAL THERAPY 7,055 2,029 0 1,089 0 44.00 06 Q4500 QCUPATI ONAL THERAPY 4,895 0 0 0 0 0 45.00 0 0 0 0 0 44.00 44.00 45.00 0 0 0 0 0 0 0 0 45.00 0								
43.00 04300 0xycen (1NHALATION) THERAPY 0 0 0 0 43.00 44.00 044000 PHYSICAL THERAPY 7,055 2,029 0 1,089 0 44.00 44.00 044000 PHYSICAL THERAPY 4,895 0 <t< td=""><td></td><td></td><td>1</td><td></td><td></td><td></td><td></td><td>1</td></t<>			1					1
44.00 04400 PHYSICAL THERAPY 7,055 2,029 0 1,089 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 4,895 0 0 0 0 45.00 46.00 04600 SPECH PATHOLOGY 196 0 0 0 45.00 48.00 04600 SPECH PATHOLOGY 0 0 0 0 47.00 48.00 04600 DENTAL CREE CHARGED TO PATIENTS 2,279 0 0 0 0 49.00 0.00 DOTOD ENTAL CREE THE XIX X ONLY 0			0	0				
45.00 0A500 CCUPATIONAL THERAPY 4,895 0 </td <td></td> <td></td> <td>7,055</td> <td>0</td> <td></td> <td>-</td> <td></td> <td></td>			7,055	0		-		
47.00 04700 LECTROCARDIOLOGY 0 0 0 0 47.00 48.00 048000 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,279 0 0 0 48.00 9.00 04900 DRUGS CHARGED TO PATIENTS 2,279 0 0 0 0 49.00 0.00 0000 DETAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 0 0 0 0 50.00				-			0	1
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 46 0 0 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 2, 279 0 0 0 0 49.00 50.00 05000 DENTAL CARE - TI TLE XIX ONLY 0 <td< td=""><td>46.00</td><td>04600 SPEECH PATHOLOGY</td><td>196</td><td>0</td><td>0</td><td>0 0</td><td>0</td><td>46.00</td></td<>	46.00	04600 SPEECH PATHOLOGY	196	0	0	0 0	0	46.00
49.00 DAUGS CHARGED TO PATLENTS 2,279 0 0 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0			0	0	(0 0	0	
50.00 OSOOD DENTAL CARE - TITLE XIX ONLY O			1 1	0	(0 0		1
51.00 OSIOO SUPPORT SURFACES O </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td>-</td> <td>1</td>				0		0	-	1
OUTPATIENT SERVICE COST CENTERS Image: Cost Centers 60.00 06000 (CLINIC 0<			-	0		-		
60.00 06000 CLINIC 0 0 0 0 0 0 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 61.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 63.00 0 0 0 0 62.00 63.00 62.00 63.00 62.00 63.00	51.00		U	0	<u> </u>		0	51.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 62.00 06200 FOHC 0 0 0 62.00 63.00 62.00 63.00 62.00 63.00	60.00		0	0	(0 0	0	60.00
63.00 DAY CARE 0 0 0 0 0 0 0 63.00 0THER REIMBURSABLE COST CENTERS 0<	61.00		0	0	1		0	1
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HMBE HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0 0 0 70.00 71.00 71.00 71.00 73.00 CMAC 0	62.00	06200 FQHC						62.00
70.00 07000 HOME HEALTH AGENCY COST 0 <t< td=""><td>63.00</td><td></td><td>0</td><td>0</td><td>(</td><td>0 0</td><td>0</td><td>63.00</td></t<>	63.00		0	0	(0 0	0	63.00
71.00 07100 AMBULANCE 370 0 0 0 0 71.00 73.00 07300 CMHC 0 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 08100 INTEREST EXPENSE 82.00 83.00 08300 HOSPICE 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 114,899 38,150 27,715 19,305 88,761 89.00 90.00 GPG00 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 91.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 92.00 93.00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 92.00 93.00 09200 PHYSI CI ANS PRI VAT	70.00				1			70.00
73.00 07300 CMHC 0 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>				0				
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 81.00 08100 INTEREST EXPENSE 80.00 82.00 08200 UTI LI ZATI ON REVIEW - SNF 82.00 83.00 08300 HOSPI CE 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 114,899 38,150 27,715 19,305 88,761 89.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 90.00 90.00 91.00 90.00 91.00 90.00 91.00 91.00 92.00 92.00 93.00 91.00 92.00 93.00 91.00 92.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00 95.00 97.00 0 0 0 97.00 96.00 Cross Foot Adj				0				
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 80.00 81.00 83.00 08300 HOSPICE 0 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 114,899 38,150 27,715 19,305 88,761 89.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 90.00	75.00		0	0	1		0	/ 5. 00
82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 HOSPICE 0 0 0 83.00 83.00 08300 HOSPICE 0 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 114,899 38,150 27,715 19,305 88,761 89.00 NONREL MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 91.00 09100 BARBER AND BEAUTY SHOP 25 135 0 73 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 94.00 0400 PATIENTS LAUNDRY 0 0 0 0 93.00 95.00 OSUD OAYCARE 8,173 0 0 0 0 98.00	80.00							80.00
83.00 08300 HOSPICE 0 0 0 0 83.00 83.00 89.00 SUBTOTALS (sum of lines 1-84) 114,899 38,150 27,715 19,305 88,761 89.00 NONREL MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 91.00 09100 BARBER AND BEAUTY SHOP 25 135 0 73 0 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.00 93.00 09400 PATI ENTS LAUNDRY 0 0 0 0 92.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 93.00 95.00 09500 DAYCARE 8,173 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00	81.00	08100 INTEREST EXPENSE						81.00
89.00 SUBTOTALS (sum of lines 1-84) 114,899 38,150 27,715 19,305 88,761 89.00 NONREL MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00								82.00
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0			0	0	(0 0		
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 <td>89.00</td> <td></td> <td>114, 899</td> <td>38, 150</td> <td>27, 715</td> <td>5 19, 305</td> <td>88, 761</td> <td>89.00</td>	89.00		114, 899	38, 150	27, 715	5 19, 305	88, 761	89.00
91.00 09100 BARBER AND BEAUTY SHOP 25 135 0 73 0 91.00 92.00 09200 PHYSICLANS PRIVATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 95.00 DAYCARE 8,173 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 98.00 0 0 99.00	00.00						0	00.00
92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 95.00 09500 DAYCARE 8,173 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 98.00 99.00								
93.00 09300 NONPAID WORKERS 0 0 0 93.00 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 95.00 95.00 95.00 0 0 0 95.00 95.00 95.00 0 0 0 95.00 98.00 98.00 98.00 98.00 98.00 99.00 99.00 99.00 99.00 99.00 0 0 0 99.00			25	135				
94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 94.00 94.00 94.00 94.00 94.00 95.00 00 0 0 95.00 95.00 DAYCARE 8,173 0 0 0 0 95.00 98.00 99.00 Negative Cost Centers 0 0 0 0 99.00 99.00 0 0 0 0 99.00 0 0 0 99.00 0 0 0 99.00 0 0 0 0 99.00 0 99.00 0 0 0 0 99.00			0	0				1
95.00 09500 DAYCARE 8,173 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 99.00			0	0		o o		
99.00 Negative Cost Centers 0 0 0 0 0 99.00		09500 DAYCARE	8, 173	0	0	0 0	0	95.00
						0 0	-	
100.00 101AL 123,097 38,285 27,715 19,378 88,761 100.00				0	(
	100.00	n IOTAL	123, 097	38, 285	27, 715	p 19, 378	88, 761	100.00

	Financial Systems	PEACE CARE A		N 045440		eu of Form CMS-	2540-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315413	Period: From 01/01/2022 To 12/31/2022		pared: 2 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00 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	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION	4, 678					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0				10.00
11.00		0	0		0 1 1 2		11.00
12.00 13.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0	0		0 1, 133		12.00 13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0		14.00
15.00	01500 RECREATION	0	0		0 0		1
	INPATIENT ROUTINE SERVICE COST CENTERS	-		•			1
30.00	03000 SKILLED NURSING FACILITY	4, 678	0		0 1, 133	3 2, 824	30.00
31.00	03100 NURSING FACILITY	0	0		0 0		31.00
32.00	03200 I CF/I I D	0	0		0 (32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 (0 0	33.00
40, 00	ANCI LLARY SERVI CE COST CENTERS	0	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	ol o	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	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0				48.00 49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0		50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0		
	OUTPATIENT SERVICE COST CENTERS					1 .	
60.00	06000 CLI NI C	0	0		0 (0 0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 (0 0	
62.00	06200 FQHC		0				62.00
63.00	06300 DAY CARE OTHER REIMBURSABLE COST CENTERS	0	0	1	0 (0 0	63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0 0	70.00
	07100 AMBULANCE	0	0		0 0		
73.00	07300 CMHC	0	0)	0 0	0 0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF		0		0		82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 4, 678	0 0		0 0 1, 133	0 0 2,824	83.00 89.00
09.00	NONREI MBURSABLE COST CENTERS	4,070	0	1	0 1,13	2,024	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 (0 0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0 0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 (0 0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0 0	
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	
95.00	09500 DAYCARE	0	0		U (0	
98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0	0		0 0	0	98.00 99.00
99.00 100.00		4, 678	0		0 1, 133		100.00
100.00		I 7,070	0	1	SI 1, 150	1 2,024	1.00.00

Heal th	Financial Systems	PEACE CARE A	T ST. ANNS		In Lie	u of Form CMS-:	2540-10
	TION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/22/2023 1:2	pared: 2 pm
	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	
	GENERAL SERVICE COST CENTERS	1	1	1			
1.00 2.00 3.00 4.00 5.00 6.00 7.00	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						1.00 2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY						8.00 9.00 10.00 11.00 12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	FE 251				13.00 14.00
15.00	01500 RECREATION	0	55, 351				15.00
30. 00 31. 00 32. 00	03000 SKI LLED NURSI NG FACI LI TY 03100 NURSI NG FACI LI TY 03200 I CF/I I D	000000000000000000000000000000000000000	55, 351 0 0		8 0 0 0 0 0	666, 658 0 0	30. 00 31. 00 32. 00
33.00	03300 OTHER LONG TERM CARE	0		1	0 0	0	33.00
	ANCILLARY SERVICE COST CENTERS	1	1	-			
40.00	04000 RADI OLOGY	0	0	1		176	
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY			45	5 O 0 O	455 0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
44.00	04400 PHYSI CAL THERAPY	0	0	40, 65	9 0	40, 659	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	4, 89		4, 895	1
46.00	04600 SPEECH PATHOLOGY	0	0	19		196	•
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0		4 2,27	6 0	46 2, 279	48.00 49.00
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY				0 0	2,2/9	1
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	
	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 OTHER REIMBURSABLE COST CENTERS	0	0	1	0 0	0	63.00
70 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	0	37	0 0		71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS	T	1	1			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW - SNF						81.00 82.00
83.00	08300 HOSPI CE	0	0		0 0	0	•
89.00	SUBTOTALS (sum of lines 1-84)	0	-	715, 73		715, 734	
	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	0	2, 26	6 0	2, 266	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	•
93.00 94.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY					0	
94.00 95.00	09500 DAYCARE			8, 17	3 0	8, 173	
98.00	Cross Foot Adjustments	0	0	0,17	0 0	0,173	•
99.00	Negative Cost Centers	0	0		0 0	0	
100.00	TOTAL	0	55, 351	726, 17	3 0	726, 173	100. 00

ST ALLOCATION - STATISTICAL BASIS		AT ST. ANNS Provider		eri od:	worksheet B-1	
				rom 01/01/2022 o 12/31/2022	Date/Time Pre	nare
			,	12/31/2022	5/22/2023 1:2	
	CAPITAL RE	LATED COSTS				
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	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						
00 00100 CAP REL COSTS - BLDGS & FIXTURES	90, 706					1
00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00 00300 EMPLOYEE BENEFITS	0	90, 706				2
00 00400 ADMINISTRATIVE & GENERAL	15, 376	-			12, 274, 228	4
00 00500 PLANT OPERATION, MAINT. & REPAIRS	3, 460				1, 055, 485	5
00 00600 LAUNDRY & LINEN SERVICE	3, 214	3, 214	C	0	27, 117	6
00 00700 HOUSEKEEPI NG	880				1, 182, 920	
	8,032	8, 032			1, 783, 234	8
00 00900 NURSI NG ADMI NI STRATI ON 00 01000 CENTRAL SERVI CES & SUPPLY			353, 129		466, 405	9 10
00 01100 PHARMACY				0	0	11
00 01200 MEDICAL RECORDS & LIBRARY	C	0	37, 735	0	112, 960	12
00 01300 SOCIAL SERVICE	130				167, 222	13
00 01400 NURSING AND ALLIED HEALTH EDUCATION 00 01500 RECREATION	5, 883		-	-	0	14 15
INPATIENT ROUTINE SERVICE COST CENTERS	5,003	5, 883	211, 606	<u>ı</u> 0	342, 664	1 13
00 03000 SKILLED NURSING FACILITY	49,669	49, 669	2, 977, 878	0	4, 775, 971	30
00 03100 NURSING FACILITY	C	-		-	0	31
	C		C	-	0	32
00 03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	C	0 0	C	0	0	33
00 04000 RADI OLOGY	С	0	C	0	17, 595	40
00 04100 LABORATORY	C		C		45, 376	41
00 04200 I NTRAVENOUS THERAPY	C	° °	C	0	0	42
00 04300 0XYGEN (INHALATION) THERAPY	0		C 507 220	0	0	43
00 04400 PHYSI CAL THERAPY 00 04500 OCCUPATI ONAL THERAPY	3, 808				703, 473 488, 103	
00 04600 SPEECH PATHOLOGY			14, 841		19, 576	
00 04700 ELECTROCARDI OLOGY	C	0	C		0	47
00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	C	0	4, 604	48
00 04900 DRUGS CHARGED TO PATIENTS	0	0		0	227, 238	49
00 05000 DENTAL CARE - TITLE XIX ONLY 00 05100 SUPPORT SURFACES				-	0	50 51
OUTPATIENT SERVICE COST CENTERS				0	0	
00 06000 CLINIC	C	0 0	C	0	0	60
00 06100 RURAL HEALTH CLINIC	C	0	C	0	0	61
00 06200 FOHC						62
00 06300 DAY CARE OTHER REIMBURSABLE COST CENTERS	C	0	C	0	0	63
00 07000 HOME HEALTH AGENCY COST	C	0 0	C	0	0	70
00 07100 AMBULANCE	C			-	36, 904	71
	C	0 0	C	0	0	73
SPECIAL PURPOSE COST CENTERS 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80
00 08100 INTEREST EXPENSE						81
00 08200 UTILIZATION REVIEW - SNF						82
00 08300 HOSPI CE	C	-	-	0	0	
00 SUBTOTALS (sum of lines 1-84)	90, 452	90, 452	6, 642, 448	-2, 611, 843	11, 456, 847	89
NONREI MBURSABLE COST CENTERS 00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN	C		C	0	0	90
00 09100 BARBER AND BEAUTY SHOP	254				2, 479	
00 09200 PHYSICIANS PRIVATE OFFICES	C			0	0	92
00 09300 NONPAID WORKERS	C	0	C	0	0	93
00 09400 PATIENTS LAUNDRY 00 09500 DAYCARE			0	0	0 814, 902	94 95
00 Cross Foot Adjustments		, 0		0	814,902	95
00 Negative Cost Centers						99
2.00 Cost to be allocated (per Wkst. B,	726, 173	0	2, 119, 396		2, 611, 843	
Part I)						
3.00 Unit cost multiplier (Wkst. B, Part I)	8.005788	0. 000000	0. 319069		0. 212791	
4.00 Cost to be allocated (per Wkst. B, Part II)					123, 097	104
5.00 Unit cost multiplier (Wkst. B, Part			0.000000		0. 010029	105
		1		1		1 22

Heal th	Financial Systems	PEACE CARE A	T ST. ANNS		In Lie	u of Form CMS-	2540-10
	LLOCATION - STATISTICAL BASIS				Period: From 01/01/2022	Worksheet B-1	
					To 12/31/2022		
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/22/2023 1:2 NURSI NG	2 pm
		OPERATION,	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAI NT. & REPAI RS	LAUNDRY)			(DI RECT	
		(SQUARE FEET)	(00	7.00	0.00	NURSI NG)	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00
3.00 4.00	00400 ADMINISTRATIVE & GENERAL						3.00 4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	71, 870					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	3, 214					6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY	880 8, 032					7.00 8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0,002		0,002		124, 797	1
10.00	01000 CENTRAL SERVICES & SUPPLY	0	-	0	0	0	
11. 00 12. 00	01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY	0	-			0	
13.00	01300 SOCI AL SERVI CE	130	-			0	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	-		-	0	
15.00	01500 RECREATION INPATIENT ROUTINE SERVICE COST CENTERS	5, 883	0	5, 883	3 0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	49, 669	35, 652	49, 669	9 106, 956	124, 797	30.00
31.00	03100 NURSING FACILITY	0	C	C	0 0	0	31.00
32.00	03200 I CF/I I D	0	-			0	
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C	0	0 0	0	33.00
40.00	04000 RADI OLOGY	0	C	C	0 0	0	40.00
41.00	04100 LABORATORY	0	-			0	
42.00 43.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	-			0	
44.00	04400 PHYSI CAL THERAPY	3, 808	-		-	0	1
45.00	04500 OCCUPATI ONAL THERAPY	0	-	-		0	
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0				0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	1
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	c c	-	0	
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY	0	-		-	0	
51.00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0		η (<u> </u>	0	1 51.00
60.00	06000 CLI NI C	0	C	0)	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	C	0 0	0	
62.00 63.00	06200 FQHC 06300 DAY CARE	0	C	, c	0	0	62.00 63.00
00.00	OTHER REIMBURSABLE COST CENTERS			1	<u> </u>		
	07000 HOME HEALTH AGENCY COST	0			, 0		70.00
71.00 73.00	07100 AMBULANCE 07300 CMHC	0				0	1
73.00	SPECIAL PURPOSE COST CENTERS	0		η (0	73.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW - SNF						81.00 82.00
82.00 83.00	08200 HOSPICE	0	c c		0	0	
89.00	SUBTOTALS (sum of lines 1-84)	71, 616	-	67, 522	106, 956	124, 797	
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		^			0	90.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 254		1		0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0		0		0	92.00
93.00	09300 NONPAID WORKERS	0	0	0	0	0	
94.00 95.00	09400 PATIENTS LAUNDRY 09500 DAYCARE				ט <u>ו</u> ע ה וו	0	
98.00	Cross Foot Adjustments					0	98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1, 280, 083	90, 132	1, 450, 309	2, 477, 622	565, 652	102.00
103.00		17.811089	2. 528105	21. 398563	3 23. 164872	4. 532577	103.00
104.00	Cost to be allocated (per Wkst. B,	38, 285					104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 532698	0. 777376	0. 285912	0. 829883	0. 037485	105 00
105.00	II)	0. 332090	0.777370	0.200712	0.027003	0. 037400	100.00
	•						

Health Financial Systems	PEACE CARE AT	ST. ANNS		In Lie	eu of Form CMS-	2540-10
COST ALLOCATION - STATISTICAL BASIS				Period:	Worksheet B-1	
				From 01/01/2022 Fo 12/31/2022		
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	5/22/2023 1:2 NURSI NG AND	2 pm
	SERVICES &	(COSTED	RECORDS &		ALLI ED HEALTH	
	SUPPLY (COSTED	REQUI S)	LIBRARY (TIME SPENT)	(TIME SPENT)	EDUCATI ON (ASSI GNED	
	REQUI S)				TIME)	
	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVI CE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FI XTURES			1	1		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 5. 00 00500 PLANT OPERATI ON, MAI NT. & REPAI RS						4.00 5.00
6.00 00600 LAUNDRY & LI NEN SERVI CE						6.00
						7.00
8. 00 00800 DI ETARY 9. 00 00900 NURSI NG ADMI NI STRATI ON						8.00 9.00
10.00 01000 CENTRAL SERVICES & SUPPLY	231, 842					10.00
	0	0	25 45			11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 13. 00 01300 SOCI AL SERVI CE	0	0	35, 652			12.00 13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(
15. 00 01500 RECREATION	0	0	(0 0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 OSIOOO SKILLED NURSING FACILITY	0	0	35, 652	2 35, 652	0	30.00
31.00 03100 NURSING FACILITY	0	0	(0 0	0	31.00
32.00 03200 I CF/I I D	0	0				32.00
33. 00 03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	(0 0	0	33.00
40. 00 04000 RADI OLOGY	0	0				40.00
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS_THERAPY	0	0	(0	0	41.00
42.00 04200 INTRAVENOUS THERAPY 43.00 04300 0XYGEN (INHALATION) THERAPY	0	0			0	
44. 00 04400 PHYSI CAL THERAPY	0	0	0	0 0	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	(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	4,604	0	(0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	227, 238	0	(0	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 51.00 05100 SUPPORT SURFACES	0	0	-		0	50.00 51.00
OUTPATIENT SERVICE COST CENTERS			1			
60. 00 06000 CLINIC 61. 00 06100 RURAL HEALTH CLINIC	0	0				
62. 00 06200 FQHC	0	0			0	62.00
63. 00 06300 DAY CARE	0	0		0 0	0	63.00
OTHER REI MBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST	0	0			0	70.00
71.00 07100 AMBULANCE	0	0			0	
73.00 07300 CMHC	0	0		0 0	0	
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80,00
81. 00 08100 I NTEREST EXPENSE						81.00
82.00 08200 UTI LI ZATI ON REVIEW - SNF		_			_	82.00
83.00 08300 HOSPICE 89.00 SUBTOTALS (sum of lines 1-84)	0 231, 842	0	35, 652	0 0 2 35,652	0	
NONREI MBURSABLE COST CENTERS	231, 042	0	33, 032	55,052	0	07.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0		1
91. 00 09100 BARBER AND BEAUTY SHOP 92. 00 09200 PHYSI CLANS PRI VATE OFFICES	0	0			0	
93.00 09300 NONPALD WORKERS	0	0	0	0 0	0	
94.00 09400 PATIENTS LAUNDRY	0	0			0	1
95.00 09500 DAYCARE 98.00 Cross Foot Adjustments	U	0		0	0	95.00 98.00
99.00 Negative Cost Centers						99.00
102.00 Cost to be allocated (per Wkst. B,	0	0	136, 997	7 207, 902	0	102.00
Part I) 103.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	3. 842618	5. 831426	0. 000000	103, 00
104.00 Cost to be allocated (per Wkst. B,	0	0	1, 133			103.00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part	0,000000	0 00000	0 001770	0 070210	0. 000000	105 00
105.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 031779	0. 079210	0.00000	103.00
						-

	Financial Systems LLOCATION - STATISTICAL BASIS	PEACE CARE AT		No.: 315413	Peri od:	Worksheet B-	
,031 F	LEUCATION - STATISTICAE DASIS		TTOVIGET	10515415	From 01/01/2022		
					To 12/31/2022	Date/Time Pr 5/22/2023 1:	
		OTHER GENERAL					
	Cost Contor Description	SERVICE RECREATION					
	Cost Center Description	(CENSUS)					
		15.00					
	GENERAL SERVICE COST CENTERS	10100					
. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
. 00	00300 EMPLOYEE BENEFITS						3.0
. 00	00400 ADMINI STRATI VE & GENERAL						4.0
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.0
o. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						6.0
. 00 3. 00	00800 DI ETARY						8.0
. 00	00900 NURSI NG ADMI NI STRATI ON						9.0
0.00	01000 CENTRAL SERVICES & SUPPLY						10.0
1.00	01100 PHARMACY						11.0
2.00	01200 MEDICAL RECORDS & LIBRARY						12.0
3.00	01300 SOCIAL SERVICE						13.0
	01400 NURSING AND ALLIED HEALTH EDUCATION						14.0
5.00	01500 RECREATION	35, 652					15.0
0.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	25 (52)					
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	35, 652 0					30.0
	03200 I CF/I I D	0					32.0
	03300 OTHER LONG TERM CARE	0					33.0
	ANCI LLARY SERVI CE COST CENTERS						
0.00	04000 RADI OLOGY	0					40.0
1.00	04100 LABORATORY	0					41.0
2.00	04200 I NTRAVENOUS THERAPY	0					42.0
	04300 OXYGEN (INHALATION) THERAPY	0					43.0
4.00	04400 PHYSI CAL THERAPY	0					44.0
5.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0					45.0
	04700 ELECTROCARDI OLOGY	0					40.0
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					48.0
9.00	04900 DRUGS CHARGED TO PATIENTS	0					49.0
0. 00	05000 DENTAL CARE - TITLE XIX ONLY	0					50.0
1. 00	05100 SUPPORT SURFACES	0					51.0
	OUTPATIENT SERVICE COST CENTERS						
0.00		0					60.0
01.00 02.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0					61.0 62.0
	06300 DAY CARE	0					63.0
0.00	OTHER REIMBURSABLE COST CENTERS	0					
0. 00	07000 HOME HEALTH AGENCY COST	0					70.0
1. 00	07100 AMBULANCE	0					71.0
3.00	07300 CMHC	0					73.0
	SPECIAL PURPOSE COST CENTERS						
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.0
32.00	08200 UTILIZATION REVIEW - SNF						82.0
3.00	08300 HOSPI CE	0					83.0
9.00	SUBTOTALS (sum of lines 1-84)	35, 652					89.0
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0					90.0
1.00	09100 BARBER AND BEAUTY SHOP	0					91.0
	09200 PHYSI CLANS PRI VATE OFFI CES	0					92.0
3.00	09300 NONPAID WORKERS	0					93.0
4.00 5.00	09400 PATIENTS LAUNDRY 09500 DAYCARE	0					94.0
8.00	Cross Foot Adjustments	0					95.0
9.00	Negative Cost Centers						99.0
02.00	5	646, 251					102.0
	Part I)						
03.00		18. 126641					103. 0
04.00		55, 351					104. 0
	Part II)						
05.00	Unit cost multiplier (Wkst. B, Part	1. 552536					105.0

Health Financial Systems PEACE CARE AT ST. ANNS		In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provider		eriod:	Worksheet C	
		rom 01/01/2022 o 12/31/2022	Date/Time Pre	narod
	1	0 12/31/2022	5/22/2023 1:2	
Cost Center Description	Total (from	Total Charges	Ratio (col. 1	
	Wkst. B, Pt I,		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	21, 339		0.000000	
41. 00 04100 LABORATORY	55, 032	0	0.000000	
42. 00 04200 I NTRAVENOUS THERAPY	C	0	0.000000	
43.00 04300 OXYGEN (INHALATION) THERAPY	C	0	0.00000	
44.00 04400 PHYSI CAL THERAPY	1, 002, 477		1. 324668	
45.00 04500 OCCUPATI ONAL THERAPY	591, 967		0.824822	
46.00 04600 SPEECH PATHOLOGY	23, 742	299, 240	0. 079341	
47. 00 04700 ELECTROCARDI OLOGY	C	0	0.000000	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 584		0.00000	
49.00 04900 DRUGS CHARGED TO PATIENTS	275, 592	116, 935	2.356797	
50.00 O5000 DENTAL CARE - TITLE XIX ONLY	C	0	0.00000	
51.00 OS100 SUPPORT SURFACES	0	0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS	1			1 1 0 0 0
60. 00 06000 CLINIC	0	0	0.000000	
61.00 06100 RURAL HEALTH CLINIC				61.00
62.00 06200 FQHC			0 000000	62.00
63. 00 06300 DAY CARE		0	0.00000	
71.00 07100 AMBULANCE	44, 757		0. 000000	
100. 00 Total	2, 020, 490	1, 890, 642		100. 00

Health Financial Systems	PEACE CARE A	T ST. ANNS		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315413	Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII (1)	Skilled Nursing	PPS	
			01	Facility		
		Health Care Pi	rogram Charge	es Heal th Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges (Fr. Wkst. C Column 3)			x col. 2)	x col. 3)	
	1.00	2.00	3.00	4,00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2100	0.00		0100	
ANCI LLARY SERVICE COST CENTERS						1
40. 00 04000 RADI OLOGY	0.000000	0		0 0	C	40.00
41. 00 04100 LABORATORY	0. 000000	0		0 0	c c	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 000000	0		0 0	C	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0	1	0 0	C	43.00
44.00 04400 PHYSI CAL THERAPY	1. 324668	446, 249		0 591, 132	C	44.00
45.00 04500 OCCUPATI ONAL THERAPY	0. 824822	445, 414		0 367, 387	C	45.00
46.00 04600 SPEECH PATHOLOGY	0. 079341	288, 760		0 22, 911	C	46.00
47.00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	C	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	C	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	2. 356797	111, 614		0 263, 052	C	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	C	51.00
OUTPATIENT SERVICE COST CENTERS	-			-		
60. 00 06000 CLINIC	0. 000000	0		0 0	C	
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
63.00 06300 DAY CARE	0. 000000			0 0	C	
71.00 07100 AMBULANCE (2)	0. 000000			0	C	
100.00 Total (Sum of lines 40 - 71)		1, 292, 037		0 1, 244, 482	(C	100.00
(1) For title V and VLV use columns 1 2 and 4 only						

(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-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315413	Period: From 01/01/2022 To 12/31/2022		pared: 2 pm
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST						
1.00 Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	2.356797	1.00
2.00 Program vaccine charges (From your reco	rds, or the PS&	&R)			0	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	viders, transf	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	Part I, Col.	Costs to Tota		for Pass	
		14)	Costs - Part		Through (Col.	
			(Col. 2 / Col 1)		3 x Col. 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 SERVI CE COST CENTERS						1
40. 00 04000 RADI OLOGY	21, 339	C	0.0000	0 00	0	40.00
41.00 04100 LABORATORY	55, 032	C	0.0000	0 0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	C	0.0000	0 0	0	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY	0	C	0.0000	0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	1, 002, 477	C	0.0000	591, 132	0	44.00
45.00 04500 OCCUPATI ONAL THERAPY	591, 967	C	0.0000	367, 387	0	45.00
46.00 04600 SPEECH PATHOLOGY	23, 742	C	0.0000	22, 911	0	46.00
47.00 04700 ELECTROCARDI OLOGY	0	C	0.0000	0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 584	C	0.0000	0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	275, 592	C	0.0000		0	1 1 1 0 0
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	C	0.0000		0	00.00
51.00 05100 SUPPORT SURFACES	0	C	0.0000	0 0	0	011.00
100.00 Total (Sum of Lines 40 - 52)	1, 975, 733	C		1, 244, 482	0	100.00

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315413	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/22/2023 1:2	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				1
1.00	Inpatient days including private room days			35, 652	1.00
2.00	Private room days			0	2.00
3.00	Inpatient days including private room days applicable to the	Program		4, 581	3.00
4.00	Medically necessary private room days applicable to the Progr	am		0	4.00
5.00	Total general inpatient routine service cost		11, 864, 309	5.00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		13, 499, 139		
7.00	General inpatient routine service cost/charge ratio (Line 5		0. 878894		
8.00	Enter private room charges from your records		0	8.00	
9.00	Average private room per diem charge (Private room charges li 2)	0.00	9.00		
10.00	Enter semi-private room charges from your records	0	10.00		
11.00	Average semi-private room per diem charge (Semi-private roon semi-private room days)	d by	0.00	11.00	
12.00	Average per diem private room charge differential (Line 9 mir	nus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times	s line 12)		0.00	13.00
	Private room cost differential adjustment (Line 2 times line			0	14.00
15.00	General inpatient routine service cost net of private room co PROGRAM INPATIENT ROUTINE SERVICE COSTS	ost differential (Line 5	minus line 14)	11, 864, 309	15.00
16.00	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		332.78	16.00
17.00	Program routine service cost (Line 3 times line 16)			1, 524, 465	17.00
	Medically necessary private room cost applicable to program			0	18.00
19.00	Total program general inpatient routine service cost (Line 1	17 plus line 18)		1, 524, 465	19.00
20. 00	Capital related cost allocated to inpatient routine service on line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	666, 658	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)			18.70	21.00
	Program capital related cost (Line 3 times line 21)			85, 665	
	Inpatient routine service cost (Line 19 minus line 22)			1, 438, 800	
	Aggregate charges to beneficiaries for excess costs (From pr			0	24.00
	Total program routine service costs for comparison to the cos	st limitation (Line 23 mi	nus line 24)	1, 438, 800	
	Enter the per diem limitation (1)				26.00
	Inpatient routine service cost limitation (Line 3 times the p				27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus t		line 27)		28.00
	(Transfer to Worksheet E, Part II, line 4) (See instructions) nes 26 and 27 are not applicable for title XVIII, but may be u		I		I

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	35, 652	1.00
2.00	Program inpatient days (see instructions)	4, 581	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 128492	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315413	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Prep 5/22/2023 1:22	
		Title XVIII	Skilled Nursing	PPS	<u> </u>
			Facility		
			-	1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBUF	RSEMENT		1.00	
00	Inpatient PPS amount (See Instructions)			3, 692, 762	1.0
00	Nursing and Allied Health Education Activities (pass through p	payments)		0	2.0
00	Subtotal (Sum of Lines 1 and 2)			3, 692, 762	3.0
00	Primary payor amounts			0	4.0
00	Coinsurance			476, 136	5.0
00	Allowable bad debts (From your records)			136, 180	
00	Allowable Bad debts for dual eligible beneficiaries (See inst	ructions)		79, 889	
00	Adjusted reimbursable bad debts. (See instructions)			88, 517	
00	Recovery of bad debts - for statistical records only			0	
), 00	Utilization review			0	10.0
. 00	Subtotal (See instructions)			3, 305, 143	
. 00	Interim payments (See instructions)			3, 311, 979	
. 00	Tentati ve adjustment			0	
. 00	OTHER adjustment (See instructions)			0	14. (
. 50	Demonstration payment adjustment amount before sequestration		0		
. 55	Demonstration payment adjustment amount after sequestration			0	14.5
I. 75	Sequestration for non-claims based amounts (see instructions)			1, 115	14.7
. 99	Sequestration amount (see instructions)			47, 423	14.9
5.00	Balance due provider/program (see Instructions)			-55, 374	15.0
6. 00	Protested amounts (Nonallowable cost report items in accordance	ce with CMS Pub. 15-2, s	ection 115.2)	0	16. (
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSEF	R OF COST OR CHARGES - T	ITLE XVIII ONLY		
1.00	Ancillary services Part B			0	17. (
3. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.0
. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. (
. 00	Medicare Part B ancillary charges (See instructions)			0	20.0
. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. (
. 00	Primary payor amounts			0	
. 00	Coinsurance and deductibles			0	
. 00	Allowable bad debts (From your records)			0	
. 01	Allowable Bad debts for dual eligible beneficiaries (see inst	ructions)		0	
. 02	Adjusted reimbursable bad debts (see instructions)			0	
. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.0
. 00	Interim payments (See instructions)			0	26.0
. 00	Tentative adjustment			0	27.0
. 00	Other Adjustments (See instructions) Specify			0	
3. 50	Demonstration payment adjustment amount before sequestration			0	28.5
8. 55	Demonstration payment adjustment amount after sequestration			0	
3. 99	Sequestration amount (see instructions)			0	
9.00	Balance due provider/program (see instructions)			0	
). 00	Protested amounts (Nonallowable cost report items) in accordar	nce with CMS Pub.15-2, s	ection 115.2	0	30.0

	Financial Systems PEACE CARE AT			u of Form CMS-	-2540
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY	Provi der No.: 315413	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part II Date/Time Pro 5/22/2023 1:2	
		Title XIX	Skilled Nursing	Cost	
			Facility		
				1.00	_
	COMPUTATION OF NET COST OF COVERED SERVICES			1.00	
. 00	Inpatient ancillary services (see Instructions)			(1.
. 00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, li	ine 5)			2
. 00	Outpatient services	The sy			5 3
. 00	Inpatient routine services (see instructions)				0 4
00	Utilization reviewphysicians' compensation (from provider i	records)			5 5
00	Cost of covered services (Sum of Lines 1 - 5)			(
00	Differential in charges between semiprivate accommodations ar	nd less than semi-private	accommodations		5 7
. 00	SUBTOTAL (Line 6 minus line 7)	na ress than sem private			5 8
. 00	Primary payor amounts				5 9
	Total Reasonable Cost (Line 8 minus line 9)				0 10
5.00	REASONABLE CHARGES				4 10
1. 00	Inpatient ancillary service charges			(0 11
	Outpatient service charges				0 12
	Inpatient routine service charges				0 13
	Differential in charges between semiprivate accommodations ar	nd less than seminrivate	accommodations		2 14
	Total reasonable charges	nd ress than sem private			0 15
5.00	CUSTOMARY CHARGES				1 13
6 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	(16
	Amounts that would have been realized from patients liable for	1 5	9		17
/.00	had such payment been made in accordance with 42 CFR 413.13(e	1 5	n a charge basi s	(יי <u>ו</u> י
8.00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.00000	18
	Total customary charges (see instructions)				19
7.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				4 ' '
0. 00	Cost of covered services (see Instructions)			(D 20
	Deducti bl es				21
	Subtotal (Line 20 minus line 21)				22
	Coi nsurance				23
	Subtotal (Line 22 minus line 23)				24
	Allowable bad debts (from your records)				25
	Subtotal (sum of lines 24 and 25)				26
	Unrefunded charges to beneficiaries for excess costs erroneou	usly collected based on c	orrection of		27
	cost limit				· [- /
3. 00	Recovery of excess depreciation resulting from provider termi	ination or a decrease in	program	(28
	utilization		pi ogi alli		-
9.00	Other Adjustments (see instructions) Specify			(29
	Amounts applicable to prior cost reporting periods resulting	from disposition of depr	eciable assets ((30
1 00	if minus, enter amount in parentheses)	- 27 20)			1
	Subtotal (Line 26 plus or minus lines 29, and 30, minus line	es 27 and 28)			31
	Interim payments Balance due provider/program (Line 31 minus line 32) (indicat) 32) 33
3.00					

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315413	Period: From 01/01/202 To 12/31/202		epare
		Ti tl	e XVIII	Skilled Nursin Facility		<u> </u>
		I npati en	nt Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero List separately each retroactive lump sum adjustment		3, 333, 1	28 0	000	
00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	
04				0	0	
)5	Provider to Program			0	0	1 3
50	ADJUSTMENTS TO PROGRAM	06/28/2022	21, 1	49	0	3
51		00, 20, 2022		0	0	
52				0	0	3 3
53				0	0) 3
54				0	0	
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-21, 1	49	0) 3
	- 3.98)				_	
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, 311, 9	79	0	4
	TO BE COMPLETED BY CONTRACTOR		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)2	TENTATI VE TO PROVI DER			0	0	
)2)3				0	0	
,5	Provider to Program					4 3
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
2				0	0	
9	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	5
00	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
01	PROGRAM TO PROVIDER			0	0	6
)2	PROVI DER TO PROGRAM		55, 3	74	0	
00	Total Medicare program liability (see instructions)		3, 256, 6		0	
			Contra	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.

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der		Period: From 01/01/2022 To 12/31/2022	Worksheet G Date/Time Pre 5/22/2023 1:2	epare
-		General Fund	Speci fi c	Endowment Fund	Plant Fund	2 pm
		1.00	Purpose Fund 2.00	3.00	4.00	
						_
0	CURRENT ASSETS Cash on hand and in banks	888, 283		0 0	0	1.
0	Temporary investments	12, 916, 474		0 0	0	
0	Notes receivable	0		0 0	0	3.
0	Accounts receivable	3, 012, 632		0 0	0	
0 0	Other receivables Less: allowances for uncollectible notes and accounts	99, 283 -1, 265, 196		0 0	0	
0	recei vabl e	-1,205,190		0	0	ή ο
0	Inventory	0		0 0	0	7
0	Prepaid expenses	269, 789		0 0	0	
0	Other current assets	49,037		0 0	0	
00 00	Due from other funds TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	1, 126, 919 17, 097, 221		0 0 0 0	0	
00	FIXED ASSETS	17,077,221		0 0	0	4 ''
00	Land	2, 997, 898		0 0	0	12
00	Land improvements	29, 300		0 0	0	
00	Less: Accumulated depreciation	-2, 126		0 0	0	
00 00	Buildings Less Accumulated depreciation	25, 823, 045 -17, 527, 145		0 0 0 0	0	
00	Leasehold improvements	0		0 0	0	
00	Less: Accumulated Amortization	0		0 0	0	
00	Fixed equipment	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	
00 00	Automobiles and trucks Less: Accumulated depreciation	0			0	
00	Major movable equipment	3, 041, 643		0 0	0	
00	Less: Accumulated depreciation	-2, 638, 603		0 0	0	
00	Minor equipment - Depreciable	0		0 0	0	
00	Minor equipment nondepreciable	0		0 0	0	
00 00	Other fixed assets	0 11, 724, 012		0 0 0 0	0	
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	11,724,012		0 0	0	20
00	Investments	0		0 0	0	29
00	Deposits on Leases	0		0 0	0	
00	Due from owners/officers	-229, 458		0 0	0	
00 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	154, 947 -74, 511		0 0	0	
00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	28, 746, 722		0 0	0	
	Liabilities and Fund Balances					
~~	CURRENT LI ABI LI TI ES	20 520				1
00	Accounts payable Salaries, wages, and fees payable	38, 539 1, 453, 687		0 0 0 0	0	
00	Payroll taxes payable	22, 943		0 0	0	
	Notes & Loans payable (Short term)	322, 675		0 0	0	
00	Deferred income	0		0 0	0	
00	Accel erated payments	0			0	40
00 00	Due to other funds Other current liabilities	1, 393, 061		0 0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	3, 230, 905		0 0	0	
	LONG TERM LI ABI LI TI ES					
00	Mortgage payable	8, 783, 529		0 0	0	
00	Notes payable	0		0 0	0	
00 00	Unsecured Loans Loans from owners:	0			0	
00	Other long term liabilities	0			0	
00	OTHER (SPECIFY)	0		0 0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	8, 783, 529		0 0	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	12,014,434		0 0	0	51
00	CAPI TAL ACCOUNTS General fund balance	16, 732, 288				52
00	Specific purpose fund	10, 132, 200		0		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0	-	56
00 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
00	replacement, and expansion				0	/ ⁵⁶
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	16, 732, 288		0 0	0	59
						60

Heal th	Financial Systems	PEACE CARE A	T ST. A	NNS			In Lie	u of Form CN	IS-2	540-10
STATEM	IENT OF CHANGES IN FUND BALANCES		Pr	rovi der	No.: 315413		eriod: com 01/01/2022 o 12/31/2022	Worksheet (Date/Time F 5/22/2023	Prep	
		General	Fund		Speci al	Pur	rpose Fund	Endowment Fu	Ind	
		1.00	2.	00	3,00		4.00	5.00		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17)		21, -4, 16,	46, 649 714, 364 732, 285 732, 288 732, 288 0 732, 288		0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	5.00	0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
	Fund balance at end of period per balance sheet (Line 11 - line 18)	Endowment Fund	,	PI ant		_			_	
		6.00	7.		8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ROUNDING	0		000000000000000000000000000000000000000	8.00	0				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 16.00 17.00 18.00 19.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	000000000000000000000000000000000000000		000000000000000000000000000000000000000		0 0 0 0				10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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 01/01/2022 12/31/2022	Worksheet G-2 Parts I-II Date/Time Pre 5/22/2023 1:22	bared:		
	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, 499, 1	39		13, 499, 139	1.00		
2.00	NURSING FACILITY			0		0	2.00			
3.00	ICF/IID				0		0	3.00		
4.00	OTHER LONG TERM CARE			587, 6	62		587, 662	4.00		
5.00	Total general inpatient care services (Sum of	lines 1 - 4)		14, 086, 8	01		14, 086, 801	5.00		
	All Other Care Services									
6.00	ANCI LLARY SERVI CES			1, 890, 6	42	0	1, 890, 642	6.00		
7.00	CLINIC					0	0	7.00		
8.00	HOME HEALTH AGENCY COST					0	0	8.00		
9.00	AMBULANCE					0	0	9.00		
10.00	RURAL HEALTH CLINIC					0	0	10.00		
10. 10	FQHC					0	0	10. 10		
11.00	СМНС					0	0	11.00		
12.00	HOSPICE				0	0	0	12.00		
13.00	ROUTINE CHARGES / BED HOLD			890, 4	80	0	890, 408	13.00		
14.00	Total Patient Revenues (Sum of lines 5 - 13)	(Transfer column 3	to	16, 867, 8	51	0	16, 867, 851	14.00		
	Worksheet G-3, Line 1)									
	Cost Center Description									
						1.00	2.00			
	PART II – OPERATING EXPENSES									
1.00	Operating Expenses (Per Worksheet A, Col. 3, I	Line 100)					16, 517, 720	1.00		
2.00	Add (Specify)					0		2.00		
3.00						0		3.00		
4.00						0		4.00		
5.00						0		5.00		
6.00						0		6.00		
7.00						0		7.00		
8.00	Total Additions (Sum of lines 2 - 7)						0	8.00		
9.00	Deduct (Specify)					0		9.00		
10.00						0		10.00		
11.00						0		11.00		
12.00						0		12.00		
13.00						0		13.00		
14.00	Total Deductions (Sum of lines 9 - 13)						0	14.00		
15.00	Total Operating Expenses (Sum of lines 1 and 8	8, minus line 14)					16, 517, 720	15.00		
						'				

Heal th	ealth Financial Systems PEACE CARE AT ST. ANNS In Lie							
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES			Provider No.: 315413	Peri od:	Worksheet G-3			
				From 01/01/2022				
	To 12/31/2022							
					5/22/2023 1:22	2 pm		
				-	1.00			
1.00	1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)							
2.00	Less: contractual allowances and discounts on	2, 724, 745	2.00					
3.00	Net patient revenues (Line 1 minus line 2)		14, 143, 106	3.00				
4.00	Less: total operating expenses (From Workshee	16, 517, 720	4.00					
5.00	Net income from service to patients (Line 3 m		-2, 374, 614	5.00				
	Other income:							
6.00	Contributions, donations, bequests, etc				296, 455	6.00		
7.00	Income from investments				366, 088	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 abstracts				0	18.00		
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)				0 100	19.00		
20.00						20.00		
21.00	Rental of vending machines				2, 752			
22.00	Rental of skilled nursing space				0	22.00		
23.00	Governmental appropriations					23.00		
24.00	PRIOR YEAR				29, 945	24.00		
24.01	NON PATIENT REVENUE				-3, 035, 090			
24.50	COVI D-19 PHE Fundi ng				0	24.50		
25.00	Total other income (Sum of lines 6 - 24)				-2, 339, 750	25.00		
26.00	Total (Line 5 plus line 25)				-4, 714, 364	26.00		
27.00	Other expenses (specify)				0	27.00		
28.00					0	28.00		
29.00					0	29.00		
	Total other expenses (Sum of lines 27 - 29)				0	30.00		
31.00	Net income (or loss) for the period (Line 26	minus line 30)			-4, 714, 364	31.00		