In Lieu of Form CMS-2540-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315452 Worksheet S Parts I, II & III Peri od: From 01/01/2022 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/22/2023 5: 21 pm PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: 5/22/2023 Ti me: 5: 21 pm use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN (2) Settled without audit

9. NPR Date:

11. Contractor Vendor Code

for no utilization.

8.[N] Last Cost Report for this Provider CCN

10.[0]If line 4, column 1 is "4": Enter number of times reopened

12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

(3) Settled with audit

(4) Reopened

(5) Amended

5. Date Received:

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 ST. JOSEPHS (CUSACK) (315452) 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			SI GNATURE STATEMENT	
1	Don	ald Lynch	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Donal d Lynch			2
3	Signatory Title	ADMI NI STRATOR			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-29, 640	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	-29, 640	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.

Health Financial Systems PEACE CARE ST. JOSEPHS (CUSACK) In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315452 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/22/2023 5:21 pm 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 537 PAVONIA AVENUE PO Box: 1.00 2.00 City: JERSEY CITY State: NJ Zi p Code: 07306 2.00 3.00 County: HUDSON CBSA Code: 35614 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF PEACE CARE ST. JOSEPHS 315452 12/01/1997 N Р Ν 4.00 (CUSACK) 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 | SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 847, 806 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 847, 806 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0

Heal th	ealth Financial Systems PEACE CARE ST. JOSEPHS (CUSACK) In Lie					2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31		Worksheet S-2	
COMPLEX INDENTIFICATION DATA From 01/01/2022					Part I	
To 12/31/2022						pared:
					1. 00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrati	ve and General cost	N	42. 00
	center? Enter Y or N. If yes, check bo	x, and submit supporting s	schedule listing	cost centers and		
	amounts.	5	Ü			
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		N	43. 00
44.00	If line 43 is yes, enter the home offi	ce chain number and enter	the name and add	lress of the home		44.00
	office on lines 45, 46 and 47.					
	1.00	3.00				
	If this facility is part of a chain or	ganization, enter the name	e and address of	the home office on the	lines	
	bel ow.					
45.00	00 Name: Contractor's Name: Contractor's Number:					45. 00
46.00	00 Street: PO Box:					46. 00
47.00	I7.00 City: Zip Code:					47. 00

JMPLE	ED NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Provider	No.: 315452	Period: From 01/01/2022 To 12/31/2022	Worksheet S- Part II Date/Time Pr 5/22/2023 5:	epared:
				Y/N	Date	
	Conoral Instruction, For all column 1 reconors	occonton in column 1 "V" fo	va Vaa aa "N"	1.00	2.00	
	General Instruction: For all column 1 responses responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	es enter in corumn i, i ic	or Yes or in	TOI NO. FOI AIT	the date	
00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If column 1 is "Y", enter 1			N		1.0
	instructions)		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and in column	N			2.0
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or firelationships? (see instructions)	, chain home offices, drug d to the provider or its , or members of the board	Y			3. 0
			Y/N	Туре	Date	
	Cincarial Data and Day		1. 00	2. 00	3. 00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepare	ared by a Cortified Public	Y	С		4.0
. 00	Accountant? (Y/N) Column 2: If yes, enter "A" Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	' for Audited, "C" for te copy or enter date	1	C		4.0
. 00	Are the cost report total expenses and total those on the filed financial statements? If or reconciliation.	revenues different from	N			5. 0
	Approved Educational Activities			Y/N 1. 00	Legal Oper. 2.00	
00	Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2: Is the	provider the	N	N	6. (
	legal operator of the program? (Y/N)	, ,	•			
00	Were costs claimed for Allied Health Programs			N		7. (
00	Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) see		for Nursing	N		8. (
. 00	School and/or Allied Health Program? (Y/N) se		for Nursing	N	Y/N 1. 00	8. (
		e instructions.		N	· ·	
00	Bad Debts Is the provider seeking reimbursement for bad period? If "Y", submit copy.	d debts? (Y/N) see instructions to collection policy change du	ons. Iring this cos	st 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 debt	d debts? (Y/N) see instructions to collection policy change du	ons. Iring this cos	st reporting	1. 00 Y	9. (
00 00 00 00 00 00 00 00 00 00 00 00 00	Bad Debts Is the provider seeking reimbursement for bad lifline 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	d debts? (Y/N) see instructions debts? (Y/N) see instruction collection policy change dud/or coinsurance waived? If "	ons. uring this cos Y", see instr	et reporting ructions.	1. 00 Y N N	9. (
	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d debts? (Y/N) see instructions. d debts? (Y/N) see instruction collection policy change dud/or coinsurance waived? If "Y	ons. uring this cos Y", see instr	et reporting ructions.	1.00 Y N N Part B	9. (10. (11. (12. (
00 0. 00 1. 00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d debts? (Y/N) see instructions. d debts? (Y/N) see instruction collection policy change dud/or coinsurance waived? If "You cost reporting period? If "You bescription	ons. Iring this cos Y", see instru Pa Y/N	st reporting ructions. uctions. art A Date	1.00 Y N N Part B Y/N	9. (
00 0. 00 1. 00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d debts? (Y/N) see instructions. d debts? (Y/N) see instruction collection policy change dud/or coinsurance waived? If "Y	ons. uring this cos Y", see instr	et reporting ructions.	1.00 Y N N Part B	9. (
0000.00	Bad Debts Is the provider seeking reimbursement for bad lifline 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	d debts? (Y/N) see instructions. d debts? (Y/N) see instruction collection policy change dud/or coinsurance waived? If "You cost reporting period? If "You bescription	ons. Iring this cos Y", see instru Pa Y/N	st reporting ructions. uctions. art A Date	1.00 Y N N Part B Y/N	9. (
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt 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"	d debts? (Y/N) see instructions. d debts? (Y/N) see instruction collection policy change dud/or coinsurance waived? If "You cost reporting period? If "You bescription	ons. Y", see instru Pa Y/N 1.00	st reporting ructions. actions. art A Date 2.00	1.00 Y N N Part B Y/N 3.00	9. 10. 11. 12. 1
. 00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt 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.	d debts? (Y/N) see instruction de debts? (Y/N) see instruction de collection policy change du defor coinsurance waived? If "Cost reporting period? If "Yescription 0	ons. Irring this cos Y", see instru ", see instru Pr Y/N 1.00	st reporting ructions. actions. art A Date 2.00	1.00 Y N N N Part B Y/N 3.00 Y	9. 10. 11. 12.
. 00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt 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	d debts? (Y/N) see instruction de debts? (Y/N) see instruction de collection policy change du defor coinsurance waived? If "Cost reporting period? If "Yescription 0	ons. y", see instru ", see instru Y/N 1.00	st reporting ructions. actions. art A Date 2.00	1.00 Y N N Part B Y/N 3.00	9. 10. 11. 12. 13. 14. 14. 1
00 0. 00 1. 00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt 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 instruction de debts? (Y/N) see instruction de collection policy change du defor coinsurance waived? If "Cost reporting period? If "Yescription 0	ons. y", see instru ", see instru Y/N 1.00	st reporting ructions. actions. art A Date 2.00	1.00 Y N N N Part B Y/N 3.00 Y	9. (10. (11. (12. (12. (12. (12. (12. (12. (12
00 0.00 1.00 2.00 3.00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt 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 instruction de debts? (Y/N) see instruction de collection policy change du defor coinsurance waived? If "Cost reporting period? If "Yescription 0	ons. Irring this cos Y", see instru Pa Y/N 1.00 N	st reporting ructions. actions. art A Date 2.00	1.00 Y N N N Part B Y/N 3.00 Y	9. (10. (11. (12. (13. (14. (

Health Financial Systems PEACE CARE ST. JOSEPHS (CUSACK) In Lieu of Form						u of Form CMS-:	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE			Provi der No.: 31545		eriod: rom 01/01/2022	Worksheet S-2 Part II	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE						pared: 1 pm
			1.00		2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/posit	i on	SLAVKA		PARTI LOVA		19. 00
	held by the cost report preparer in columns 1, 2, a	nd 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost report		HEALTH CARE RESOURCES				20. 00
	preparer.						
21.00	Enter the telephone number and email address of the	cost	609-987-1440		SLAVKA. PARTI LOV	/A@HCRNJ. NET	21. 00
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems PEACE CARE ST. JOSKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE PEACE CARE ST. JOSEPHS (CUSACK)

| Period: | Worksheet S-2 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315452 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				То	12/31/2022	Date/Time Pre 5/22/2023 5: 2	
		Part B			."		
		Date					
		4. 00					
	PS&R Data						
13.00	Was the cost report prepared using the PS&R	04/20/2023					13. 00
	only? If either col. 1 or 3 is "Y", enter						
	the paid through date of the PS&R used to						
	prepare this cost report in cols. 2 and 4. (see Instructions.)						
14. 00	Was the cost report prepared using the PS&R						14. 00
14.00	for total and the provider's records for						14.00
	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.						
15. 00	If line 13 or 14 is "Y", were adjustments						15. 00
	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.						
16.00							16.00
	adjustments made to PS&R data for						
	corrections of other PS&R Report						
	information? If yes, see instructions.						
17. 00	If line 13 or 14 is "Y", then were						17. 00
	adjustments made to PS&R data for Other? Describe the other adjustments:						
18 00	Was the cost report prepared only using the						18. 00
10.00	provider's records? If "Y" see Instructions.						10.00
			3. 00				
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the title		PREPARER				19. 00
	held by the cost report preparer in columns 1 respectively.	, ∠, and 3,					
20. 00	Enter the employer/company name of the cost r	report					20.00
20.00	preparer.	opor t					20.00
21. 00	Enter the telephone number and email address	of the cost					21. 00
	report preparer in columns 1 and 2, respective						

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

Provi der No.: 315452

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

5/22/2023 5: 21 pm Inpatient Days/Visits Title XVIII Number of Beds Bed Days Title V Title XIX Component Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 139 50, 735 С 4, 739 20, 368 1. 00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7.00 7.00 0 0 50, 735 8.00 Total (Sum of lines 1-7) 139 4.739 20, 368 8.00 Inpatient Days/Visits Di scharges Title XIX Title XVIII Component Other Total Title V 6.00 7.00 8.00 9.00 10.00 1.00 SKILLED NURSING FACILITY 6, 788 31, 895 0 136 17 1. 00 0 2.00 NURSING FACILITY 0 2.00 0 0 ICE/LID 3 00 3 00 C 0 4.00 HOME HEALTH AGENCY COST 0 4.00 5.00 Other Long Term Care 0 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 0 7.00 8.00 Total (Sum of lines 1-7) 6,788 31, 895 136 17 8.00 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 13.00 11.00 12.00 14.00 15.00 1.00 SKILLED NURSING FACILITY 0.00 1, 198. 12 1.00 128 281 NURSING FACILITY 2.00 0 0.00 0.00 2.00 C 3.00 ICF/IID 0 C 0.00 3.00 HOME HEALTH AGENCY COST 4.00 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 0.00 0.00 7.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 128 281 0.00 34.85 1, 198. 12 8.00 Average Length Admi ssi ons of Stay Title XVIII Title V Title XIX 0ther Component Total 16, 00 17.00 18.00 19 00 20.00 1.00 SKILLED NURSING FACILITY 113. 51 203 138 1. 00 NURSING FACILITY 0.00 0 2.00 2.00 0 LCF/LLD 0.00 0 3.00 0 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 0.00 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 00 C 0 7 00 Total (Sum of lines 1-7) 113. 51 203 138 8.00 8.00 Admi ssi ons Full Time Equivalent Total Component Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 350 0.00 134.90 1.00 NURSING FACILITY 0.00 2.00 2.00 0 0.00 3.00 ICF/IID 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0 0.00 0.00 5.00 6.00 SNF-Based CMHC 0.00 6.00 0.00 7.00 HOSPI CE 0.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 350 134.90 0.00 8.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | Part Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315452

				''	0 12/31/2022	5/22/2023 5: 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		
	I	1.00	2. 00	3. 00	4. 00	5. 00	
	PART II - DI RECT SALARI ES						
4 00	SALARI ES	/ 770 040		/ 770 040	000 (70 00	04.40	1 00
1.00	Total salaries (See Instructions)	6, 770, 818	0	6, 770, 818	i i		
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		4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	6, 770, 818	0	6, 770, 818			6. 00
7.00	Other Long Term Care	0	0	0	0.00		
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		
9.00	CMHC	0	0	0	0.00		
10.00	HOSPI CE	0	0	0	0.00		
11. 00	Other excluded areas	0	0	0	0.00		11. 00
12. 00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12. 00
13. 00	through 11) Total Adjusted Salaries (line 6 minus line	6, 770, 818	_	/ 770 010	200 (72 00	24 12	13. 00
13.00	12)	0, 770, 818	0	6, 770, 818	280, 672. 00	24. 12	13.00
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1, 772, 345	0	1, 772, 345	29, 000. 00	61. 12	14. 00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15. 00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1, 609, 706	0	1, 609, 706			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 609, 706	0	1, 609, 706			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315452

				_		5/22/2023 5: 2	1 pm
		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						
1.00	Employee Benefits	0	C		0.00	0.00	1.00
2.00	Administrative & General	426, 811		426, 811	20, 822. 00	20. 50	2.00
3.00	Plant Operation, Maintenance & Repairs	125, 740	C	125, 740	5, 504. 00	22. 85	3.00
4.00	Laundry & Li nen Servi ce	180, 548	C	180, 548	9, 802. 00	18. 42	4.00
5.00	Housekeepi ng	421, 025	(421, 025	23, 143. 00	18. 19	5. 00
6.00	Di etary	943, 165	(943, 165	51, 896. 00	18. 17	6.00
7.00	Nursing Administration	471, 984	(471, 984	8, 616. 00	54. 78	7. 00
8.00	Central Services and Supply	0	C) (0.00	0.00	8. 00
9.00	Pharmacy	0	C) (0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	(0.00	0.00	10.00
11.00	Soci al Servi ce	112, 066	(112, 066	2, 855. 00	39. 25	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	360, 095	(360, 095	13, 629. 00	26. 42	13.00
14.00	Total (sum lines 1 thru 13)	3, 041, 434	C	3, 041, 434	136, 267. 00	22. 32	14.00

Health Financial Systems	PEACE CARE ST. JOSEPHS (CUSACK)	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315452	Peri od: Worksheet S-3 From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared:

PART IV - WAGE RELATED COSTS 1.00			То	12/31/2022	Date/Time Prep 5/22/2023 5:2	
PART IV - WAGE RELATED COSTS 1.00						, p
PART I V - WAGE RELATED COSTS Part A - Core List						
Part A - Core List RETIREMENT COST						
RETIREMENT COST		PART IV - WAGE RELATED COSTS				
RETIREMENT COST						
1.00						
2.00	1.00	401K Employer Contributions			-69, 805	1. 00
0	2.00					2. 00
Prior Year Pension Service Cost 0					0	3. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Pl an Administration Fees 0 0 6.00 401K/TSA Pl an Administration Fees 0 0 6.00 401K/TSA Pl an Administration Fees 0 0 6.00 401K/TSA Pl an Administration Fees 0 0 0 401K/TSA Pl an Administration Fees 0 0 0 0 401K/TSA Pl an Administration Fees 0 0 0 0 401K/TSA Pl an Administration Fees 0 0 0 0 0 401K/TSA Pl an Administration Fees 0 0 0 0 0 0 401K/TSA Pl an Administration Fees 0 0 0 0 0 0 0 0 0		Prior Year Pension Service Cost			0	
Social Accounting/Management Fees-Pension Plan Social Soci						
The color of the	5.00				0	5. 00
To Employee Managed Care Program Administration Fees 10 7.00 HEALTH AND INSURANCE COST 18.00 HEALTH AND INSURANCE COST 18.00 Health Insurance (Purchased or Self Funded) 888, 608 8.00 9.00 Prescription Drug Plan 0 9.00 17.10 17.17 10.0	6.00	Legal /Accounting/Management Fees-Pension Plan			0	6. 00
HEALTH AND INSURANCE COST	7. 00				0	7. 00
Real th Insurance (Purchased or Self Funded) Real th Insurance (Purchased or Self Funded) Real th Insurance (Purchased or Self Funded) Real th Insurance (Interpretation Drug Plan 17,179 10.00 Real th Hearing and Vision Plan 17,179 10.00 Real th Insurance (If employee is owner or beneficiary) 5,935 11.00 12.00 Recident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Recident Insurance (If employee is owner or beneficiary) 0 13.00 Recident Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Recident Insurance (If employee is owner or beneficiary) 0 14.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 16.0				1	-	
9.00 Prescription Drug Plan 0 9.00 10.00 Dental Hearing and Vision Plan 17, 179 10.00 10.00 Dental Hearing and Vision Plan 17, 179 10.00 10.00 Life Insurance (If employee is owner or beneficiary) 5,935 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 193,967 15.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 16.00 17.00 TAXES 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 35,705 19.00 19.00 Outside the proof of the	8.00				888. 608	8. 00
10.00 Dental, Hearing and Vision Plan 17,179 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 5,935 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 12.						
11.00						
12.00						
13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 193,967 15.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion) 16.00 TAXES 17.00 FICA-Employers Portion Only 538,117 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 35,705 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,609,706 24.00 Part B - Other than Core Related Cost						
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00						
15.00 Workers' Compensation Insurance 193, 967 15.00					0	
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion)						
Non cumulative portion TAXES TAXES TAXES TAXES TO TO TAXES TO TO TO TO TO TO TO T			v accrual required by	FASB 106.		
TAXES			,		_	
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 35,705 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER						
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 35,705 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER	17.00	FICA-Employers Portion Only			538, 117	17. 00
19.00 Unemployment Insurance 35,705 19.00						
20.00 State or Federal Unemployment Taxes					35. 705	19. 00
OTHER Executive Deferred Compensation						
22.00 Day Care Cost and Allowances 0 22.00				<u>'</u>		
22.00 Day Care Cost and Allowances 0 22.00	21. 00	Executive Deferred Compensation			0	21. 00
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost 1 0 23.00 1,609,706 24.00 Amount Reported 1.00					0	22. 00
Amount Reported 1.00 Part B - Other than Core Related Cost					0	
Amount Reported 1.00 Part B - Other than Core Related Cost					1, 609, 706	
Part B - Other than Core Related Cost						
Part B - Other than Core Related Cost						
25. 00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25. 00		Part B - Other than Core Related Cost				
	25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00

Provi der No.: 315452

Amount Reported Related to Salaries (cot) Salaries (1	0 12/31/2022	5/22/2023 5: 2	
1 + col 2 Salary in col 2 Col 4 Salary in col 2 Col 4 Salary in col 2 Col 4 Salary in col 3 Col 4 Col 4		Occupational Category	Amount	Fri nge	Adj usted	Paid Hours		
Direct Salaries		,	Reported	Benefits	Salaries (col.	Related to	Wage (col. 3 ÷	
Direct Salaries Nursing Occupations					1 + col . 2)	Salary in col.	col . 4)	
Direct Salaries Nursing Occupations						3		
Nursing Occupations 1,558,166 370,442 1,928,608 26,943.00 71.58 1.00			1.00	2. 00	3. 00	4. 00	5. 00	
1.00 Registered Nurses (RNs)								
2. 00 Li censed Practical Nurses (LPNs) 675, 262 160, 538 835, 800 21, 839, 00 38, 27 2, 00 3. 00 Certif fied Nursin g Assistant/Nursing 1, 799, 724 427, 870 2, 227, 594 95, 624, 00 23, 30 3, 00 Assistants/Aides 4. 00 Total Nursing (sum of lines 1 through 3) 4, 033, 152 958, 850 4, 992, 002 144, 406, 00 34, 57 4, 00 6. 00 Physical Therapists 0 0 0 0, 00 0, 00 0, 00 7. 00 Physical Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 8. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 9. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 10. 01 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0, 00 0, 00 0, 00 10. 00 Occupational Therapy Assistants 0 0 0, 00 0, 00 0, 00			1 550 477	070 440	1 222 (22	0	74 50	
3.00 Certified Nursing Assistant/Nursing								
Assi stants/Ai des								
4.00 Total Nursing (sum of lines 1 through 3) 4,033,152 958,850 4,992,002 144,406.00 34.57 4.00 5.00 Physical Therapists 0 0 0 0.00 0.00 0.00 5.00 7.00 Physical Therapy Assistants 0 0 0 0.00 10.00 11.00 0.00 0.00 0.00 0.00 11.00 0.00 0.00 0.00 0.00 12.00 Respi ratory Therapists 0 0 0 0.00 0.00 0.00 0.0	3.00		1, 799, 724	427, 870	2, 227, 594	95, 624. 00	23. 30	3. 00
5.00 Physical Therapists 0 0 0 0.00 0.00 0.00 5.00 6.00 Physical Therapy Asides 0 0 0 0.00 0.00 0.00 0.00 7.00 8.00 Occupational Therapy Aides 0 0 0 0.00 <t< td=""><td>4 00</td><td></td><td>4 022 152</td><td>050 050</td><td>4 002 002</td><td>144 404 00</td><td>24 57</td><td>4 00</td></t<>	4 00		4 022 152	050 050	4 002 002	144 404 00	24 57	4 00
6.00 Physical Therapy Assistants 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			4, 033, 132	930, 030	4, 992, 002			
7. 00 Physical Therapy Aides 0 0 0 0.00 0.00 7. 00 8. 00 Occupati onal Therapists 0 0 0 0.00 0.00 0.00 8. 00 9. 00 Occupati onal Therapy Assistants 0 0 0 0.00<		'		0				
8.00 Occupational Therapists 0 0 0 0 0 0 0.00 8.00 9.00 9.00 Occupational Therapy Assistants 0 0 0 0 0 0.00 0.00 9.00 10.00 10.00 Occupational Therapy Aides 0 0 0 0 0 0.00 0.00 11.00 Speech Therapists 0 0 0 0 0 0.00 0.00 11.00 11.00 12.00 Respiratory Therapists 0 0 0 0 0 0.00 0.00 11.00 11.00 12.00 Respiratory Therapists 0 0 0 0 0 0.00 0.00 12.00 13.00 Occupational Therapy Assistants Nursing Occupations 13.00 Contract Labor Nursing Occupations 14.00 Registered Nurses (RNs) 12.69, 219 269, 219 8, 110.00 33.20 16.00 18.00 Physical Therapists 248, 081 248, 081 3, 299.00 48.20 17.00 18.00 Physical Therapy Assistants 266, 266 266, 266 266, 266 3, 254.00 81, 83 19.00 19.00 Occupational Therapy Assistants 124, 690 124, 690 1, 939.00 64.31 22.00 Occupational Therapy Asistants 124, 690 124, 690 1, 939.00 64.31 22.00 Occupational Therapy Asistants 124, 690 10.00 0.00 0.00 0.00 23.00 Respiratory Therapists 115, 389 115, 389 115, 389 175, 300 72.4 42, 20.00 Respiratory Therapists 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.				0				
9.00 Occupational Therapy Assistants 0 0 0 0 0 0 0.00 0.00 9.00 10.00 11.00 Occupational Therapy Aides 0 0 0 0 0 0.00 10.00 11.00 Speech Therapists 0 0 0 0 0 0.00 10.00 11.00 11.00 Respiratory Therapists 0 0 0 0 0 0.00 0.00 11.00 11.00 Occupations 0 0 0 0 0 0.00 0.00 12.00 13.00 Occupations 0 0 0 0 0 0 0.00 0.00 13.00 Occupations 0 0 0 0 0 0 0 0 0 0.00 13.00 Occupations 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 3		0				
10.00 Occupational Therapy Aides 0 0 0 0 0 0 0.00 0.00 10.00 11.00 Speech Therapists 0 0 0 0 0 0.00 0.00 11.00 12.00 Respiratory Therapists 0 0 0 0 0 0.00 0.00 12.00 12.00 Other Medical Staff 0 0 0 0 0 0.00 0.00 12.00 13.00 Occupations				0				
11.00 Speech Therapists 0 0 0 0 0 0 0 0 0				0				
12.00 Respiratory Therapists 0 0 0 0 0 0 0 0 0				0				
13.00 Other Medical Staff O O O O O O O O O		1 '		0				
Contract Labor Nursi ng Occupations 326,909 326,909 4,261.00 76.72 14.00 15.00 Li censed Practical Nurses (LPNs) 44,870 44,870 928.00 48.35 15.00 16.00 Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des 269,219 269,219 8,110.00 33.20 16.00 17.00 17.00 18.00 Physi cal Therapi sts 248,081 248,081 248,081 3,041.00 81.58 18.00 19.00 Physi cal Therapy Assi stants 266,266 266,266 266,266 3,254.00 81.83 19.00 19.00 Physi cal Therapy Assi stants 266,266 266,266 266,266 3,254.00 81.83 19.00 20.00				0				
Nursing Occupations Registered Nurses (RNs) 326,909 326,909 4,261.00 76.72 14.00	13.00		<u>ا</u>		'I	0.00	0.00	13.00
14. 00 Registered Nurses (RNs) 326, 909 4, 261. 00 76. 72 14. 00 15. 00 Li censed Practi cal Nurses (LPNs) 44, 870 44, 870 928. 00 48. 35 15. 00 16. 00 Cert if ied Nursi ng Assi stant/Nursi ng Assi stant/Nursi ng Assi stants/Ai des 269, 219 269, 219 8, 110. 00 33. 20 16. 00 17. 00 Total Nursi ng (sum of li nes 14 through 16) 640, 998 640, 998 13, 299. 00 48. 20 17. 00 18. 00 Physi cal Therapi sts 248, 081 248, 081 3, 041. 00 81. 58 18. 00 19. 00 Physi cal Therapy Assi stants 266, 266 266, 266 3, 254. 00 81. 83 19. 00 20. 00 Physi cal Therapy Ai des 0 0 0. 00 0. 00 20. 00 21. 00 Occupati onal Therapi sts 376, 921 376, 921 5, 874. 00 64. 17 21. 00 22. 00 Occupati onal Therapy Assi stants 124, 690 124, 690 1, 939. 00 64. 31 22. 00 24. 00 Speech Therapi sts 115, 389 115, 389 1, 593. 00 72. 44 24. 00 25. 00 Respi ratory Therapi sts 0 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0								
16. 00 Certified Nursing Assistant/Nursing Assistant/Nursing Assistants/Aides 269, 219 269, 219 8, 110. 00 33. 20 16. 00 17. 00 Total Nursing (sum of lines 14 through 16) 640, 998 640, 998 13, 299. 00 48. 20 17. 00 18. 00 Physical Therapists 248, 081 248, 081 3, 041. 00 81. 58 18. 00 19. 00 Physical Therapy Assistants 266, 266 266, 266 3, 254. 00 81. 83 19. 00 20. 00 Physical Therapy Aides 0 0. 00 0. 00 0. 00 20. 00 21. 00 Occupational Therapists 376, 921 376, 921 5, 874. 00 64. 17 21. 00 23. 00 Occupational Therapy Assistants 124, 690 124, 690 1, 939. 00 64. 31 22. 00 24. 00 Speech Therapists 0 0. 00 0. 00 0. 00 23. 00 25. 00 Respiratory Therapists 0 0. 00 0. 00 0. 00 25. 00	14.00		326, 909		326, 909	4, 261. 00	76. 72	14.00
Assi stants/Ai des 17. 00 Total Nursi ng (sum of lines 14 through 16) 640, 998 18. 00 Physical Therapists 248, 081 248, 081 3, 041. 00 81. 58 18. 00 19. 00 Physical Therapy Assi stants 266, 266 20. 00 Physical Therapy Ai des 0 0 0.00 0.00 20. 00 21. 00 Occupati onal Therapists 376, 921 376, 921 5, 874. 00 64. 17 21. 00 22. 00 Occupati onal Therapy Assi stants 124, 690 124, 690 1, 939. 00 64. 31 22. 00 23. 00 Occupati onal Therapy Ai des 0 0 0.00 0.00 23. 00 24. 00 Speech Therapists 15, 389 115, 389 1, 593. 00 72. 44 24. 00 25. 00 Respiratory Therapists 0 0 0.00 0.00 25. 00	15.00	Licensed Practical Nurses (LPNs)	44, 870		44, 870	928.00	48. 35	15.00
17. 00 Total Nursing (sum of lines 14 through 16) 640,998 13,299.00 48.20 17.00 18. 00 Physical Therapists 248,081 248,081 3,041.00 81.58 18.00 19. 00 Physical Therapy Assistants 266,266 266,266 3,254.00 81.83 19.00 20. 00 Physical Therapy Aides 0 0.00 0.00 0.00 20.00 21. 00 Occupational Therapists 376,921 376,921 5,874.00 64.17 21.00 22. 00 Occupational Therapy Assistants 124,690 124,690 1,939.00 64.31 22.00 23. 00 Occupational Therapy Aides 0 0.00 0.00 0.00 23.00 24. 00 Speech Therapists 115,389 115,389 1,593.00 72.44 24.00 25. 00 Respiratory Therapists 0 0.00 0.00 0.00 25.00	16.00	Certified Nursing Assistant/Nursing	269, 219		269, 219	8, 110. 00	33. 20	16.00
18. 00 Physical Therapists 248, 081 3, 041.00 81.58 18.00 19. 00 Physical Therapy Assistants 266, 266 266, 266 3, 254.00 81.83 19.00 20. 00 Physical Therapy Aides 0 0.00 0.00 0.00 20.00 21. 00 Occupati onal Therapists 376, 921 376, 921 5, 874.00 64.17 21.00 22. 00 Occupati onal Therapy Assistants 124, 690 124, 690 1, 939.00 64.31 22.00 23. 00 Occupati onal Therapy Aides 0 0.00 0.00 0.00 23.00 24. 00 Speech Therapists 115, 389 115, 389 1, 593.00 72.44 24.00 25. 00 Respiratory Therapists 0 0.00 0.00 0.00 25.00		Assi stants/Ai des						
19.00 Physical Therapy Assistants 266, 266 266, 266 3, 254.00 81.83 19.00 20.00 Physical Therapy Aides 0 0.00 0.00 20.00 21.00 Occupati onal Therapists 376, 921 376, 921 5, 874.00 64.17 21.00 22.00 Occupati onal Therapy Assistants 124, 690 124, 690 1, 939.00 64.31 22.00 23.00 Occupati onal Therapy Aides 0 0.00 0.00 0.00 23.00 24.00 Speech Therapists 115, 389 115, 389 1, 593.00 72.44 24.00 25.00 Respiratory Therapists 0 0.00 0.00 0.00 25.00								
20. 00 Physical Therapy Aides 0 0.00 0.00 20. 00 21. 00 Occupational Therapists 376, 921 376, 921 5, 874. 00 64. 17 21. 00 22. 00 Occupational Therapy Assistants 124, 690 124, 690 1, 939. 00 64. 31 22. 00 23. 00 Occupational Therapy Aides 0 0.00 0.00 0.00 23. 00 24. 00 Speech Therapists 115, 389 115, 389 1, 593. 00 72. 44 24. 00 25. 00 Respiratory Therapists 0 0.00 0.00 0.00 25. 00	18. 00		248, 081		248, 081			
21. 00 Occupational Therapists 376, 921 376, 921 5, 874. 00 64. 17 21. 00 22. 00 Occupational Therapy Assistants 124, 690 124, 690 1, 939. 00 64. 31 22. 00 23. 00 Occupational Therapy Aides 0 0. 00 0. 00 0. 00 23. 00 24. 00 Speech Therapists 115, 389 115, 389 1, 593. 00 72. 44 24. 00 25. 00 Respiratory Therapists 0 0. 00 0. 00 0. 00 25. 00	19. 00		266, 266		266, 266			
22. 00 Occupational Therapy Assistants 124,690 124,690 1,939.00 64.31 22.00 23. 00 Occupational Therapy Aides 0 0.00 0.00 23.00 24. 00 Speech Therapists 115,389 115,389 1,593.00 72.44 24.00 25. 00 Respiratory Therapists 0 0.00 0.00 0.00 25.00	20.00		0		· · · · · · · · · · · · · · · · · · ·			
23. 00 Occupational Therapy Aides 0 0.00 0.00 23. 00 24. 00 Speech Therapists 115, 389 115, 389 1, 593. 00 72. 44 24. 00 25. 00 Respiratory Therapists 0 0.00 0.00 0.00 25. 00								
24. 00 Speech Therapi sts 115, 389 115, 389 1, 593. 00 72. 44 24. 00 25. 00 Respi ratory Therapi sts 0 0 0. 00 0. 00 25. 00			124, 690		124, 690			
25. 00 Respiratory Therapists 0 0 0. 00 0. 00 25. 00			0		0			
			115, 389		115, 389			
26.00 Other Medical Staff 0 0,00 0.00 26.00			0		0			
	26. 00	Other Medical Staff	0		0	0.00	0.00	26. 00

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provi der No.: 315452

	To 12/31/2022	Date/lime Prepared: 5/22/2023 5:21 pm
	Group	Days
1.00	1. 00 RUX	2.00
2.00	RUL	2.00
3.00	RVX	3. 00
4. 00	RVL	4.00
5. 00	RHX	5. 00
6.00	RHL	6. 00
7. 00 8. 00	RMX RML	8.00
9.00	RLX	9.00
10. 00	RUC	10.00
11. 00	RUB	11. 00
12.00	RUA	12.00
13. 00 14. 00	RVC RVB	13. 00 14. 00
15. 00	RVA	15. 00
16. 00	RHC	16. 00
17. 00	RHB	17. 00
18.00	RHA	18.00
19. 00 20. 00	RMC RMB	19. 00 20. 00
21. 00	RMA	21. 00
22. 00	RLB	22. 00
23. 00	RLA	23. 00
24.00	ES3	24. 00
25. 00 26. 00	ES2 ES1	25. 00 26. 00
27. 00	HE2	27. 00
28. 00	HE1	28. 00
29. 00	HD2	29. 00
30. 00 31. 00	HD1 HC2	30. 00 31. 00
32.00	HC1	32.00
33. 00	HB2	33.00
34. 00	HB1	34.00
35. 00	LE2	35. 00
36. 00 37. 00	LE1 LD2	36. 00 37. 00
38.00	LD2 LD1	38.00
39. 00	LC2	39. 00
40. 00	LC1	40.00
41.00	LB2	41.00
42. 00 43. 00	LB1 CE2	42. 00 43. 00
44. 00	CE1	44. 00
45. 00	CD2	45. 00
46. 00	CD1	46. 00
47. 00	CC2	47. 00
48. 00 49. 00	CC1 CB2	48. 00 49. 00
50.00	CB2 CB1	50.00
51. 00	CA2	51.00
52. 00	CA1	52.00
53.00	SE3	53.00
54. 00 55. 00	SE2 SE1	54. 00 55. 00
56. 00	SSC	56. 00
57. 00	SSB	57.00
58. 00	SSA	58. 00
59. 00 60. 00	I B2 I B1	59. 00 60. 00
61. 00	I A2	61. 00
62. 00	I A1	62. 00
63. 00	BB2	63.00
64. 00	BB1	64. 00
65. 00 66. 00	BA2 BA1	65. 00 66. 00
67. 00	PE2	67.00
68. 00	PE1	68. 00
69. 00	PD2	69.00
70.00	PD1	70.00
71.00	PC2	71.00
72. 00 73. 00	PC1 PB2	72. 00 73. 00
74. 00	PB1	74. 00
75. 00	PA2	75. 00

Health Financial Systems	PEACE CARE ST. JOSEPH	HS (CUSACK))	In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der		Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-	
					5/22/2023 5:2	2 <u>1 pm</u>
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL			1			100. 00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Registe payments beginning 10/01/2003. Congress e expenses. For lines 101 through 106: Ente column 2 the percentage of total expenses line 1, column 3. Indicate in column 3 "Y with direct patient care and related expe (See instructions)	xpected this increase r in column 1 the amou for each category to " for yes or "N" for n	to be used nt of the total SNF o if the s	l for direct pexpense for e revenue from pending refle	aatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101. 00 Staffi ng						101.00
102.00 Recruitment						102.00
103.00 Retention of employees						103.00
104. 00 Trai ni ng						104. 00
105. 00 OTHER (SPECIFY)	line 1 column 2)					105.00
106.00 Total SNF revenue (Worksheet G-2, Part I,	Title 1, column 3)		1			106. 00

		ACE CARE ST. JOSE				u of Form CMS-2	2540-10
RECLASSI	FICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der 1		eriod: rom 01/01/2022	Worksheet A	
				To		Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	5/22/2023 5: 2 Reclassi fi ed	ı piii
	'			+ col. 2)	ons	Trial Balance	
					Increase/Decre	(col. 3 +-	
					ase (Fr Wkst A-6)	col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ENERAL SERVICE COST CENTERS		052 550	052 550	ما	052 550	1 00
	0100 CAP REL COSTS - BLDGS & FIXTURES 0200 CAP REL COSTS - MOVABLE EQUIPMENT		952, 550 0	952, 550 0	0	952, 550 0	1. 00 2. 00
1	0300 EMPLOYEE BENEFITS	О	1, 710, 260	1, 710, 260	o	1, 710, 260	3. 00
	0400 ADMINISTRATIVE & GENERAL	426, 811	1, 859, 221	2, 286, 032	o	2, 286, 032	4. 00
	0500 PLANT OPERATION, MAINT. & REPAIRS	125, 740	895, 302	1, 021, 042	0	1, 021, 042	5. 00
	0600 LAUNDRY & LINEN SERVICE 0700 HOUSEKEEPING	180, 548 421, 025	0 158, 100	180, 548 579, 125	0	180, 548 579, 125	6. 00 7. 00
	0800 DI ETARY	943, 165	533, 876	1, 477, 041	o	1, 477, 041	8. 00
	0900 NURSING ADMINISTRATION	471, 984	77, 510	549, 494	o	549, 494	9. 00
	1000 CENTRAL SERVI CES & SUPPLY	0	0	0	0	0	10.00
	1100 PHARMACY 1200 MEDICAL RECORDS & LIBRARY		0	0	0	0	11. 00 12. 00
	1300 SOCIAL SERVICE	112, 066	Ö	112, 066	Ö	112, 066	13. 00
1	1400 NURSING AND ALLIED HEALTH EDUCATION	O	0	0	0	0	14. 00
	1500 RECREATION	360, 095	25, 856	385, 951	0	385, 951	15. 00
_	NPATIENT ROUTINE SERVICE COST CENTERS 3000 SKILLED NURSING FACILITY	3, 729, 384	1, 006, 927	4, 736, 311	O	4, 736, 311	30. 00
	3100 NURSING FACILITY	0	0	4, 730, 311	ő	4, 730, 311	31. 00
	3200 CF/IID	O	0	0	O	0	32. 00
	3300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	NCILLARY SERVICE COST CENTERS 4000 RADIOLOGY	٥	22, 579	22, 579	ol	22, 579	40. 00
1	4100 LABORATORY	o	47, 338	47, 338	o	47, 338	41. 00
	4200 I NTRAVENOUS THERAPY	O	0	0	o	0	42. 00
	4300 OXYGEN (INHALATION) THERAPY	0	407 017	0	0	0	43.00
1	4400 PHYSI CAL THERAPY 4500 OCCUPATI ONAL THERAPY		486, 916 467, 481	486, 916 467, 481	0	486, 916 467, 481	44. 00 45. 00
	4600 SPEECH PATHOLOGY	o o	183, 963	183, 963	ő	183, 963	46. 00
	4700 ELECTROCARDI OLOGY	O	0	0	O	0	47. 00
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
	4900 DRUGS CHARGED TO PATIENTS 5000 DENTAL CARE - TITLE XIX ONLY		239, 034	239, 034	0	239, 034 0	49. 00 50. 00
1	5100 SUPPORT SURFACES	o	o	0	ő	0	51. 00
_	UTPATIENT SERVICE COST CENTERS						
	6000 CLINIC 6100 RURAL HEALTH CLINIC	0	0	0	0	0	60. 00 61. 00
	6200 FQHC	٥	U	U	U	U	62.00
	THER REIMBURSABLE COST CENTERS						02.00
1	7000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
1	7100 AMBULANCE	0	56, 165	56, 165		56, 165	1
	7300 CMHC PECIAL PURPOSE COST CENTERS	0	0	0	0	0	73. 00
	8000 MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80. 00
1	8100 INTEREST EXPENSE		0	0	0	0	81. 00
	8200 UTILIZATION REVIEW - SNF 8300 HOSPICE	0	0	0	0	0	82. 00 83. 00
83. 00 08 89. 00	SUBTOTALS (sum of lines 1-84)	6, 770, 818	8, 723, 078	15, 493, 896	0	15, 493, 896	89. 00
	ONREI MBURSABLE COST CENTERS	577757515	0,720,070	10/1/0/0/0	٥	10/ 1/0/ 0/0	07.00
	9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
	9100 BARBER AND BEAUTY SHOP 9200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	91. 00 92. 00
1	9300 NONPAID WORKERS		0	0	ol Ol	0	92.00
94. 00 0	9400 PATIENTS LAUNDRY	o	o	O	o	0	94. 00
100.00	TOTAL	6, 770, 818	8, 723, 078	15, 493, 896	O	15, 493, 896	100. 00

Heal th Financial Systems

PEACE CARE ST. JOSEPHS (CUSACK)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No.: 315452

Provider No.: 315452

Period:
From 01/01/2022
To 12/31/2022

Adjustments to Expenses (Fr Wkst A-8)

Cost Center Description

Adjustments to Expenses (Fr Col. 6)

6 00 7 00

				572272023 5.	Z I DIII
	Cost Center Description	Adjustments to	Net Expenses		
	'		For Allocation		
		Wkst A-8)	(col. 5 +-		
			col . 6)		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		_
				T T T T T T T T T T T T T T T T T T T	4
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	952, 550		1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	ol	0		2. 00
	1 1			1	•
3.00	00300 EMPLOYEE BENEFITS	٩	1, 710, 260		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-20, 361	2, 265, 671		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	ol	1, 021, 042		5. 00
			180, 548		•
6.00	00600 LAUNDRY & LINEN SERVICE	٩		•	6. 00
7.00	00700 HOUSEKEEPI NG	0	579, 125		7. 00
8.00	00800 DI ETARY	ol	1, 477, 041		8. 00
	00900 NURSI NG ADMI NI STRATI ON			•	•
9. 00	1 1	٩	549, 494	1	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	0		10.00
11. 00	01100 PHARMACY	ol	0		11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	ا ما	0		12. 00
		٥	U		•
13. 00	01300 SOCIAL SERVICE	0	112, 066		13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	ol	0		14. 00
15. 00			205 051		15. 00
15.00	01500 RECREATION	<u> </u>	385, 951		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	0	4, 736, 311		30. 00
31. 00	03100 NURSING FACILITY	ا م		1	•
		٥	0	1	31. 00
32.00	03200 CF/IID	0	0		32. 00
33 00	03300 OTHER LONG TERM CARE	ol	0		33. 00
00.00	ANCI LLARY SERVICE COST CENTERS				- 00.00
				T	-
40.00	04000 RADI OLOGY	0	22, 579		40. 00
41.00	04100 LABORATORY	ol	47, 338		41.00
	04200 I NTRAVENOUS THERAPY	ا ا	0	1	42. 00
	1 1	٩	U		•
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		43. 00
44.00	04400 PHYSI CAL THERAPY	ol	486, 916		44.00
45. 00	04500 OCCUPATI ONAL THERAPY	ام	467, 481		45. 00
		9	407, 401		
46.00	04600 SPEECH PATHOLOGY] 0	183, 963		46. 00
47.00	04700 ELECTROCARDI OLOGY	ol	0		47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	•	48. 00
		9	-	l .	
49. 00	04900 DRUGS CHARGED TO PATIENTS	o o	239, 034		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	l ol	0		50.00
51.00	05100 SUPPORT SURFACES	ام	0		51.00
51.00		<u> </u>	U		_ 31.00
	OUTPATIENT SERVICE COST CENTERS	,			
60.00	06000 CLI NI C	l ol	0		60.00
61.00	06100 RURAL HEALTH CLINIC	ام	0		61.00
		١	J		
62. 00	06200 FQHC				62. 00
	OTHER REIMBURSABLE COST CENTERS				
70.00	07000 HOME HEALTH AGENCY COST	0	0		70. 00
				1	
	07100 AMBULANCE	١	56, 165	•	71. 00
73. 00	07300 CMHC	0	0		73.00
	SPECIAL PURPOSE COST CENTERS				
00 00		0	0		٠٠ ٥٠ ا
	08000 MALPRACTICE PREMIUMS & PAID LOSSES	٩	0	1	80. 00
81.00	08100 I NTEREST EXPENSE	0	0		81. 00
82 00	08200 UTILIZATION REVIEW - SNF	ol	0		82. 00
	08300 HOSPI CE		0	l .	83. 00
	· · · · · · · · · · · · · · · · · · ·	0	o ₁		•
89. 00	SUBTOTALS (sum of lines 1-84)	-20, 361	15, 473, 535		89. 00
	NONREI MBURSABLE COST CENTERS				
00.00		ام	0		90.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	١	U		
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	1	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES		0		92. 00
	09300 NONPALD WORKERS		0	•	93. 00
		٥		l .	
	09400 PATI ENTS LAUNDRY	0	0		94. 00
100.00	TOTAL	-20, 361	15, 473, 535		100.00
				1	•

Health Financial Systems PE	ACE CARE ST. JOSEPH	S (CUSACK)		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od: From 01/01/2022 To 12/31/2022	Worksheet A-6 Date/Time Pre 5/22/2023 5:2	pared:
			Increases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
TOTALS						
100. 00	Total Reclassificat of columns 4 and 5 equal sum of column 9)	must `		0	0	100.00

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

Health Financial Systems PE	EACE CARE ST. JOSEPH	S (CUSACK))	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315452	Peri od:	Worksheet A-6)
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	pared:
					5/22/2023 5: 2	
			Decreases			
	Cost Cente	r	Li ne #	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.

In Lieu of Form CMS-2540-10 Health Financial Systems PEACE CARE ST. JOSEPHS (CUSACK) RECONCILIATION OF CAPITAL COSTS CENTERS Peri od: Worksheet A-7

Provi der No.: 315452

From 01/01/2022 Date/Time Prepared: 5/22/2023 5:21 pm 12/31/2022 Acqui si ti ons Description Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 281, 004 0 0 1.00 Land Improvements 616, 455 2.00 0 0 0 0 2.00 30, 551, 004 3.00 Buildings and Fixtures 3.00 10, 260 10, 260 0 Building Improvements 4.00 0 4.00 5.00 Fixed Equipment 0 0 5.00 0 6.00 Movable Equipment 4, 557, 283 69, 043 69, 043 0 6.00 Subtotal (sum of lines 1-6) 0 7.00 38, 005, 746 79, 303 0 7.00 79, 303 0 8.00 Reconciling Items 0 8.00 9.00 Total (line 7 minus line 8) 38, 005, 746 79, 303 0 79, 303 9.00 Fully Endi ng Bal ance Description Depreci ated Assets 6.00 7. 00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 2, 281, 004 1.00 1.00 Land 2.00 Land Improvements 616, 455 0 2.00 3.00 Buildings and Fixtures 30, 561, 264 0 3.00 0 Building Improvements 4.00 4.00 Fixed Equipment 5.00 5.00 6.00 Movable Equipment 4, 626, 326 0 6.00 7.00 Subtotal (sum of lines 1-6) 0 38, 085, 049 7.00 Reconciling Items 8.00 0 8.00

38, 085, 049

0

9.00

9.00

Total (line 7 minus line 8)

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der No.: 315452 Peri od: Worksheet A-8 From 01/01/2022 | Worksheet A-8 | To 12/31/2022 | Date/Time Prepared:

				10 12/31/2022	5/22/2023 5: 2	
				Expense Classification on		Pili
				To/From Which the Amount is		
				To Troil will cir the Amedite 13	to be haj astea	
	Dii (1)	(2) D!- F	A	C+ C+	I N-	
	Description (1)	(2) Basis For	Amount	Cost Center	Line No.	
		Adjustment	0.00	0.00		
		1.00	2. 00	3. 00	4. 00	
1. 00	Investment income on restricted funds		0		0.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	(8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4.00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7.00	Parking Lot (chapter 21)		Ó		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	Ö			8. 00
0.00	physician adjustment	0 2				0.00
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)					10. 00
11. 00	Nonallowable costs related to certain					11. 00
11.00	Capi tal expendi tures (chapter 24)		0		0.00	11.00
12 00		A-8-1	12 011		•	12. 00
12. 00	Adjustment resulting from transactions with	A-8-1	-12, 911			12.00
40.00	related organizations (chapter 10)				0.00	40.00
13.00	Laundry and linen service		0	1		13.00
14. 00	Revenue - Employee meals		0			14. 00
15. 00	Cost of meals - Guests		0			15. 00
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					
17. 00	Sale of drugs to other than patients		0			17. 00
18. 00	Sale of medical records and abstracts		0		0.00	18. 00
19. 00	Vending machines		0		0.00	19.00
20.00	Income from imposition of interest, finance		0		0.00	20.00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		0		0.00	21.00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		Ó	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)		_			
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1 00	23. 00
20.00	Bopt cor att on Barrarings and Trixtal co			FI XTURES		20.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2 00	24. 00
27.00	Sopressia troff movable equipment		١	EQUI PMENT	2.00	27.00
25. 00	Other adjustment (specify)	1	_	LEGOT I WEIN I	0.00	25. 00
25. 00		A	7 450	ADMINISTRATIVE & GENERAL	4.00	
		A		•	4.00	
100.00	Total (sum of lines 1 through 99) (Transfer	1	-20, 361			100. 00
	to Worksheet A, col. 6, line 100)	1	l	1	I	l

⁽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 ST. JOSEPHS (CUSACK)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider N

OFFICE COSTS

OFFICE COSTS				from 01/01/2022 Parts I-II fo	Dranamad.
				o 12/31/2022 Date/Time F 5/22/2023 5	
	Li ne No.	Cost (Center	Expense Items	
	1. 00	2.		3. 00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
CLAIMED HOME OFFICE COSTS:					
. 00		ADMI NI STRATI VE		PEACE CARE ADMINISTRATION	1.00
2.00	1	ADMI NI STRATI VE		FINANCE - PEACE CARE	2. 0
3.00		ADMI NI STRATI VE		PEACE CARE HR SALARY	3.00
. 00		ADMI NI STRATI VE		PEACE CARE DEVELOPMENT	4.00
5. 00		ADMI NI STRATI VE	& GENERAL	MARKETI NG	5.00
0.00	0. 00	l			6.00
7. 00	0. 00	l .			7.00
3. 00	0. 00				8.00
0.00	0. 00				9. 0
0.00 TOTALS (sum of lines 1-9). Transfer column					10. 0
6, line 100 to Worksheet A-8, column 3, line	9				
12.					_
	Amount	Amount	Adjustments		
	Allowable In	Included in	(col. 4 minus		
	Cost	Wkst. A, col.	col . 5)		
	4. 00	5. 00	6, 00	-	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI				D OPCANI ZATI ONS OP	
CLAIMED HOME OFFICE COSTS:	KLD AS A KLSULI	OI TRANSACTIO	NO WITH KELATE	D OROANI ZATI ONS OR	
. 00	233, 374	233, 374	C		1.00
. 00	8. 511	8, 511	l c		
	8, 511 131, 548	8, 511 131, 548	C		2. 00
. 00	131, 548	131, 548	C C		2. 00 3. 00
. 00		131, 548 71, 489	0 0		2. 00 3. 00 4. 00
. 00 . 00 . 00	131, 548	131, 548	C C		2. 00 3. 00 4. 00 5. 00
. 00 . 00 . 00 . 00	131, 548	131, 548 71, 489	0 0		2. 00 3. 00 4. 00 5. 00 6. 00
. 00 . 00 . 00 . 00 . 00	131, 548	131, 548 71, 489	0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3. 00 3. 00 3. 00 3. 00 3. 00 4. 00	131, 548	131, 548 71, 489	0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 3.00 5.00 7.00 8.00 9.00 9.00 1.00	131, 548	131, 548 71, 489	-12, 911 C C C C C C		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3. 00 4. 00 5. 00 7. 00 8. 00 9. 00	131, 548 71, 489 0 0 0 0 0 444, 922	131, 548 71, 489 12, 911 0 0 0	-12, 911 C C C C C C		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00

Provider No.: 315452

Worksheet A-8-1 From 01/01/2022

Parts I-II Date/Time Prepared: 5/22/2023 5:21 pm 12/31/2022

Symbol (1)	Name	Percentage of	
		Ownershi p	
1.00	2. 00	3. 00	

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

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

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

1.00	В	0. 00	1.00
2. 00		0.00	2. 00
3. 00		0. 00	3. 00
4. 00		0. 00	4. 00
5. 00		0. 00	5. 00
6. 00		0. 00	6. 00
7. 00		0. 00	7. 00
8. 00		0. 00	8. 00
9. 00		0. 00	9. 00
10. 00		0. 00	10.00
100.00 G. Other (financial or non-financial)		0. 00	100.00
speci fy:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in rel ated organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Name Percentage of Type of Business Ownership 4.00 5.00 6.00	Rel ated Organi	zation(s) and/	or Home Office	
Ownershi p				
	Name		Type of Business	
4, 00 5, 00 6, 00		Ownershi p		1
	4. 00	5. 00	6. 00	

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

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

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

1.00	PEACE CARE, INC.	100.00 PARENT COMPANY	1.00
2.00		0.00	2.00
3. 00		0.00	3.00
4. 00		0.00	4. 00
5. 00		0.00	5.00
6. 00		0.00	6.00
7. 00		0.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

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

Health Financial Systems PEACE COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315452 | Peri od: From 01/01/2022

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

				To	12/31/2022	Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/22/2023 5: 2	ı pm
			5711 1 1712 N.C.E	25 000.0			
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		for Cost	FI XTURES	EQUI PMENT	BENEFITS		
		Allocation					
		(from Wkst A					
		col. 7) 0	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	952, 550	952, 550				1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0		0			2. 00
3.00	00300 EMPLOYEE BENEFITS	1, 710, 260	0	0	1, 710, 260		3.00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 265, 671	131, 100	0	107, 809	2, 504, 580	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 021, 042	59, 392	0	31, 761	1, 112, 195	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	180, 548	13, 358	0	45, 605	239, 511	6. 00
7. 00	00700 HOUSEKEEPI NG	579, 125	19, 168	0	106, 348	704, 641	7. 00
8. 00	00800 DI ETARY	1, 477, 041	111, 882	0	238, 237	1, 827, 160	8. 00
9.00	00900 NURSING ADMINISTRATION	549, 494	0	0	42, 490	591, 984	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY		0	0	0	0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	112, 066	3, 029	0	28, 307	143, 402	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	112,000	3, 02 7	0	20, 307	143, 402	14. 00
15. 00	01500 RECREATION	385, 951	59, 988	0	90, 957	536, 896	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	000,701	077 700	<u> </u>	70, 707	000,070	10.00
30.00	03000 SKILLED NURSING FACILITY	4, 736, 311	544, 403	0	1, 018, 746	6, 299, 460	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
		0	0	0	0	0	32. 00
33. 00		0	0	0	0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	22 570	ol.		ما	22 570	40.00
40.00	04000 RADI OLOGY 04100 LABORATORY	22, 579	0	0	0	22, 579	40.00
41. 00 42. 00	04200 I NTRAVENOUS THERAPY	47, 338	0	0	0	47, 338 0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	486, 916	6, 257	0	o	493, 173	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	467, 481	0, 207	0	0	467, 481	45. 00
46.00	04600 SPEECH PATHOLOGY	183, 963	0	0	O	183, 963	
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	239, 034	0	0	0	239, 034	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
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	O	0	0	O	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC		0	0	0	0	61.00
62. 00	06200 FQHC	١		U	o _l	U	62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	56, 165	O	0	0	56, 165	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 HOSPI CE	15 472 525	040 577	0	1 710 240	15 440 543	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	15, 473, 535	948, 577	0	1, 710, 260	15, 469, 562	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	n	ol	n	n	Ω	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		3, 973	0	0	3, 973	
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES		0, , , o	ő	ol	0, 770	92. 00
93.00	09300 NONPALD WORKERS	O	o	0	o	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	o	0	o	0	94. 00
98. 00	Cross Foot Adjustments	0	o	0	o	0	98. 00
99. 00	Negative Cost Centers	0	0	0	O	0	99. 00
100.00) TOTAL	15, 473, 535	952, 550	0	1, 710, 260	15, 473, 535	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315452 | Period: | Worksheet B | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

In Lieu of Form CMS-2540-10

				T	o 12/31/2022	Date/Time Pre 5/22/2023 5: 2	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	i pili
	oust deliter beserver on	& GENERAL	OPERATION,	LINEN SERVICE	HOUSEKEEL THO	DIEMMI	
			MAINT. &				
			REPAI RS				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS	2 504 500					3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	2, 504, 580 214, 788	1, 326, 983	,			4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	46, 255	23, 261				6. 00
7. 00	00700 HOUSEKEEPI NG	136, 081	33, 378		874, 100		7. 00
8. 00	00800 DI ETARY	352, 863	194, 822		134, 054	2, 508, 899	8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	114, 325	171, 022	0	0	2, 000, 077	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	10.00
11. 00	01100 PHARMACY	o	0	o o	o	0	11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12. 00
13.00	01300 SOCIAL SERVICE	27, 694	5, 275	0	3, 630	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	. 0	0	0	0	14. 00
15.00	01500 RECREATION	103, 686	104, 459	0	71, 876	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	1, 216, 561	947, 974	309, 027	652, 283	2, 508, 899	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/IID	0	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	4, 360	0		0	0	40. 00
41. 00	04100 LABORATORY	9, 142	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	10.000	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	95, 242	10, 896		7, 497	0	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	90, 280	0	1	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	35, 527	0	0	0	0	46. 00
47. 00 48. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	46, 162	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	40, 102	0	1	0	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0		0	0	51.00
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,, ,	ο _ι		31.00
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	O	O	0	0	0	61.00
62.00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	O	0	0	0	70. 00
71. 00	07100 AMBULANCE	10, 847	0			0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82.00						0	82. 00
83. 00	08300 HOSPI CE	0 500 010	4 222 245	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	2, 503, 813	1, 320, 065	309, 027	869, 340	2, 508, 899	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1 1		0	ما	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	767	6, 918	_	4, 760	0	1
91.00	09200 PHYSICIANS PRIVATE OFFICES	767	U, 710	0	4, 760	0	92.00
93. 00	09300 NONPALD WORKERS		0		0	0	93.00
94. 00	09400 PATIENTS LAUNDRY		0	0	0	0	94. 00
98. 00	Cross Foot Adjustments		n	o o	0	0	98. 00
99. 00	Negative Cost Centers	0	n	ا م	0	0	99.00
100.00		2, 504, 580	1, 326, 983	309, 027	874, 100	2, 508, 899	ł
	•					•	

Provi der No.: 315452

			1	0 12/31/2022	5/22/2023 5: 2	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	, p
'	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	9. 00	10. 00	11. 00	12. 00	13. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 00300 EMPLOYEE BENEFITS						3. 00
4.00 O0400 ADMINISTRATIVE & GENERAL						4. 00
5.00 O0500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7. 00 00700 HOUSEKEEPI NG 8. 00 00800 DI ETARY						7. 00 8. 00
9.00 00900 NURSING ADMINISTRATION	706, 309					9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	700, 309	0				10.00
11. 00 01100 PHARMACY	0	0	0			11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0		12. 00
13. 00 01300 SOCIAL SERVICE		0	0	0	180, 001	13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION		0	0	0	0	14. 00
15. 00 01500 RECREATION	o o	Ö	0	0	l	15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	٩	<u> </u>				10.00
30. 00 03000 SKI LLED NURSI NG FACI LI TY	706, 309	ol	0	0	180, 001	30. 00
31. 00 03100 NURSING FACILITY	0	o	0			31. 00
32. 00 03200 CF/IID	o	o	0		l	32. 00
33.00 03300 OTHER LONG TERM CARE	o	O	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS		-,				
40. 00 04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00 04100 LABORATORY	O	o	0	0	0	41. 00
42.00 04200 I NTRAVENOUS THERAPY	o	o	0	0	0	42. 00
43.00 O4300 OXYGEN (INHALATION) THERAPY	0	o	0	0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00 O4900 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						
60. 00 06000 CLI NI C	0	0	0			60.00
61. 00 06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00 06200 FQHC						62. 00
OTHER REIMBURSABLE COST CENTERS		ما	0			70.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 07100 AMBULANCE 73. 00 07300 CMHC	0	0	0		0	71.00
73. 00 07300 CMHC SPECIAL PURPOSE COST CENTERS	U	υĮ	U	0	U	73. 00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00 08100 INTEREST EXPENSE						81. 00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00 08300 HOSPI CE	0	0	0	0	0	
89.00 SUBTOTALS (sum of lines 1-84)	706, 309	ő	-	_		
NONREI MBURSABLE COST CENTERS	700,007	<u> </u>			100,001	07.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00 09100 BARBER AND BEAUTY SHOP	o	O	0	0	l e	91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	0	o	0		0	92.00
93. 00 09300 NONPALD WORKERS	0	o	0	0	0	93. 00
94.00 09400 PATIENTS LAUNDRY	0	o	0	0	0	94.00
98.00 Cross Foot Adjustments	0	o				98. 00
99.00 Negative Cost Centers	0	o	0	0	0	99. 00
100. 00 TOTAL	706, 309	o	0	0	180, 001	100. 00

Provider No.: 315452

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

Part I

From 01/01/2022 Date/Time Prepared: 12/31/2022 5/22/2023 5:21 pm OTHER GENERAL SERVI CE Cost Center Description NURSING AND RECREATI ON Subtotal Post Stepdown Total ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 RECREATION 15.00 0 816, 917 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 816, 917 13, 637, 431 0 13, 637, 431 30.00 31.00 03100 NURSING FACILITY 0 0 31.00 0 0 32.00 03200 | CF/IID 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 33.00 O 0 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 26, 939 40.00 26, 939 41.00 04100 LABORATORY 0000000000 0 56, 480 0 56, 480 41.00 04200 I NTRAVENOUS THERAPY 42 00 42 00 Ω C 0 43.00 04300 OXYGEN (INHALATION) THERAPY 43.00 Ω 04400 PHYSI CAL THERAPY 606, 808 606, 808 44.00 0 44.00 04500 OCCUPATIONAL THERAPY 557, 761 45.00 557.761 45.00 04600 SPEECH PATHOLOGY 46.00 Ω 219, 490 219, 490 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 C 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 C 0 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 285, 196 49.00 285, 196 05000 DENTAL CARE - TITLE XIX ONLY 50.00 C 0 0 0 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 0 0 61.00 C 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω \cap 0 Λ 71.00 07100 AMBULANCE 0 0 67,012 0 67,012 71.00 73.00 07300 CMHC 73.00 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CF 83.00 Λ 83 00 89.00 SUBTOTALS (sum of lines 1-84) 816, 917 15, 457, 117 15, 457, 117 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 00000 0 91.00 09100 BARBER AND BEAUTY SHOP 0 16, 418 16, 418 91.00 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 92.00 09300 NONPALD WORKERS 93.00 0 0 0 93.00 0 94.00 09400 PATIENTS LAUNDRY Ω 0 94 00 0 98.00 Cross Foot Adjustments C 0 0 98.00 99.00 Negative Cost Centers 99.00 0 100.00 TOTAL 816, 917 15, 473, 535 15, 473, 535 100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2540-10

Period:	Worksheet B
From 01/01/2022	Part II
To 12/31/2022	Date/Time Prepared:
5/29/2023 5:21 pm	

			' '	3 12/31/2022	5/22/2023 5: 2	
		CAPI TAL REL	ATED COSTS		0, 22, 2020 0.2	, p
Cost Center Description	Directly Assigned New Capital	BLDGS & FIXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
	Related Costs					
	0	1. 00	2. 00	2A	3. 00	
GENERAL SERVICE COST CENTERS		1	T	T		
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 3.00 00300 EMPLOYEE BENEFITS 4.00 00400 ADMINISTRATIVE & GENERAL	0	0 131, 100	0	0 131, 100	0	1. 00 2. 00 3. 00 4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	0	59, 392	0	59, 392	0	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	0	13, 358		13, 358	0	6.00
7. 00 00700 HOUSEKEEPI NG	0	19, 168		19, 168	0	1
8. 00 00800 DI ETARY	0	111, 882	0	111, 882	0	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	
10. 00 01000 CENTRAL SERVI CES & SUPPLY	0	0	0	0	0	10.00
11. 00 01100 PHARMACY	0	0	0	0	0	11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	12.00
13. 00 01300 SOCIAL SERVICE	0	3, 029	0	3, 029	0	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00 01500 RECREATION	0	59, 988	0	59, 988	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 SKILLED NURSING FACILITY	0	544, 403	0	544, 403	0	
31. 00 03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00 03200 I CF/I I D	0	0	0	0	0	32. 00
33. 00 O3300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS			_	_1		
40. 00 04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00 04100 LABORATORY	0	0	0	0	0	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00 04400 PHYSI CAL THERAPY	0	6, 257	0	6, 257	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	U	0	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	U	0	50.00
51. 00 05100 SUPPORT SURFACES	0	U	0	U	0	51.00
OUTPATIENT SERVICE COST CENTERS 60. 00 06000 CLINIC	0	0	0	ol	0	60.00
61. 00 06100 RURAL HEALTH CLINIC		0		0	0	61.00
62. 00 06200 FQHC	٩	U	U	٩	U	62.00
OTHER REIMBURSABLE COST CENTERS						02.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	ol	0	70.00
71. 00 07100 AMBULANCE	o	0	Ö	Ö	0	71.00
73. 00 07300 CMHC	0	0	0	o	0	73. 00
SPECIAL PURPOSE COST CENTERS		<u>~</u> _		<u>~</u> 1		70.00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100 INTEREST EXPENSE						81.00
82.00 08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 08300 HOSPI CE	o	0	0	ol	0	
89.00 SUBTOTALS (sum of lines 1-84)	o	948, 577		948, 577	0	
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	o	3, 973	0	3, 973	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	O	o	0	ol	0	
93. 00 09300 NONPALD WORKERS	O	o	0	ol	0	
94.00 09400 PATIENTS LAUNDRY	O	o	0	o	0	
98.00 Cross Foot Adjustments				o		98. 00
99.00 Negative Cost Centers		o	0	ol	0	99. 00
100. 00 TOTAL	0	952, 550	0	952, 550	0	100. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS PEACE CARE ST. JOSEPHS (CUSACK) Provi der No.: 315452

				T	0 12/31/2022	Date/Time Prep 5/22/2023 5: 2	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	ı pili
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	121 100					3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	131, 100 11, 243	70. 635				4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	2, 421	1, 238				6. 00
7.00	00700 HOUSEKEEPI NG	7, 123	1, 777		28, 068		7. 00
8.00	00800 DI ETARY	18, 471	10, 370	0	4, 305	145, 028	8. 00
9.00	00900 NURSING ADMINISTRATION	5, 984	0		0	0	9. 00
10.00	1	0	0	0	0	0	10. 00 11. 00
11. 00 12. 00	1	0	0		0	0	12.00
13. 00	1	1, 450	281) o	117	0	13. 00
14.00	1	0	0		О	0	14. 00
15. 00		5, 427	5, 560	0	2, 308	0	15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1 47 647		4.15 000	
30.00		63, 679	50, 461		20, 944	145, 028	30.00
31. 00 32. 00		0	0		0	0	31. 00 32. 00
33. 00		0	0		ő	0	33. 00
	ANCI LLARY SERVI CE COST CENTERS		-		-1	-	
40.00	04000 RADI OLOGY	228	0	0	0	0	40. 00
41. 00		479	0		0	0	41. 00
42. 00	1	0	0	_	0	0	42.00
43. 00 44. 00		4, 985	580	_	241	0	43. 00 44. 00
45. 00		4, 726	0		0	0	45. 00
46. 00		1, 860	0		0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	1	0	0	0	0	0	48. 00
49. 00	1 1	2, 416	0	0	0	0	49. 00
50. 00 51. 00	1 1	0	0		0	0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>	0	31.00
60.00		0	0	0	0	0	60. 00
61. 00	1	0	0	0	0	0	61. 00
62. 00							62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		0	0	O	0	70. 00
71. 00		568	0		0	0	71. 00
73. 00	1	0	0			0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00							80.00
81. 00 82. 00							81. 00 82. 00
83. 00		0	0	0	0	0	
89. 00		131, 060	70, 267		27, 915	145, 028	
	NONREI MBURSABLE COST CENTERS	,,		,	,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	
91.00		40	368	1	153	0	
92. 00 93. 00		0	0		0	0	92. 00 93. 00
94.00			0	0	0	0	93.00
98. 00			0	0	o	0	98. 00
99. 00		0	0	0	O	0	99. 00
100.00	O TOTAL	131, 100	70, 635	17, 017	28, 068	145, 028	100. 00

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | Propared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS PEACE CARE ST. JOSEPHS (CUSACK) Provi der No.: 315452

				10	12/31/2022	5/22/2023 5: 2	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	, p
	, , , , , , , , , , , , , , , , , , ,	ADMI NI STRATI ON			RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY	F 004					8. 00
9.00	00900 NURSING ADMINISTRATION	5, 984	0				9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0				10. 00 11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0		12. 00
13. 00	01300 SOCIAL SERVICE	0	0	0	0	4, 877	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	4, 077	14. 00
15. 00	01500 RECREATION	0	0	-	ol	0	15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>	<u> </u>		13.00
30. 00	03000 SKILLED NURSING FACILITY	5, 984	0	0	ol	4, 877	30. 00
31. 00	03100 NURSING FACILITY	0	0		ol	0	31. 00
32. 00	03200 CF/IID	0	0	0	o	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	o	0	33. 00
	ANCILLARY SERVICE COST CENTERS	•					
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00	04100 LABORATORY	0	0	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 OCCUPATI ONAL THERAPY	0	0	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	l ol	O	0	40.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	60. 00 61. 00
62. 00	06200 FQHC		U	٥	ď	U	62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	ol	0	70. 00
71. 00	07100 AMBULANCE	0	0	1	o	0	71. 00
73.00	07300 CMHC	0	0	0	o	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 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0		0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	5, 984	0	0	0	4, 877	89. 00
00.00	NONREI MBURSABLE COST CENTERS		^		ما		00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0		0	0	91. 00 92. 00
92. 00 93. 00	09300 NONPALD WORKERS		0		0	0	
93.00	09400 PATI ENTS LAUNDRY		0		0	0	93. 00 94. 00
98.00	Cross Foot Adjustments		0		٩	U	94. 00 98. 00
99.00	Negative Cost Centers		0		٥	0	
100.00		5, 984			0		100. 00
. 55. 50	1.5	0, 704		١	٩	1, 077	

Provider No.: 315452

Peri od:

From 01/01/2022

ALLOCATION OF CAPITAL RELATED COSTS

Part II

Date/Time Prepared: 12/31/2022 5/22/2023 5:21 pm OTHER GENERAL SERVI CE Cost Center Description NURSING AND RECREATI ON Subtotal Post Step-Down Total ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9.00 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 RECREATION 15.00 0 73, 283 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 73, 283 925, 676 0 925, 676 30.00 31.00 03100 NURSING FACILITY 0 0 31.00 0 0 32.00 03200 | CF/IID 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 0 33.00 O 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 228 40.00 228 41.00 04100 LABORATORY 0000000000 0 479 0 479 41.00 04200 I NTRAVENOUS THERAPY 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 C 0 43.00 04400 PHYSI CAL THERAPY 12,063 0 0 12,063 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 4.726 4.726 45.00 04600 SPEECH PATHOLOGY 46.00 Ω 1,860 1,860 46.00 47.00 04700 ELECTROCARDI OLOGY 0 47.00 C 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 C 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 2, 416 2, 416 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 C 0 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 0 61.00 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω \cap 0 Ω 71.00 07100 AMBULANCE 0 0 568 0 568 71.00 73.00 07300 CMHC 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 0 Λ 83.00 89.00 SUBTOTALS (sum of lines 1-84) 0 73, 283 948, 016 948, 016 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 00000 0 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP C 4,534 4,534 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 92.00 09300 NONPALD WORKERS 93.00 0 0 93.00 94.00 09400 PATIENTS LAUNDRY Ω 0 94.00 0 98.00 Cross Foot Adjustments C 0 0 98.00 99. 00 Negative Cost Centers 0 99.00 100.00 TOTAL 73, 283 952, 550 952, 550 100. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315452

					o 12/31/2022	Date/Time Pre 5/22/2023 5:2	
		CAPITAL REI	ATED COSTS			372272023 3.2	
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	3.00	4A	4. 00	
1 00	GENERAL SERVICE COST CENTERS	7/ 707		I	T		1 00
1. 00 2. 00 3. 00 4. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	76, 727	1	6, 770, 817		12 0/0 055	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	10, 560 4, 784 1, 076 1, 544	4, 784 1, 076	125, 740 180, 548	0		1
8. 00 9. 00 10. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	9, 012 0 0	l	943, 165	0	1, 827, 160 591, 984 0	1
11. 00 12. 00 13. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0 0 244	0 0 244	0 0 112, 066	0	0 0 143, 402	1
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 RECREATION	4, 832	4, 832	360, 095	0	536, 896	14. 00 15. 00
30. 00 31. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	43, 851 0	43, 851 0	0	0	0	31. 00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0				32. 00 33. 00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	47, 338	41. 00
42. 00 43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 504	0 504	0	0	0 0 493, 173	44. 00
45. 00 46. 00 47. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0 0	0 0	0 0	0	467, 481 183, 963 0	45. 00 46. 00 47. 00
48. 00 49. 00 50. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0 0	0 0	0 0		0 239, 034 0	48. 00 49. 00 50. 00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
60. 00 61. 00 62. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC	0	1				60. 00 61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00 71. 00 73. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0	0 0	0	0	56, 165	
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES					3	80.00
81. 00 82. 00 83. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0	0	0	0	0	81. 00 82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	76, 407					
90. 00 91. 00 92. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0 320 0		0	0		91. 00
93. 00 94. 00 98. 00	09300 NONPALD WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0	· -	0	0	93. 00 94. 00 98. 00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	952, 550	0	1, 710, 260		2, 504, 580	99. 00 102. 00
103. 00 104. 00	Unit cost multiplier (Wkst. B, Part I)	12. 414795	0. 000000	0. 252593 0		0. 193121 131, 100	
105.00				0. 000000		0. 010109	105. 00

Provi der No.: 315452

				'	0 12/31/2022	5/22/2023 5:2	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	, p
		OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(POUNDS OF			<i>(</i>	
		REPAI RS	LAUNDRY)			(DI RECT	
		(SQUARE FEET) 5.00	6. 00	7. 00	8. 00	NURSI NG) 9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	61, 383	l e				5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 076		i			6. 00
7.00	00700 HOUSEKEEPI NG	1, 544		58, 763			7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	9, 012	1	9, 012	95, 685	167 706	8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0			0	157, 705 0	10.00
11. 00	01100 PHARMACY				0	0	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0	i c	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	244	Ö	244	0	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	o c	0	0	14. 00
15.00	01500 RECREATION	4, 832	0	4, 832	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	43, 851	31, 895	43, 851	95, 685	157, 705	30. 00
31. 00	03100 NURSING FACILITY	0	1	C	0	0	31. 00
32.00	03200 I CF/IID	0		0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0		0	0	33. 00
40. 00	04000 RADI OLOGY	0	1	0	٥	0	40. 00
41. 00	04100 LABORATORY		0		0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	1	i c	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	o c	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	504	0	504	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	C	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	O C	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	C	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		1		0	0	51. 00
31.00	OUTPATIENT SERVICE COST CENTERS			1	<u> </u>	0	31.00
60.00	06000 CLI NI C	0	0	C		0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	o c	0	0	61.00
62.00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	ł	1		0	70. 00
71. 00	07100 AMBULANCE	0				0	71. 00
73. 00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	<u> </u> C	0	0	73. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			1			80. 00
	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	C	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	61, 063	31, 895	58, 443	95, 685	157, 705	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		_	-	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	320				0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES 09300 NONPALD WORKERS	0	1	1	-	0	92.00
93. 00 94. 00	09400 PATI ENTS LAUNDRY	0	0	O C	0	0	93. 00 94. 00
98. 00	Cross Foot Adjustments		0		U	U	98. 00
99. 00	Negative Cost Centers						99. 00
102.00		1, 326, 983	309, 027	874, 100	2, 508, 899	706, 309	
30	Part I)					,	
103.00	Unit cost multiplier (Wkst. B, Part I)	21. 618086	9. 688885	14. 875006	26. 220400	4. 478672	103. 00
104.00		70, 635	17, 017	28, 068	145, 028	5, 984	104. 00
105 00	Part II)	4 450707	0 500500		4 545/00	0.0070::	105 00
105.00	Unit cost multiplier (Wkst. B, Part	1. 150726	0. 533532	0. 477647	1. 515682	0. 037944	105.00
	1 117	I	I	I	ı I		I

	ALLOCATION - STATISTICAL BASIS	7102 071112 011. 300	Provi der	No.: 315452 P	eri od:	Worksheet B-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
	Cook Control December 1	CENTRAL	DUADMACY	MEDICAL		5/22/2023 5: 2	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	NURSING AND ALLIED HEALTH	
		SUPPLY	REQUIS)	LI BRARY	(TIME SPENT)	EDUCATI ON	
		(COSTED		(TIME SPENT)		(ASSI GNED	
		REQUI S) 10. 00	11. 00	12. 00	13.00	TI ME) 14. 00	
	GENERAL SERVICE COST CENTERS						
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 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00 6. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						7.00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	222 224					9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	239, 034	0				10. 00 11. 00
	01200 MEDICAL RECORDS & LIBRARY	O	0	31, 895	5		12. 00
13.00	l l	0	0	C	31, 895	_	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 RECREATION		0			0	14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			,ı		13.00
30. 00		0	0	31, 895		0	
31.00	03100 NURSING FACILITY 03200 CF/IID	0	0	C	_	0	31. 00 32. 00
	03300 OTHER LONG TERM CARE	0	0			0	33.00
	ANCILLARY SERVICE COST CENTERS						
40. 00 41. 00	1	0	0	C		0	
	04200 I NTRAVENOUS THERAPY	0	0		_	0	
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	d	O	0	43. 00
	04400 PHYSI CAL THERAPY	0	0	C	0	0	44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0			0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	o	0	Č	o o	0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	239, 034	0			0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	O	0	ď		0	1
	OUTPATIENT SERVICE COST CENTERS			_			
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0		0	60. 00 61. 00
62. 00	06200 FQHC		O		, 	O .	62. 00
70.00	OTHER REIMBURSABLE COST CENTERS			1 .			
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	C		0	
	07300 CMHC	0	0			0	1
	SPECIAL PURPOSE COST CENTERS						
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 H0SPI CE	0	0		o	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	239, 034	0	31, 895	31, 895	0	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	С	ol	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	1		0	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	0	0	0	
94. 00	09400 PATI ENTS LAUNDRY		0			0	1
98. 00	Cross Foot Adjustments						98. 00
99.00	Negative Cost Centers		0		100 001	0	99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	0	0]	180, 001	0	102. 00
103.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.000000		0. 000000	•
104.00		0	0	C	4, 877	0	104. 00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 152908	0. 000000	105. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315452

			To 12/31/2022 Date/Time Pro 5/22/2023 5:2	
		OTHER GENERAL	072272020 0.2	Į piii
		SERVI CE		
	Cost Center Description	RECREATION		
		(CENSUS) 15.00		
	GENERAL SERVICE COST CENTERS	13.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL			4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE			5. 00 6. 00
7. 00	00700 HOUSEKEEPING			7. 00
8. 00	00800 DI ETARY			8.00
9. 00	00900 NURSING ADMINISTRATION			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00	01100 PHARMACY			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY			12. 00
13.00	01300 SOCIAL SERVICE			13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 RECREATION	31, 895		14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	31, 643		15.00
30. 00	03000 SKILLED NURSING FACILITY	31, 895		30.00
31. 00	03100 NURSING FACILITY	0		31. 00
32.00	03200 CF/IID	0		32. 00
33. 00	03300 OTHER LONG TERM CARE	0		33. 00
	ANCILLARY SERVICE COST CENTERS			
40.00		0		40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0		41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0		43. 00
44. 00	04400 PHYSI CAL THERAPY			44. 00
45. 00		O		45. 00
46. 00	04600 SPEECH PATHOLOGY	0		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0		47. 00
48. 00		0		48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0		49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0		51.00
01.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		31.00
60.00	06000 CLI NI C	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0		61. 00
62. 00	06200 FOHC			62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0		70. 00
71. 00	07100 AMBULANCE	0		71. 00
	07300 CMHC			73. 00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		
	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
	08100 I NTEREST EXPENSE			81. 00
	08200 UTILIZATION REVIEW - SNF			82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 31, 895		83. 00 89. 00
69.00	NONREI MBURSABLE COST CENTERS	31, 693		09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0		91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00	09300 NONPAI D WORKERS	0		93. 00
94. 00	09400 PATIENTS LAUNDRY	0		94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers			98. 00 99. 00
102.00		816, 917		102. 00
102.00	Part I)	310, 717		102.00
103.00		25. 612698		103. 00
104.00	71	73, 283		104. 00
105 00	Part II)	0.007/00		105 00
105.00	Unit cost multiplier (Wkst. B, Part	2. 297633		105. 00
	1 1117	ı l		1

Health Financial Systems	PEACE CARE ST. JOSEPHS (CUSACK)	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY	AND OUTPATIENT COST CENTERS Provider No.:	315452 Peri od: Worksheet C

To 12/31/2022 Date/Time Prepared: 5/22/2023 5: 21 pm Ratio (col. 1 Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col . 2 col . 18 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 26, 939 15, 889 1. 695450 40.00 41.00 04100 LABORATORY 56, 480 40, 803 1.384212 41.00 42. 00 04200 I NTRAVENOUS THERAPY 0 0.000000 42.00 0 0.000000 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 44. 00 04400 PHYSI CAL THERAPY 606, 808 1, 048, 613 0.578677 44.00 04500 OCCUPATIONAL THERAPY 856, 869 0.650929 45.00 557, 761 45.00 04600 SPEECH PATHOLOGY 46.00 46.00 219, 490 212, 578 1.032515 47. 00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 12, 768 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 285, 196 1. 288573 49.00 221, 327 50.00 05000 DENTAL CARE - TITLE XIX ONLY O 0.000000 50.00 05100 SUPPORT SURFACES 51.00 0.000000 51.00 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 60.00 0.000000 60.00 0 0 61.00 06100 RURAL HEALTH CLINIC 61.00 62. 00 06200 FQHC 62.00 71. 00 07100 AMBULANCE 67, 012 0. 000000 71.00 100.00 Total 1, 819, 686 2, 408, 847 100. 00

Health Financial Systems P	EACE CARE ST. JO	OSEPHS (CUSACK))	In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/22/2023 5: 2	
		Ti tl a	XVIII (1)	Skilled Nursing		ΙΡΙΙΙ
		11116	XVIII (1)	Facility	113	
		Heal th Care Pi	rogram Charges		Program Cost	
					3	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TIENT COST					
ANCILLARY SERVICE COST CENTERS	T	T	T		Г	
40. 00 04000 RADI OLOGY	1. 695450			0 12, 726	l .	
41. 00 04100 LABORATORY	1. 384212			0 25, 147	0	1
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000		1	0	0	
43.00 O4300 OXYGEN (INHALATION) THERAPY	0. 000000		1	0	0	
44. 00 04400 PHYSI CAL THERAPY	0. 578677		1	0 220, 484	•	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 650929			0 250, 090	•	
46. 00 04600 SPEECH PATHOLOGY	1. 032515			0 99, 005	l	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000)	0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000		1	0	0	1 .0.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 288573			0 174, 904	0	1
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000)	0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0. 000000	0)	0	0	
61.00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62. 00
71.00 07100 AMBULANCE (2)	0. 000000	ł control de la control de		0	0	
100.00 Total (Sum of Lines 40 - 71)		1, 023, 380	1	0 782, 356	0	100.00

⁽¹⁾ For title V and XIX use columns 1, 2, and 4 only.

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

Heal th	Financial Systems PE	ACE CARE ST. JO			In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315452	Period: From 01/01/2022 To 12/31/2022	Worksheet D Parts II-III Date/Time Pre 5/22/2023 5:2	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		·			1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	1. 288573	1.00
2.00	Program vaccine charges (From your reco				,	15	2. 00
3.00	Program costs (Line 1 x line 2) (Title 1	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	19	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied	
		Part I, Col. 18	(From Wkst. B, Part I, Col.	Costs to Tota		Health Costs for Pass	
		10	14)	Costs to Tota	, , , ,	Through (Col.	
			17)	(Col. 2 / Col		3 x Col . 4)	
				1)			
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	26, 939	l e	0.00000			
	04100 LABORATORY	56, 480	0	0.00000		0	41.00
	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0		0.00000		0	
	04400 PHYSI CAL THERAPY	606, 808		0.00000		0	44.00
	04500 OCCUPATI ONAL THERAPY	557, 761		0.00000			45. 00
	04600 SPEECH PATHOLOGY	219, 490		0.00000		0	46.00
	04700 ELECTROCARDI OLOGY	0		0.00000		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	0.00000		0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	285, 196	0	0. 00000	174, 904	0	49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000	0	0	00.00
	05100 SUPPORT SURFACES	0	0	0.00000		0	0 00
100.00	Total (Sum of lines 40 - 52)	1, 752, 674	0)	782, 356	0	100. 00

OMPUT.	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315452	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/22/2023 5:2	pare
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	INPATIENT DAYS				1
00	Inpatient days including private room days			31, 895] 1.
00	Private room days			0	2.
00	Inpatient days including private room days applicable to the			4, 739	
00	Medically necessary private room days applicable to the Progr	am		0	4.
00	Total general inpatient routine service cost			13, 637, 431	5.
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			14, 213, 955	6
00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5	divided by line 6)		0. 959440	
00	Enter private room charges from your records	divided by Time 0)		0. 737440	1
00	Average private room per diem charge (Private room charges li	ne 8 divided by private	room days. Line	0.00	
	2)	с алигаа ау рилиага			
. 00	Enter semi-private room charges from your records			0	10
. 00	Average semi-private room per diem charge (Semi-private room	charges line 10, divide	ed by	0.00	11
	semi-private room days)				
. 00	Average per diem private room charge differential (Line 9 min			0.00	
. 00	Average per diem private room cost differential (Line 7 times			0.00	
. 00	Private room cost differential adjustment (Line 2 times line General inpatient routine service cost net of private room co		minus Lino 14)	0 13, 637, 431	
. 00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	st differential (Line 5	III lius II lie 14)	13, 037, 431	13
. 00	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		427. 57	16
00	Program routine service cost (Line 3 times line 16)	,		2, 026, 254	17
00	Medically necessary private room cost applicable to program			0	18
. 00	Total program general inpatient routine service cost (Line 1			2, 026, 254	
. 00	Capital related cost allocated to inpatient routine service c	osts (From Wkst. B, Par	t II column 18,	925, 676	20
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)				
	Per diem capital related costs (Line 20 divided by line 1)			29. 02	
. 00	Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22)			137, 526 1, 888, 728	
	Aggregate charges to beneficiaries for excess costs (From pr	ovider records)		1, 000, 720	
	Total program routine service costs for comparison to the cos		nus Line 24)	1, 888, 728	
. 00	Enter the per diem limitation (1)	t Trim tation (Line 23 iiii	ilus illie 24)	1, 000, 720	26
	Inpatient routine service cost limitation (Line 3 times the p	er diem limitation line	26) (1)		27
	Reimbursable inpatient routine service costs (Line 22 plus t				28
	(Transfer to Worksheet E, Part II, line 4) (See instructions)		,		
Li	nes 26 and 27 are not applicable for title XVIII, but may be u	sed for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COST	S FOR PPS PASS-THROUGH		1.00	
00	Total SNF inpatient days			31, 895	1
00	Program inpatient days (see instructions)			4, 739	
00	Total nursing & allied health costs. (see instructions) (Do no	t complete for titles V	or XIX)	0	3
00	Nursing & allied health ratio. (line 2 divided by line 1)			0. 148581	4
00	Program nursing & allied health costs for pass-through. (line	2 times line 1)		0	5

Health Financial Systems	PEACE CARE ST. J	OSEPHS (CUSACK)	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII	Provi der No.: 315452	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 5/22/2023 5:21 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing Facility	PPS	<u>. p</u>
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSI	MENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	_IVILIV I		3, 748, 615	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		3, 740, 019	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	yerres)		3, 748, 615	3. 00
4. 00	Primary payor amounts			0, 710, 010	4. 00
5. 00	Coinsurance			509, 007	5. 00
6.00	Allowable bad debts (From your records)			413, 676	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		221, 907	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			268, 889	
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			3, 508, 497	
12.00	Interim payments (See instructions)			3, 496, 406	
13.00	Tentati ve adjustment			0	13. 00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			3, 388	14. 75
14. 99	Sequestration amount (see instructions)			38, 343	14. 99
15.00	Balance due provider/program (see Instructions)			-29, 640	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			19	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			19	
20. 00	Medicare Part B ancillary charges (See instructions)			15	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			15	
22. 00	Primary payor amounts			0	
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			15	
26. 00	Interim payments (See instructions)			15	
27. 00	Tentative adjustment Other Adjustments (See instructions) Specific			0	
28. 00 28. 50	Other Adjustments (See instructions) Specify Demonstration payment adjustment amount before sequestration			0	28. 00 28. 50
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50 28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)			0	29. 00
	Protested amounts (Nonallowable cost report items) in accordance	with CMS Pub 15-2	section 115 2	0	
55. 50	1. States a amounts (Monari Swabi C Cost Topor t Ttollis) Til dood dallo	omo 1 db. 10 2,	00007011 110.2	٥١	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315452 | Period: From 01/01/2022 To 12/31/2022 | Date/Time Prepared: 5/22/2023 5: 21 pm

Title XVIII | Skilled Nursing | PPS

		11 (1)	e AVIII	Facility	PF3	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	11 00	3, 476, 677	0, 00	15	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	07/15/2022	19, 729		0	3. 01
3. 02	7103 GOTIMENTO TO TROVIDER	077 107 2022	17,727		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		19, 729		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		3, 496, 406		15	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Describing to Describe		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	I LIVIATI VE TO FROGRAM		0			5. 50
5. 52			0			5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
6. 00	- 5.98) Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		20 440		0	6. 01
6. 02	PROVIDER TO PROGRAM Total Modicare program Liability (see instructions)		29, 640 3, 466, 766		15	6. 02
7. 00	Total Medicare program liability (see instructions)		Contract	or Name	Contractor	7. 00
			4	00	Number	
8 00	Name of Contractor		1.	00	2. 00	8. 00
	Name of Contractor		 		1	0.00

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

Health Financial Systems

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

Provi der No.: 315452

ini y)				72,01,2022	5/22/2023 5: 2	21 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	Assets CURRENT ASSETS					-
. 00	Cash on hand and in banks	764, 051	0	0	0	1.0
. 00	Temporary investments	0	0	0	0	2. 0
. 00	Notes receivable	0	0	0	0	
. 00	Accounts receivable	3, 167, 812		0	0	
. 00	Other receivables	2, 340		0	0	
. 00	Less: allowances for uncollectible notes and accounts receivable	-1, 419, 098	0	0	0	6.0
. 00	Inventory	0	0	0	0	7. C
. 00	Prepaid expenses	128, 421	ő	0	0	1
. 00	Other current assets	31, 898	0	0	0	9. (
0. 00	Due from other funds	150, 073		0	0	
1. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 825, 497	0	0	0	11. (
2. 00	FI XED ASSETS Land	2, 281, 004	0	0	0	12.0
3. 00	Land improvements	616, 455		0	0	
	Less: Accumulated depreciation	-508, 222	Ö	0	0	1
5. 00	Bui I di ngs	30, 595, 795	0	0	0	1
6. 00	Less Accumulated depreciation	-19, 230, 421	0	0	0	16.0
7. 00	Leasehold improvements	0	0	0	0	
	Less: Accumulated Amortization	0	0	0	0	
	Fixed equipment	0	0	0	0	
0.00	Less: Accumulated depreciation Automobiles and trucks	02 557	0	0	0	20. 0 21. 0
2. 00	Less: Accumulated depreciation	92, 557	0	0	0	1
	Maj or movable equipment	4, 591, 795	ľ	0	0	1
	Less: Accumulated depreciation	-4, 422, 060		0	0	1
	Mi nor equi pment - Depreci abl e	0	0	0	0	1
6. 00	Mi nor equipment nondepreciable	0	0	0	0	26. (
7. 00	Other fixed assets	0	0	0	0	1
8. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	14, 016, 903	0	0	0	28. 0
9. 00	OTHER ASSETS Investments	I 0	0	0	0	29. (
0.00	Deposits on Leases	0	0	0	0	
	Due from owners/officers	-1, 021, 051	Ö	0	0	1
2. 00	Other assets	3, 585, 152	0	0	0	1
3. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	2, 564, 101	0	0	0	33.0
4. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	19, 406, 501	0	0	0	34.0
	Liabilities and Fund Balances					-
5. 00	CURRENT LIABILITIES Accounts payable	662, 199	0	0	0	35. 0
6. 00	Salaries, wages, and fees payable	4, 174, 315		0	0	
7. 00	Payrol I taxes payable	11, 774	0	0	0	1
8. 00	Notes & Loans payable (Short term)	0	0	0	0	38. 0
9. 00	Deferred income	0	0	0	0	1
0.00	Accel erated payments	0	_	_	_	40.0
	Due to other funds	0	_	0	0	1
2. 00	Other current liabilities TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	202, 484 5, 050, 772				1
3.00	LONG TERM LIABILITIES	5,050,772	0	U	0	43.0
4. 00	Mortgage payable	0	0	0	0	44. 0
5. 00	Notes payable	0	0	0	0	1
6. 00	Unsecured Loans	o	0	0	0	46.0
7. 00	Loans from owners:	0	0	0	0	1
8. 00	Other long term liabilities	0	0	0	0	
9. 00	OTHER (SPECIFY)	0	0	0	0	1
0.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	F 0F0 773	0	0	0	
1.00	TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS	5, 050, 772	0	U	0	31.0
2. 00	General fund balance	14, 355, 729				52.
3. 00	Specific purpose fund	,,	0			53.
4. 00	Donor created - endowment fund balance - restricted			0		54.
5. 00	Donor created - endowment fund balance - unrestricted			0		55.
6.00	Governing body created - endowment fund balance			0		56.
_	Plant fund balance - invested in plant				0	1
7.00	Plant fund balance - reserve for plant improvement,	1			0	58. (
7. 00 8. 00						
8. 00	repl acement, and expansi on	14 355 720	^	0	0	50 0
		14, 355, 729 19, 406, 501		0	0	

15.00

16.00

17.00

18.00

19.00

PEACE CARE ST. JOSEPHS (CUSACK) STATEMENT OF CHANGES IN FUND BALANCES Provider No.: 315452 Peri od: Worksheet G-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/22/2023 5:21 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 15, 868, 411 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -1, 368, 038 2.00 3.00 Total (sum of line 1 and line 2) 14, 500, 373 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 ROUNDI NG 0 5.00 6.00 0 6.00 0 0 0 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 14, 500, 374 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 OTHER DEDUCTIONS 144, 645 0 13.00 14.00 0 0 14.00 0 0 15.00 0 15.00 0 16.00 0 16.00 17.00 0 17.00 Total deductions (sum of lines 13 - 17) 18.00 144, 645 18.00 Fund balance at end of period per balance 19.00 14, 355, 729 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 ROUNDI NG 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 0 10.00 0 0 11.00 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 12.00 OTHER DEDUCTIONS 13.00 13.00 14.00 0 14.00

0

0

0

0

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 13 - 17)

sheet (Line 11 - line 18)

Fund balance at end of period per balance

Health Financial Systems	PEACE CARE ST. JO	SEPHS (CUSACK)	1	In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATIN	IG EXPENSES	Provi der	No.: 315452	From 01/01/2022	Worksheet G-2 Parts I-II Date/Time Pre 5/22/2023 5:2	pared:
Cost Center Description			I npati ent	Outpati ent	Total	
			1 00	2 00	3 00	

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Peri od: From 01/01/2022	Worksheet G-2 Parts I-II	
				To 12/31/2022	Date/Time Prep 5/22/2023 5: 2	
	Cost Center Description		Inpati ent	Outpati ent	Total	ı pili
	oost oontor boson per on		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		14, 213, 95	5	14, 213, 955	1.00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		14, 213, 95	5	14, 213, 955	5. 00
	All Other Care Services		T			
6.00	ANCI LLARY SERVI CES		2, 408, 84	.7	2, 408, 847	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	FOHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
	HOSPICE ROUTINE CHARGES / BED HOLD		27, 65	0	0	12. 00 13. 00
14. 00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	+0	16, 650, 45		27, 650 16, 650, 452	14. 00
14.00	Worksheet G-3, Line 1)	10	10, 030, 43	0	10, 030, 432	14.00
	Cost Center Description		l			
	5000 001101 50001 Pt 1011			1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				15, 493, 896	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	Total Dadustians (Com of Lines O 12)			0		13.00
	Total Deductions (Sum of lines 9 - 13)				15 402 004	
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				15, 493, 896	15.00

Health Financial Systems	PEACE CARE ST. JOS	SEPHS (CUSACK)	In Lie	u of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND OPERA	TING EXPENSES	Provi der No.: 315452		Worksheet G-3
			From 01/01/2022 To 12/31/2022	Date/Time Prepared:

STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315452	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
			L	5/22/2023 5:2	
				1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1			16, 650, 452	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	•		3, 241, 210	2. 00
3.00	Net patient revenues (Line 1 minus line 2)			13, 409, 242	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		15, 493, 896	4. 00
5. 00	Net income from service to patients (Line 3 minus 4)			-2, 084, 654	5. 00
,	Other income:		1	070 005	,
6. 00	Contributions, donations, bequests, etc			372, 325	6. 00
7.00	Income from investments			134, 100	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 guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other that	in patrents		0	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts Tuition (fees, sale of textbooks, uniforms, etc.)			0	18. 00 19. 00
19. 00 20. 00	Revenue from gifts, flower, coffee shops, canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of skilled nursing space			0	22.00
23. 00	Governmental appropriations			0	23. 00
24. 00	NON PATIENT REVENUE			-25, 405	
24. 50	COVI D-19 PHE Fundi ng			235, 596	
25. 00	Total other income (Sum of lines 6 - 24)			716, 616	
26. 00	Total (Line 5 plus line 25)			-1, 368, 038	
27. 00	Other expenses (specify)			1, 300, 030	27. 00
28. 00	other expenses (specify)			0	28. 00
29. 00				0	29. 00
	Total other expenses (Sum of lines 27 - 29)			0	30.00
	Net income (or loss) for the period (Line 26 minus line 30)			-1, 368, 038	
2 50	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		,	.,, 000	