Health Financial Systems

INSEDUS MEALTUCADE & DEMAR CTD

In Lieu of Form CMS_2540 10

	II SYSTEMS ST. JUSEPP	S REALINGARE & RERAD GIR		U UI FUI III CIVIS-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 s	since the beginning of the cost reporting p	eriod being deemed overpayment	ts (42 USC 1395g).	OMB NO. 0938-0463				
				Expires: 12/31/2021				
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	TH CARE Provider CCN: 31	5194 Peri od: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 5/16/2022 3:05 pm				
PART I - COST F	REPORT STATUS							
Provi der								
use only	2. [] Manually prepared cost report							
	3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report							
	3.01 [] 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					
	Settled without audit	8.[N] Last Cost Report for	this Provider CCN					
	(3) Settled with audit	9. NPR Date:						
	(4) Reopened	10.[0] fline 4, column 1 i	s "4": Enter number of	times reopened				
	(5) Amended	11.Contractor Vendor Code	4					
	5. Date Received:	12.[F] Medicare Utilization.	Enter "F" for full, "	'L" for low, or "N"				

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF 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 ST. JOSEPHS HEALTHCARE & REHAB CTR (315194) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1		SI GNATURE STATEMENT	
1			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			2
3	Signatory Title			3
4	Date			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-27, 174	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	-27, 174	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.

ILLE	Financial Systems ST. D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA		I CARE	Provider No		Period: From 01/01,		u of For Workshe Part I		
WPLE	A INDENTIFICATION DATA					To 12/31,		Date/Ti		
	1.00	2	. 00		3.00			5/16/20	022 3:0	15 pm
	Skilled Nursing Facility and Skilled Nursing			dress:	0.00					
00	Street: 315 EAST LINDSLEY ROAD	PO Box:								1.
00	City: CEDAR GROVE	State: N.	J	Zip Code: 0	7001					2.
00	County: ESSEX	CBSA Code		Urban/Rura	I: U					3.
01		CBSA Code								3.
			Compon	ent Name	Provi der		Payme	ent Syst		
					CCN	Certified	V	0, or N XVIII		-
			1	. 00	2.00	3.00	4.00		6.00	
	SNF and SNF-Based Component Identification:	I	· · ·		2100	0100	1 11 00	10100	0.00	
0	SNF		ST. JOSEPHS	6 HEALTHCAR	E 315194	12/01/1982	N	Р	N	4.
_			& REHAB CTF	2						
00	Nursing Facility									5.
00										6.
00	SNF-Based HHA									7.
)0)0	SNF-Based RHC SNF-Based FQHC									8.
	SNF-Based CMHC									10.
	SNF-Based OLTC									111.
	SNF-Based HOSPICE									12.
00	SNF-Based CORF						1			13.
						From		То		
						1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/	2021	14.
00	Type of Control (See Instructions)						2	LLC	NI	15.
								Y/ 1. C		-
	Type of Freestanding Skilled Nursing Facilit	V						1.0	0	
00	Is this a distinct part skilled nursing facil		meets the	regui rement	s set forth	in 42 CFR		N		16.
	section 483.5?									
00	Is this a composite distinct part skilled num	rsing faci	lity that	meets the r	equirements	set forth	in	N		17.
	42 CFR section 483.5?									
. 00	Are there any costs included in Worksheet A							Y		18.
	organizations as defined in CMS Pub. 15-1, cl	hapter 10?	? If yes,	complete Wo	rksheet A-8	-1.				-
00	Miscellaneous Cost Reporting Information	anant ind	di ooto with	o "\/" for		" for no		N		10
	If line 19 is yes, does this cost report mee						~	N N		19. 19.
01	utilization cost report, indicate with a "Y",				a mining a	row mearcar	C	11		17.
	Depreciation - Enter the amount of depreciat				ne method ir	ndicated on	Li nes	20 - 22	2.	1
00	Straight Line							3	387, 045	20.
00	Declining Balance								C	21.
00	Sum of the Year's Digits								C	22.
00	Sum of line 20 through 22							3	387, 045	
	If depreciation is funded, enter the balance								C	24.
	Were there any disposal of capital assets du							N		25.
00	Was accelerated depreciation claimed on any a	assets in	the curren	t or any pr	ior cost re	porting per	i od?	N		26.
00	(Y/N)	DECORE OF	at and of t	he newled t	o which thi	a agat rang	~+	N		07
00	Did you cease to participate in the Medicare applies? (Y/N)	program a	at end of t	ne period t	o which thi	s cost repo	rt	N		27.
00	Was there a substantial decrease in health in	nsurance r	proportion	of allowabl	e cost from	nrior cost		N		28.
00	reports? (Y/N)	nour anoo p	or open them		0 0001 1100	pi.o. 0001				20.
								A Part B	Other	
								2.00	3.00	
	If this facility contains a public or non-pu								ı	
	of the lower of the costs or charges enter "	Y" for eac	cn componen	t and type	of service	that qualif	ies f	or the		
00	exemption. Skilled Nursing Facility						N	N		29.
00	Nursing Facility							IN IN	N	30.
	ICF/IID									31.
	SNF-Based HHA						N	N		32.
	SNF-Based RHC							N		33.
	SNF-Based FQHC									34.
	SNF-Based CMHC							N		35.
00	SNF-Based OLTC									36.
						Y/N				-
0.5					1	1.00		2.0	00	0-
00	Is the skilled nursing facility located in a				der as a SN	IF Y				37.
	regardless of the level of care given for Ti- Are you legally-required to carry malpractice			5? (Y/N)		N				38.
00				e nolicy is		IN				38.
	Is the malpractice a "claims-made" or "occurs		I UVI II LII			1				1 07.
	Is the malpractice a "claims-made" or "occur "claims-made" enter 1. If the policy is "occu									
	Is the malpractice a "claims-made" or "occurn "claims-made" enter 1. If the policy is "occu				Premi ums	Paid Los	ses !	SelfIns	urance	
00					Premiums 1.00	Paid Los 2.00	ses s	Selflns 3.0		

Heal th	Financial Systems	ST. JOSEPHS HEALTHCARE	& REHAB CTR		In Lieu	u of Form CMS	-2540-10	
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 31		Period:	Worksheet S-	2	
COMPLE	X INDENTIFICATION DATA				From 01/01/2021 To 12/31/2021	Part I	onorod.	
					10 12/31/2021	Date/Time Pr 5/16/2022 3:		
						Y/N		
						1.00	1	
42.00	42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost							
	center? Enter Y or N. If yes, check box	c, and submit supporting s	schedule listing	cost ce	enters and			
	amounts.							
						N	43.00	
43.00 Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10? 44.00 If line 43 is yes, enter the home office chain number and enter the name and address of the home							44.00	
	office on lines 45, 46 and 47.	1						
	1.00	2.00			3.00			
	If this facility is part of a chain org	ganization, enter the nam	e and address of	the hom	me office on the	lines		
	bel ow.							
45.00	Name:	Contractor's Name:	Cc	ontracto	or's Number:		45.00	
46.00	Street:	PO Box:					46.00	
47.00	Ci ty:	State:	Zi	ip Code:			47.00	

	EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Provid	der No.: 315194	Period: From 01/01/2021	Worksheet S-2 Part II	2
	LA RELIMBORSEMENT QUESTIONNAIRE			To 12/31/2021		
				Y/N	Date	
	General Instruction: For all column 1 respons	ses enter in column 1. "Y"	for Yes or "N"	1.00 for No. For all	2.00 the date	
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites					_
00	Provider Organization and Operation Has the provider changed ownership immediate	ly prior to the beginning	of the cost	N	1	1 1.
	reporting period? If column 1 is "Y", enter instructions)	the date of the change in	column 2. (see			
			<u>Y/N</u> 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date		N	2.00	0.00	2.
00	contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personne of directors through ownership, control, or	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N				3.
				Туре	Date	
	Financial Data and Departs		1.00	2.00	3.00	-
00	Financial Data and Reports Column 1: Were the financial statements prepa	ared by a Certified Public	: Y	С	1	4.
00	Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If Are the cost report total expenses and total	" for Audited, "C" for te copy or enter date no, see instructions.	N			5.
	those on the filed financial statements? If reconciliation.	column 1 is "Y", submit			Langl Oran	
				Y/N 1.00	Legal Oper. 2.00	_
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2: Is t	he provider the	N	N	6.
00 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during	N		7.		
	School and/or Allied Health Program? (Y/N) se				Y/N	
					1.00	
	Bad Debts		tions		N	9.
00	Is the provider seeking reimbursement for ha					
			e during this cos	st reporting	N	
. 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	t collection policy change	-		N N	10.
. 00 . 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	t collection policy change	f "Y", see instr	ructions.	N	10. 11.
. 00 . 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	t collection policy change d/or coinsurance waived? I cost reporting period? If	f "Y", see instru	uctions.	N N Part B	10. 11.
. 00 . 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	t collection policy change	f "Y", see instr	ructions.	N	10. 11. 12.
00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data	t collection policy change d/or coinsurance waived? I cost reporting period? If Description	f "Y", see instru "Y", see instru Pr Y/N 1.00	uctions. art A Date 2.00	N Part B Y/N 3.00	10. 11. 12.
00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	t collection policy change d/or coinsurance waived? I cost reporting period? If Description	f "Y", see instru "Y", see instru Pa Y/N	uctions.	N Part B Y/N	10. 11. 12.
00 00 00 00 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y"	t collection policy change d/or coinsurance waived? I cost reporting period? If Description 0	f "Y", see instru "Y", see instru Pr Y/N 1.00	uctions. art A Date 2.00	N Part B Y/N 3.00	10. 11. 12.
00 00 00 00 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior <u>PS&R Data</u> 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",	t collection policy change d/or coinsurance waived? I cost reporting period? If Description 0	f "Y", see instru 	uctions. art A Date 2.00	N Part B Y/N 3.00 Y	10. 11. 12. 13.
. 00 . 00 . 00 . 00	<pre>If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in cols. 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</pre>	t collection policy change d/or coinsurance waived? I cost reporting period? If Description 0	f "Y", see instru 	uctions. art A Date 2.00	N Part B Y/N 3.00 Y	10. 11.
00 . 00 . 00 . 00 . 00 . 00 . 00	<pre>If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in cols. 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 Report information? If yes, see instructions.</pre>	t collection policy change d/or coinsurance waived? I cost reporting period? If Description 0	f "Y", see instru 	uctions. art A Date 2.00	N Part B Y/N 3.00 Y N	10. 11. 12. 13. 13.

Heal th	Financial Systems	ST. JOSEPHS HEALTHCA	ARE & REHAB C	TR	In Lieu	u of Form CMS-2	2540-10
	O NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der		Period:	Worksheet S-2	
COMPLEX	K REIMBURSEMENT QUESTIONNAIRE				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	pared:
						5/16/2022 3:0	5 pm
			1.	00	2. (00	
C	Cost Report Preparer Contact Informatic	on					
19.00	Enter the first name, last name and the	e title/position SL	_AVKA		PARTI LOVA		19.00
	held by the cost report preparer in co	lumns 1, 2, and 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the	cost report HE	EALTH CARE RE	SOURCES			20.00
	preparer.						
	Enter the telephone number and email a		09-987-1440		SLAVKA. PARTI LOV	/A@HCRNJ. NET	21.00
	report preparer in columns 1 and 2, res	specti vel y.					

	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provi der No.: 315194	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prep 5/16/2022 3:05	ared
		Part B Date 4.00				
	PS&R Data					
. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	04/01/2022				13. (
. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14.(
. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15.
. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16.
. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.
. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.
			3.00			
. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns 1 report includes		EPARER			19.
. 00	respectively. Enter the employer/company name of the cost r preparer.	report				20.
. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.

	D NURSING FACILITY AND SKILLED NURSING X STATISTICAL DATA	ST. JOSEPHS HEALTH	Provi der	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet S-3 Part I Date/Time Prep 5/16/2022 3:05	
				l np	oatient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Avai LabLe	Title V	Title XVIII	Title XIX	
	1	1.00	2.00	3.00	4.00	5.00	
00 00	SKILLED NURSING FACILITY NURSING FACILITY	151 0	55, 115 0			13, 362 0	1.00 2.00
00		0	0			0	3.00
00 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0	(0 0	0	4.00 5.00
00	SNF-Based CMHC	Ŭ	0				6.00
00	HOSPICE	0	0	(0	7.00
00	Total (Sum of lines 1-7)	151 Inpatient D	55, 115 avs/Vi si ts	(Di scharges	13, 362	8.00
			-				
	Component	0ther 6.00	Total 7.00	Title V 8.00	Title XVIII 9.00	Title XIX 10.00	
00	SKILLED NURSING FACILITY	24, 964	43, 043			16	1.0
00	NURSING FACILITY	0	0	(ס	0	2.0
00 00	ICF/IID HOME HEALTH AGENCY COST	0	0			0	3.0 4.0
00	Other Long Term Care	0	0				5.0
00	SNF-Based CMHC						6.0
00	HOSPICE	0	0	(-	0 16	7.0
00	Total (Sum of lines 1-7)	24, 964 Di scha	43, 043 arges	Ave	nage Length of		8. C
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
00	SKILLED NURSING FACILITY	146	286			835.13	1.0
00 00	NURSING FACILITY	0	0			0.00 0.00	2.0 3.0
00	HOME HEALTH AGENCY COST	0	0			0.00	4. C
00	Other Long Term Care	0	0				5. C
00 00	SNF-Based CMHC HOSPICE	0	0	0.00	0.00	0.00	6. C
00	Total (Sum of lines 1-7)	146	0 286			835.13	8.0
		Average Length		Admi	ssi ons		
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
00 00	SKILLED NURSING FACILITY NURSING FACILITY	150. 50 0. 00	0	164	4 42 0	120 0	1.C 2.C
00		0.00	0		0	0	3.0
00	HOME HEALTH AGENCY COST						4.0
00	Other Long Term Care	0. 00				0	5.0
00 00	SNF-Based CMHC HOSPICE	0.00	0	(0 0	0	6. (7. (
00	Total (Sum of Lines 1-7)	150. 50	0				8.0
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I 22.00	Workers 23.00	-		
00	SKILLED NURSING FACILITY	326	131.00		0		1.0
00	NURSING FACILITY	0	0.00	0.00	ס		2.0
00	ICF/IID HOME HEALTH AGENCY COST	0	0.00				3.0
	THUME HEALTH AGENCY CUST		0.00	0.00	J		4.0
00			0 00	0.00	0		5 (
00 00 00 00	Other Long Term Care SNF-Based CMHC	0	0. 00 0. 00				5.C 6.C

ST. JOSEPHS HEALTHCARE & REHAB CTR

Heal th	Financial Systems ST.	JOSEPHS HEALTH	ICARE & REHAB C	TR	In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2021 To 12/31/2021		narodi
					10 12/31/2021	5/16/2022 3:0	
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARI ES			1		1	
1.00	Total salaries (See Instructions)	8, 002, 688	0	8, 002, 68			1.00
2.00	Physician salaries-Part A	0	C		0 0.00		2.00
3.00	Physician salaries-Part B	0	0		0 0.00		3.00
4.00	Home office personnel	0	0		0.00		4.00
5.00	Sum of lines 2 through 4	0	0		0.00		5.00
6.00	Revised wages (line 1 minus line 5)	8, 002, 688	0	8, 002, 68			6.00
7.00	Other Long Term Care	0	0		0.00		
8.00	HOME HEALTH AGENCY COST	0	0		0 0.00		
9.00	СМНС	0	0		0.00		
10.00	HOSPI CE	0	0		0 0.00		
	Other excluded areas	0	0		0.00		
	Subtotal Excluded salary (Sum of lines 7 through 11)	0	C		0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	8, 002, 688	C	8, 002, 68	8 272, 331.00	29.39	13.00
	OTHER WAGES & RELATED COSTS			1			
14.00	Contract Labor: Patient Related & Mgmt	602, 304	C	602, 30	4 9, 280. 00	64.90	14.00
	Contract Labor: Physician services-Part A	0	0		0.00	0.00	15.00
16.00	Home office salaries & wage related costs	0	0		0.00	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1, 995, 029	C	1, 995, 02	9		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, 995, 029	0	1, 995, 02	9		22.00
	instructions)			l			

Heal th	Financial Systems ST	JOSEPHS HEALTH	ICARE & REHAB C	TR	In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Pre 5/16/2022 3:0	pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
		1.00	2.00	3.00	4,00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	1.00	2.00	3.00	4.00	5.00	
1.00	Employee Benefits	0	0		0 0.00	0.00	1.00
2.00	Administrative & General	481, 431	0	481, 43	1 11, 852.00		
3.00	Plant Operation, Maintenance & Repairs	194, 830	0	194, 83	0 6, 412. 00	30.39	3.00
4.00	Laundry & Linen Service	0	0		0.00	0.00	4.00
5.00	Housekeepi ng	479, 069	0	479, 06	9 20, 097. 00	23.84	5.00
6.00	Dietary	854, 890	0	854, 89	0 40, 495. 00	21.11	6.00
7.00	Nursing Administration	996, 789	0	996, 78	9 27, 462. 00	36.30	7.00
8.00	Central Services and Supply	0	0		0 0.00	0.00	8.00
9.00	Pharmacy	0	0		0 0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0		0 0.00	0.00	10.00
11.00	Social Service	136, 554	. 0	136, 55	4, 160. 00	32.83	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	193, 160	0	193, 16	0 8, 909. 00	21.68	13.00
14.00	Total (sum lines 1 thru 13)	3, 336, 723	0	3, 336, 72	3 119, 387. 00	27.95	14.00

SNF WA	GE RELATED COSTS	Provider No.: 315194	Peri od: From 01/01/2021 To 12/31/2021	5/16/2022 3:0	pare
				Amount	
				Reported	<u> </u>
				1.00	<u> </u>
	PART IV - WAGE RELATED COSTS Part A - Core List				-
	RETIREMENT COST				+
. 00	401K Employer Contributions			0	1 1.
00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2
00	Qualified and Non-Qualified Pension Plan Cost			0	
. 00	Prior Year Pension Service Cost			0	
00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			0	4
00	401K/TSA Plan Administration fees			297, 830	5
00	Legal /Accounting/Management Fees-Pension Plan			277,030	
00	Employee Managed Care Program Administration Fees			0	
00	HEALTH AND INSURANCE COST			0	1
00	Health Insurance (Purchased or Self Funded)			531, 871	8
00	Prescription Drug Plan			273, 889	-
	Dental, Hearing and Vision Plan			19, 982	
	Life Insurance (If employee is owner or beneficiary)			12, 495	
	Accident Insurance (If employee is owner or beneficiary)			12, 190	
	Disability Insurance (If employee is owner or beneficiary)			37, 591	
1.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0,,0,1	14
	Workers' Compensation Insurance			62, 214	1
5.00	Retirement Health Care Cost (Only current year, not the extraor	dinary accrual require	ed by FASB 106.	02,211	
	Non cumulative portion)			-	
	TAXES				
. 00	FICA-Employers Portion Only			710, 753	17
8.00	Medicare Taxes - Employers Portion Only			0	18
00 .	Unemployment Insurance			28, 560	19
0. 00	State or Federal Unemployment Taxes			0	20
	OTHER				
	Executive Deferred Compensation			0	21
	Day Care Cost and Allowances			0	1
	Tuition Reimbursement			19, 844	
4.00	Total Wage Related cost (Sum of lines 1 - 23)			1, 995, 029	24
				Amount	
				Reported	
				1.00	
- 00	Part B - Other than Core Related Cost			0	١.
. 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	2

Heal th Financial Systems

ST. JOSEPHS HEALTHCARE & REHAB CTR

In Lieu of Form CMS-2540-10

Heal th	Financial Systems SI.	JUSEPHS HEALTH	ARE & REHAB		In Lie	EU OT FORM CMS-	2540-10
SNF RE	PORTING OF DIRECT CARE EXPENDITURES		Provi der		Peri od:	Worksheet S-3	
				F	rom 01/01/2021	Part V	
				T	o 12/31/2021		
						5/16/2022 3:0	
	Occupational Category	Amount	Fri nge	Adj usted		Average Hourly	
		Reported	Benefits	Salaries (col.	Related to	Wage (col. 3 ÷	
				1 + col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
-	Direct Salaries						
	Nursing Occupations						1
1.00	Registered Nurses (RNs)	2, 148, 626	535, 642	2 2, 684, 268	43, 383.00	61.87	1.00
2.00	Licensed Practical Nurses (LPNs)	267, 697	66, 730				2.00
3.00	Certified Nursing Assistant/Nursing	2, 249, 642	560, 82				3.00
5.00	Assi stants/Ai des	2, 249, 042	500, 023	2,010,407	102, 074.00	27.33	5.00
4.00	Total Nursing (sum of lines 1 through 3)	4, 665, 965	1, 163, 203	5, 829, 168	152, 944. 00	38.11	4.00
4.00 5.00	Physical Therapists	4,003,703	1, 103, 200	5, 027, 100	0.00		
	5	0	(
6.00	Physical Therapy Assistants	0	(0.00		
7.00	Physical Therapy Aides	0	(0.00		
8.00	Occupational Therapists	0	() C	0.00		
9.00	Occupational Therapy Assistants	0	() C	0.00		
	Occupational Therapy Aides	0	() C	0.00		
11.00	Speech Therapists	0	() C	0.00	0.00	11.00
12.00	Respi ratory Therapi sts	0	(0 0	0.00	0.00	12.00
13.00	Other Medical Staff	0	() C	0.00	0.00	13.00
	Contract Labor						1
	Nursing Occupations						1
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
	Licensed Practical Nurses (LPNs)	0			0.00		
	Certified Nursing Assistant/Nursing	0			0.00		
101.00	Assi stants/Ai des				0.00	0.00	
17 00	Total Nursing (sum of lines 14 through 16)	0			0.00	0.00	17.00
	Physical Therapists	168, 021		168, 021			
	Physical Therapy Assistants	153, 345		153, 345			
	Physical Therapy Asistants	155, 545		155, 545			
	5 15	105 024					
	Occupational Therapists	185,034		185, 034			
	Occupational Therapy Assistants	138, 938		138, 938			
	Occupational Therapy Aides	0		C	0.00		
	Speech Therapists	124, 987		124, 987			
	Respiratory Therapists	0		(C	0.00		
26.00	Other Medical Staff	0		C	0.00	0.00	26.00

	From 01/01/2021 To 12/31/2021	Date/Time Pr	-7 repared
	Group	5/16/2022 3: Days	05 pm
	1.00	2.00	
	RUX		1.
	RUL RVX		2. 3.
	RVL		4.
	RHX		5.
	RHL		6.
	RMX		7.
	RML		8.
	RLX RUC		9. 10.
	RUB		11.
	RUA		12.
	RVC		13.
	RVB		14.
	RVA RHC		15. 16.
	RHB		17.
	RHA		18.
	RMC		19.
	RMB		20.
	RMA		21.
	RLB RLA		22. 23.
	ES3		23.
	ES2		24.
	ES1		26.
	HE2		27.
	HE1		28.
	HD2		29.
	HD1 HC2		30.
	HC1		32.
	HB2		33.
	HB1		34.
	LE2		35.
	LE1		36.
	LD2 LD1		37.
	LC2		39.
	LC1		40.
	LB2		41.
	LB1		42.
	CE2 CE1		43.
	CD2		44.
	CD1		46.
	CC2		47.
	CC1		48.
	CB2		49.
	CB1 CA2		50. 51.
	CA2 CA1		52.
	SE3		53.
	SE2		54.
	SE1		55.
	SSC SSB		56. 57.
	SSA		57.
	I B2		59.
	I B1		60.
	I A2		61.
	I A1 BB2		62. 63.
	BB2 BB1		64.
	BA2		65.
	BA1		66.
	PE2		67.
	PE1		68.
	PD2 PD1		69. 70.
	PD1 PC2		70.
	PC2 PC1		72.
	PB2		73.
	PB1		74.

Health Financial Systems	ST. JOSEPHS HEALTHCARE	& REHAB C	TR	In Lie	u of Form CM	S-2540-10	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315194	Period: From 01/01/2021	Worksheet S		
				To 12/31/2021	Date/Time P 5/16/2022 3		
				Group	Days		
				1.00	2.00		
76.00				PA1		76.00	
99.00				AAA		99.00	
100. 00 TOTAL						100.00	
			Expenses	Percentage	Y/N		
			1.00	2.00	3.00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101.00 Staffing						101.00	
102.00 Recruitment						102.00	
103.00 Retention of employees						103.00	
104.00 Training						104.00	
105.00 OTHER (SPECIFY)						105.00	
106.00 Total SNF revenue (Worksheet G-2, Part I,	line 1, column 3)		l			106.00	

		JOSEPHS HEALTHCA				u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 01/01/2021	Worksheet A	
					To 12/31/2021	Date/Time Pre 5/16/2022 3:0	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Reclassi fied	
				+ col. 2)	ons I ncrease/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)		
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS	1	205 (5(205 (5)		395, 656	1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		395, 656 0	395, 650		395, 050	1.00 2.00
3.00	00300 EMPLOYEE BENEFITS	0	2,004,414		-	2,004,414	1
4.00	00400 ADMINI STRATI VE & GENERAL	481, 431	1, 082, 097	1, 563, 528		1, 563, 528	
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	194, 830	667, 589	862, 419	9 0	862, 419	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	107, 888			107, 888	1
7.00 8.00	00700 HOUSEKEEPING	479,069	75, 269			554, 338	
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	854, 890 996, 789	488, 847 0	1, 343, 73 996, 78		1, 343, 737 996, 789	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	(0 0	0	
11.00	01100 PHARMACY	0	0	(0 0	0	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0	(0 0	0	
13.00	01300 SOCIAL SERVICE	136, 554	0	136, 554		136, 554	
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES	0 193, 160	12.045	206, 02	0 5 0	0 206, 025	
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	193, 100	12, 865	200, 023		200, 025	15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	4, 665, 965	784, 671	5, 450, 630	5 O	5, 450, 636	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	
32.00	03200 I CF/I I D	0	0	(-	0	
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	(0 0	0	33.00
40.00	04000 RADI OLOGY	0	11, 279	11, 279	9 0	11, 279	40.00
41.00	04100 LABORATORY	0	3, 879			3, 879	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	(0 0	0	
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	318, 790 341, 845	318, 790 341, 845		318, 790 341, 845	
46.00	04600 SPEECH PATHOLOGY	0	139, 651	139, 65		139, 651	
47.00	04700 ELECTROCARDI OLOGY	0	0	(0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46, 816	46, 810	5 O	46, 816	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	232, 936			232, 936	
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0			0	
51.00	OUTPATIENT SERVICE COST CENTERS	U	0		<u> </u>	0	51.00
60.00	06000 CLINIC	0	0	(0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00							62.00
70 00	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	70.00
	07100 AMBULANCE	0	0		-	0	
	07300 CMHC	0	0		0 0		
	SPECIAL PURPOSE COST CENTERS	· · ·			1		
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0	(0	0	
81.00	08100 INTEREST EXPENSE		0			0	
82.00 83.00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0	0			0	
89.00	SUBTOTALS (sum of lines 1-84)	8,002,688	6, 714, 492	14, 717, 180		14, 717, 180	
	NONREI MBURSABLE COST CENTERS	1		1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0	0	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFICES	0	0			0	
	09300 NONPAID WORKERS	0	0			0	1
	09400 PATI ENTS LAUNDRY	0	0		0 0	0	1
100.00	TOTAL	8, 002, 688	6, 714, 492	14, 717, 180	0 0	14, 717, 180	100.00

Heal th	Fi nanci al	Syst	ems	
DEOL 10			A D HUGTHENT	_

In Lieu of Form CMS-2540-10

	inancial Systems ST. FICATION AND ADJUSTMENT OF TRIAL BALANCE OF	JOSEPHS HEALTH EXPENSES		No.: 315194	Peri od:	u of Form CMS-254 Worksheet A
					From 01/01/2021 To 12/31/2021	Date/Time Prepa
						5/16/2022 3:05
	Cost Center Description	Adjustments to				
			For Allocation	ו		
		Wkst A-8)	(col. 5 +- col. 6)			
		6.00	7.00	-		
GE	ENERAL SERVICE COST CENTERS	0.00	7.00			
	D100 CAP REL COSTS - BLDGS & FIXTURES	0	395, 656			
	D200 CAP REL COSTS - MOVABLE EQUI PMENT			1		
	D300 EMPLOYEE BENEFITS	0				
	0400 ADMI NI STRATI VE & GENERAL	313, 787		1		
	D500 PLANT OPERATION, MAINT. & REPAIRS	0		1		
	D600 LAUNDRY & LINEN SERVICE					
	D700 HOUSEKEEPING			1		
	0800 DI ETARY	-2, 215		1		
	0900 NURSI NG ADMI NI STRATI ON	-2, 213	996, 789			
	1000 CENTRAL SERVICES & SUPPLY		770, 70			1
	1100 PHARMACY					1
	1200 MEDICAL RECORDS & LIBRARY	0				1
	1300 SOCIAL SERVICE	0	136, 554			1
	1400 NURSING AND ALLIED HEALTH EDUCATION			F		1
	1500 PATIENT ACTIVITIES					1
	NPATIENT ROUTINE SERVICE COST CENTERS	0	206, 025			' '
	3000 SKILLED NURSING FACILITY	-45,000	5, 405, 636			3
	3100 NURSING FACILITY					
		0				3
	3200 I CF/I I D	0				3
	3300 OTHER LONG TERM CARE	0	(<u>л</u>		3
	VCI LLARY SERVICE COST CENTERS		11.070			
	4000 RADI OLOGY	0				4
		0				4
	4200 I NTRAVENOUS THERAPY	0	(4
	4300 OXYGEN (INHALATION) THERAPY	0				4
	4400 PHYSI CAL THERAPY	0	318, 790	1		4
	4500 OCCUPATIONAL THERAPY	0	341, 845	1		4
	4600 SPEECH PATHOLOGY	0	139, 651			4
		0	(1		4
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46, 816	1		4
	4900 DRUGS CHARGED TO PATIENTS	0	232, 936			4
	5000 DENTAL CARE - TITLE XIX ONLY	0				5
	5100 SUPPORT SURFACES	0	(5
	JTPATIENT SERVICE COST CENTERS					
		0				6
	6100 RURAL HEALTH CLINIC	0	0			6
						6
	THER REIMBURSABLE COST CENTERS					
	7000 HOME HEALTH AGENCY COST	0				7
	7100 AMBULANCE	0				7
	7300 CMHC	0	(<u>и</u>		7
	PECIAL PURPOSE COST CENTERS	-				
	BOOO MALPRACTICE PREMIUMS & PAID LOSSES	0				8
	3100 INTEREST EXPENSE	0				8
	B200 UTILIZATION REVIEW - SNF	0				8
	B300 HOSPI CE	0				8
. 00	SUBTOTALS (sum of lines 1-84)	266, 572	14, 983, 752	2		
	ONREI MBURSABLE COST CENTERS		1			
	9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0				9
	9100 BARBER AND BEAUTY SHOP	0	0) I		9
	9200 PHYSICIANS PRIVATE OFFICES	0	0) 		9
1	9300 NONPAID WORKERS	0	0) 		9
	9400 PATIENTS LAUNDRY	0	0) I		9
0.00	TOTAL	266, 572	14, 983, 752	2		10

Health Financial Systems ST	. JOSEPHS HEALTHCARE	& REHAB C	TR	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315194	Period: From 01/01/2021	Worksheet A-6)
					Date/Time Pre 5/16/2022 3:0	epared:)5 pm
			Increases			
	Cost Cente	er	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
TOTALS						
100. 00	Total Reclassifica of columns 4 and 5 equal sum of column 9)	must		0	С	100. 00

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

Health Financial Systems ST.	JOSEPHS HEALTHCARE	& REHAB C	TR	In Lie	u of Form CMS	-2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315194	Period: From 01/01/2021	Worksheet A-	6
					Date/Time Pr 5/16/2022 3:	epared: 05 pm
		Decreases				
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
TOTALS			_			
100.00				0		0 100. 00

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

Heal th	Fi nanci al	Systems	
DECONC			COCTO

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315194	Period: From 01/01/2021 To 12/31/2021		pared:
				Acqui si ti on	S		
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5		_			
1.00	Land	4, 200	0		0 (0 0	1.00
2.00	Land Improvements	0	154, 200		0 154, 200	0 0	2.00
3.00	Buildings and Fixtures	9, 971, 556	0		0 0	0 0	3.00
4.00	Building Improvements	1, 695, 955	0		0 0	0 0	4.00
5.00	Fixed Equipment	0	0		0 0	0 0	5.00
6.00	Movable Equipment	2, 517, 106	351, 184		0 351, 184	1 0	6.00
7.00	Subtotal (sum of lines 1-6)	14, 188, 817	505, 384		0 505, 384	1 0	7.00
8.00	Reconciling Items	0	0		0 0	0 0	8.00
9.00	Total (line 7 minus line 8)	14, 188, 817	505, 384		0 505, 384	1 O	9.00
	Description	Endi ng Bal ance	Fully				
		_	Depreciated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4, 200					1.00
2.00	Land Improvements	154, 200	0				2.00
3.00	Buildings and Fixtures	9, 971, 556	0				3.00
4.00	Building Improvements	1, 695, 955	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	2, 868, 290	0				6.00
7.00	Subtotal (sum of lines 1-6)	14, 694, 201	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	14, 694, 201	0				9.00

In Lieu of Form CMS-2540-10

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ADJUST	MENTS TO EXPENSES		Provi der	No.: 315194	Period:	Worksheet A-8	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/16/2022 3:0	pared: 5 pm
					lassification on	Worksheet A	
				lo/From Whic	ch the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
	Description (1)	Adjustment	Allouitt	COS	t Center	LITTE NO.	
		1.00	2.00		3.00	4.00	
1.00	Investment income on restricted funds		0			0.00	1.00
0 00	(chapter 2)		0			0.00	0.00
2.00	Trade, quantity, and time discounts (chapter 8)		0			0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0			0.00	3.00
4.00	Rental of provider space by suppliers		0			0.00	•
	(chapter 8)						
5.00	Telephone services (pay stations excluded)		0			0.00	5.00
6.00	(chapter 21) Television and radio service (chapter 21)		0			0.00	6.00
7.00	Parking lot (chapter 21)		0			0.00	•
8.00	Remuneration applicable to provider-based	A-8-2	0			0.00	8.00
	physician adjustment						
9.00	Home office cost (chapter 21)		0			0.00	
10.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	•
11.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00	11.00
12.00	Adjustment resulting from transactions with	A-8-1	313, 787				12.00
12.00	related organizations (chapter 10)		010, 707				12.00
13.00	Laundry and linen service		0			0.00	
14.00	Revenue – Employee meals	В	-2, 215	DI ETARY		8.00	•
15.00	Cost of meals - Guests		0			0.00	
16.00	Sale of medical supplies to other than patients		0			0.00	16.00
17.00	Sale of drugs to other than patients		0			0.00	17.00
18.00	Sale of medical records and abstracts		0			0.00	
19.00	Vending machines		0			0.00	19.00
20.00	Income from imposition of interest, finance		0			0.00	20.00
21 00	or penalty charges (chapter 21)		0			0.00	01 00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21.00
	overpayments						
22.00	Utilization reviewphysicians' compensation		0	UTILIZATION	REVIEW - SNF	82.00	22.00
	(chapter 21)						
23.00	Depreciationbuildings and fixtures			CAP REL COST	S - BLDGS &	1.00	23.00
24.00	Depreciationmovable equipment			FIXTURES CAP REL COST		2.00	24.00
∠4.00				EQUI PMENT	3 - WUVADLE	2.00	24.00
25.00	SJ STV ADMIN PHYSICAN FEES	А			ING FACILITY	30.00	25.00
	Total (sum of lines 1 through 99) (Transfer		266, 572				100.00
	to Worksheet A, col. 6, line 100)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

Health Financial Systems ST.	JOSEPHS HEALTH	CARE & REHAB C	TR	In Lie	eu of Form CMS	6-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provi der	No.: 315194	Period: From 01/01/2021 To 12/31/2021	Worksheet A- Parts I-II Date/Time Pr 5/16/2022 3:	repared:
	Line No.	Cost (Center	Expense	e Items	
	1.00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	TED ORGANI ZATI ONS	S OR	
1.00	4.00	ADMI NI STRATI VE	& GENERAL	MEDI CAL CENTER ADMI NI STRATI VE		1.00
2. 00	30. 00	SKILLED NURSIN	G FACILITY	MEDI CAL CENTER SUPPLY	CENTRAL	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 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu	IS		
	Cost	Wkst. A, col. 5	col. 5)			
	4,00	5.00	6,00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN				TED ORGANIZATIONS	S OR	
CLAIMED HOME OFFICE COSTS:						
1.00	313, 787	0	313, 7	87		1.00
2.00	809, 454	809, 454		0		2.00
3.00	0	0		0		3.00
4.00	0	0		0		4.00
5.00	0	0		0		5.00
6.00	0	0		0		6.00
7.00	0	0		0		7.00
8.00	0	0		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	1, 123, 241	809, 454	313, 7	87		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						

Health Financial Systems ST.	JOSEPHS HEALTHO	CARE & REHAB CTR	In Lie	u of Form CMS-2	540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provider No.: 315194	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8- Parts I-II Date/Time Prep 5/16/2022 3:05	bared:
	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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

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

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

1.00	В	ST. JOSEPH REGIONAL MEDICAL CENTER	100.00	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.

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

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

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

Related Or	ganization(s) and/or	Home Office
Name	Percentage of	Type of Business
Hame	fi or contago or	
	Ownershi p	

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.

3	·	I		
1.00	ST. JOSEPH REGIONAL MEDICAL	100.00	HOSPI TAL	1.00
	CENTER			
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.

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

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

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

Heal th	Financial Systems ST.	JOSEPHS HEALTHO	CARE & REHAB C	TR		In Lie	u of Form CMS-	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315194		riod: m 01/01/2021 12/31/2021	Worksheet B Part I Date/Time Pre	
				1755 00070			5/16/2022 3:0	5 pm
			CAPI TAL REL	LATED COSTS				
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE		EMPLOYEE	Subtotal	
	oust center bescription	for Cost	FIXTURES	EQUI PMENT		BENEFITS	50510101	
		Allocation	11/110/120	20011112111		BEILETTO		
		(from Wkst A						
		col. 7)						
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	395, 656	395, 656		_			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0			0	0 004 444		2.00
3.00	00300 EMPLOYEE BENEFITS	2,004,414	0		0 0	2,004,414	2 0/0 0/0	3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	1, 877, 315 862, 419	63, 050 12, 675		0	120, 583 48, 799	2, 060, 948 923, 893	4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	107, 888	7, 110		0	40, 799	114, 998	
7.00	00700 HOUSEKEEPING	554, 338	10, 483		0	119, 991	684, 812	
8.00	00800 DI ETARY	1, 341, 522	34, 778		0	214, 123	1, 590, 423	
9.00	00900 NURSI NG ADMI NI STRATI ON	996, 789	0		0	249, 664	1, 246, 453	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	0	10.00
11.00	01100 PHARMACY	0	0		0	0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	0	12.00
13.00	01300 SOCI AL SERVI CE	136, 554	1, 707		0	34, 202	172, 463	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
15.00	01500 PATIENT ACTIVITIES	206, 025	31, 778		0	48, 380	286, 183	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	E 405 (0)	00/ 500		0	4 4 (0 (70	(000 000	0.00
	03000 SKI LLED NURSI NG FACI LI TY	5, 405, 636	226, 500		0	1, 168, 672	6, 800, 808	
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D	0	0		0	0	0	31.00 32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	0	
55.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		0	<u> </u>	0	33.00
40.00	04000 RADI OLOGY	11, 279	0		0	0	11, 279	40.00
41.00	04100 LABORATORY	3, 879	0		0	0	3, 879	
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	318, 790	1, 897		0	0	320, 687	44.00
45.00	04500 OCCUPATIONAL THERAPY	341, 845	2, 354		0	0	344, 199	
46.00	04600 SPEECH PATHOLOGY	139, 651	471		0	0	140, 122	
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	46, 816	0		0	0	46, 816	
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	232, 936	450 0		0	0	233, 386 0	
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	
01100	OUTPATIENT SERVICE COST CENTERS				-		<u> </u>	
60.00		0	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	0	61.00
62.00	06200 FQHC							62.00
	OTHER REIMBURSABLE COST CENTERS	1 1						
	07000 HOME HEALTH AGENCY COST	0	0		0	0		
	07100 AMBULANCE	0	0		0	0	0	•
/3.00	07300 CMHC	0	0		0	0	0	73.00
80.00	SPECIAL PURPOSE COST CENTERS 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	o	0	
89.00	SUBTOTALS (sum of lines 1-84)	14, 983, 752	393, 253		0	2,004,414	14, 981, 349	89.00
	NONREI MBURSABLE COST CENTERS					·		1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	2, 403		0	0	2, 403	
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0	0	0	
93.00	09300 NONPALD WORKERS	0	0		0	0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	0	
98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0	0		0	0	0	
99.00 100.00		14, 983, 752	395, 656		0	2,004,414	14, 983, 752	
100.00		17,703,732	575,050	I	9	2,004,414	17, 703, 732	1.00.00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315194	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/16/2022 3:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT & REPAI RS	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1.00 2.00 3.00 4.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	2, 060, 948					1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY	147, 343 18, 340 109, 215 253, 642	1, 071, 236 23, 807 35, 099 116, 449	157, 14	45 0 829, 126 0 95, 375	2, 055, 889	5.00 6.00 7.00 8.00
9.00 10.00 11.00 12.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY	198, 786 0 0 0	C C C C		0 0 0 0 0 0 0 0 0 0	0 0 0 0	10. 00 11. 00
13.00 14.00 15.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	27, 505 0 45, 641	5, 717 C 106, 404		0 4,682 0 0 0 87,148	0 0 0	14.00
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	1,084,605 0 0 0	758, 399 C C		45 621, 150 0 0 0 0 0 0 0 0	2, 055, 889 0 0 0	31.00 32.00
40. 00 41. 00 42. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	1, 799 619 0			0 0 0 0 0 0	0 0 0	41.00
43.00 44.00 45.00 46.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	0 51, 143 54, 893	0 6, 352 7, 881	2	0 0 0 5, 202 0 6, 455 0 1, 291	0 0 0 0	44. 00 45. 00
47.00 47.00 48.00 49.00 50.00 51.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	22, 347 0 7, 466 37, 221 0 0	1, 576 C C 1, 506 C C C C C		0 1, 291 0 0 0 0 0 1, 233 0 0 0 0	0 0 0 0 0 0 0	47.00 48.00 49.00 50.00
51.00	OUTPATIENT SERVICE COST CENTERS	0	L.	/	0 0	0	51.00
60. 00 61. 00 62. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	C		0 0 0 0	0	
70. 00 71. 00 73. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0	C C C		0 0 0 0 0 0	0 0 0	71.00
80. 00 81. 00 82. 00 83. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0			0 0	0	80.00 81.00 82.00 83.00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	2,060,565	1, 063, 190	157, 14	45 822, 536	2, 055, 889	89.00
90.00 91.00 92.00 93.00 94.00 98.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments	0 383 0 0 0 0	C 8, 046 C C C		0 0 0 6,590 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	91.00 92.00 93.00 94.00
98.00 99.00 100.00	Cross Foot Adjustments Negative Cost Centers TOTAL	0 0 2, 060, 948	C C 1, 071, 236		0 0 0 0 45 829, 126	0	99.00

	Financial Systems ST. ALLOCATION - GENERAL SERVICE COSTS	JOSEPHS HEALTH		No.: 315194	Peri od:	eu of Form CMS-: Worksheet B	2540-10
CUST	ILLUCATION - GENERAL SERVICE COSTS		Provider	NO 313194	From 01/01/2021 To 12/31/2021	Part Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/16/2022 3:0 SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	THANMAGT	RECORDS & LI BRARY	SOUTHE SERVICE	
	1	9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						1
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00
3.00 4.00	00400 ADMINI STRATI VE & GENERAL						4.00
4.00 5.00	00500 PLANT OPERATION, MAINT, & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	1, 445, 239					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	(D			10.00
11.00	01100 PHARMACY	0	(0		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	(D	0 (12.00
13.00	01300 SOCIAL SERVICE	0	(0	0 0	210, 367	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	(0 0	-	
15.00	01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	(/	0 (0 0	15.00
30, 00	03000 SKILLED NURSING FACILITY	1, 445, 239	(0 (210, 367	30.00
	03100 NURSI NG FACI LI TY	1, 443, 237	(0 0		
32.00	03200 I CF/I I D	0	(0 0	-	
33.00	03300 OTHER LONG TERM CARE	0	(0 0		
	ANCI LLARY SERVICE COST CENTERS	- <u>-</u>					
40.00	04000 RADI OLOGY	0	(0 (0 0	40.00
41.00	04100 LABORATORY	0	(D	0 (0 0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	(0 (0 0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	(0 (0 0	
44.00	04400 PHYSI CAL THERAPY	0	(2	0 0	0 0	
45.00	04500 OCCUPATIONAL THERAPY	0	(0 0	0	
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	(
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 0		
48.00	04900 DRUGS CHARGED TO PATIENTS	0	(0 0		
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	(0 0	-	
51.00	05100 SUPPORT SURFACES	0	(0 0	-	1
	OUTPATIENT SERVICE COST CENTERS					-	
60.00	06000 CLINIC	0	(0 (0 0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	(þ	0 (0 0	61.00
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS			1			70.00
70.00 71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	(0 0		
73.00	07300 CMHC	0	(0 0		
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	(<u>/</u>	0	<u> </u>	/3.00
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	0	(0 0	o o	83.00
89.00	SUBTOTALS (sum of lines 1-84)	1, 445, 239	(0 (210, 367	89.00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	(0 0		
91.00	09100 BARBER AND BEAUTY SHOP	0	(0 (-	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	(2	0 0	-	
93.00	09300 NONPALD WORKERS	0	(2	0 (
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	(0 0	0	94.00 98.00
98.00 99.00	Negative Cost Centers		(0 0	0 0	1
100.00	U U	1, 445, 239	(210, 367	
100.00		1,440,207	(1		210, 307	1100.00

 ST. JOSEPHS HEALTHCARE & REHAB CTR
 In Lieu of Form CMS-2540-10

 Provider No.: 315194
 Period: From 01/01/2021
 Worksheet B Part I

00017	LECONTION - GENERAL SERVICE COSTS		TTOVIGET	F	rom 01/01/2021 o 12/31/2021		pared:
			OTHER GENERAL			5/16/2022 3:0	5 pm
			SERVI CE				
	Cost Center Description	NURSI NG AND	PATIENT	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH	ACTI VI TI ES		Adjustments		
		EDUCATI ON					
		14.00	15.00	16.00	17.00	18.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1	1		1.00
2.00	00200 CAP REL COSTS - BEDGS & FIXTORES						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00	01300 SOCIAL SERVICE	0					13.00
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES	0	525, 376				14.00 15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	525, 376				15.00
30.00	03000 SKILLED NURSING FACILITY	0	525, 376	13, 658, 978	0	13, 658, 978	30.00
31.00	03100 NURSING FACILITY	0	323, 376		-		
32.00	03200 I CF/I I D	0	0	-	-		
33.00	03300 OTHER LONG TERM CARE	0	C		-		1
	ANCI LLARY SERVICE COST CENTERS	-		•			1
40.00	04000 RADI OLOGY	0	C	13, 078	8 0	13, 078	40.00
41.00	04100 LABORATORY	0	C	4, 498	8 0	4, 498	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	C	0 0	-	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	0 0	, O	0	
44.00	04400 PHYSI CAL THERAPY	0	0	383, 384		383, 384	•
45.00	04500 OCCUPATIONAL THERAPY	0		413, 428		413, 428	•
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0		165, 336	0	165, 336 0	1
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		54, 282		54, 282	
49.00	04900 DRUGS CHARGED TO PATIENTS	0		273, 346		273, 346	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0				0	1
51.00	05100 SUPPORT SURFACES	0	C		0 0	-	
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	C) C	0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	C) C	0 0	0	
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	-		-	-	-	
70.00	07000 HOME HEALTH AGENCY COST	0	C	-	-	-	
71.00	07100 AMBULANCE	0		۳ ۱	-	-	
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0) C	0 0	0	73.00
80.00		1					80.00
81.00							81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	C	ol c	0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	525, 376	14, 966, 330	0 0	14, 966, 330	89.00
	NONREI MBURSABLE COST CENTERS						
90.00		0	C) C		0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	C	17, 422	0		
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	C	0 0	0	0	
93.00		0			0	0	
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0			0	0	
98.00 99.00	Negative Cost Centers				0	0	
99.00 100.00	5		525, 376	14, 983, 752			
. 50. 00		. 0	020,070	1, , , , , , , , , , , , , , , , , ,	. 0	1, ,00, ,02	1.00.00

	TI ON OF CAPITAL RELATED COSTS	JOSEPHS HEALTHC		No.: 315194 P	eriod: rom 01/01/2021	u of Form CMS- Worksheet B Part II Date/Time Pre 5/16/2022 3:0	pared:
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FI XTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		0	1.00	2.00	2A	3.00	
	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	0	0	0	0	0	3.00
4.00	00400 ADMINISTRATIVE & GENERAL	0	63, 050	0	63, 050	0	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	12, 675		12, 675	0	
6.00	00600 LAUNDRY & LINEN SERVICE	0	7, 110		7, 110	0	
7.00	00700 HOUSEKEEPI NG	0	10, 483		10, 483	0	
8.00		0	34, 778	0	34, 778	0	
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0	0	0	0	
	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	
	01300 SOCIAL SERVICE	0	1, 707	0	1, 707	0	
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	1, 707	0	1, 707	0	
	01500 PATIENT ACTIVITIES	0	31, 778	0	31, 778	0	
	INPATIENT ROUTINE SERVICE COST CENTERS			-			1
30.00	03000 SKILLED NURSING FACILITY	0	226, 500	0	226, 500	0	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 I CF/I I D	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS	1 1					
40.00	04000 RADI OLOGY	0	0	0	0	0	
41.00	04100 LABORATORY	0	0	0	0	0	
42.00 43.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	0	0	0	0	0	
	04400 PHYSI CAL THERAPY	0	1, 897		1, 897	0	
45.00	04500 OCCUPATI ONAL THERAPY	0	2, 354		2, 354	0	
	04600 SPEECH PATHOLOGY	0	471		471	0	
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	450	0	450	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	-		-	-	-	
	06000 CLINIC	0	0			0	
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0	0	0	0	61.00 62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	0	0		-		
	07300 CMHC	0	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF				_	_	82.00
83.00	08300 HOSPI CE	0	202.252	0	-	0	•
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	393, 253	0	393, 253	0	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	2, 403		2, 403	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	2, .50	0	2, .30	0	
93.00	09300 NONPAI D WORKERS	0	0	0	0	0	
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
98.00	Cross Foot Adjustments				0		98.00
99.00	Negative Cost Centers		0	0	0	0	
100.00	TOTAL	0	395, 656	0	395, 656	0	100. 00

Heal th Financial	Systems
ALLOCATION OF CA	PLTAL RELATED COSTS

Heal th	Financial Systems ST.	JOSEPHS HEALTH	CARE & REHAB C	TR	In Lie	u of Form CMS-2	2540-10
	ATION OF CAPITAL RELATED COSTS		Provi der		eriod:	Worksheet B	
					rom 01/01/2021 o 12/31/2021	Part II Date/Time Pre	narod
				1	0 12/31/2021	5/16/2022 3:0	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DIETARY	
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	(00	7.00	0.00	
	CENEDAL SEDVICE COST CENTEDS	4.00	5.00	6.00	7.00	8.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	63,050					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	4, 508	17, 183				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	561	382				6.00
7.00	00700 HOUSEKEEPI NG	3, 341	563		14, 387		7.00
8.00	00800 DI ETARY	7, 760	1, 868	0	1, 655	46, 061	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	6, 081	0	0	0	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00	01100 PHARMACY	0	0	0	0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	841	92		81	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	, v	0	0	14.00
15.00	01500 PATIENT ACTIVITIES	1, 396	1, 707	0	1, 512	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	22 101	10 1/5	0.053	10 700	44 041	20.00
30.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	33, 181	12, 165 0			46, 061	30.00
31.00 32.00	03200 ICF/IID	0	0	0	0	0	31.00 32.00
33.00	03300 OTHER LONG TERM CARE	0	0	-		0	32.00
55.00	ANCI LLARY SERVICE COST CENTERS	U	0	<u> </u>	0	0	33.00
40.00	04000 RADI OLOGY	55	0	0	0	0	40.00
41.00	04100 LABORATORY	19	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	1, 565	102	0	90	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	1,679	126	0	112	0	45.00
46.00	04600 SPEECH PATHOLOGY	684	25	0	22	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	228	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1, 139	24		21	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
(0.00			0	0	0	0	40.00
60.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0			0	60.00
61.00 62.00	06200 FQHC	0	0	0	0	0	61.00 62.00
02.00	OTHER REIMBURSABLE COST CENTERS	I					02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100 AMBULANCE	0	0	-		0	71.00
73.00	07300 CMHC	0	0			0	
	SPECIAL PURPOSE COST CENTERS				· · · · · ·		
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	63, 038	17, 054	8, 053	14, 273	46, 061	89.00
	NONREI MBURSABLE COST CENTERS	r		1			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	12	129			0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	, i i i i i i i i i i i i i i i i i i i	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0		0	0	94.00 98.00
98.00 99.00	Negative Cost Centers		0	0	0	0	98.00 99.00
99.00 100.00		63, 050	17, 183	8, 053	14, 387		100.00
100.00		03,000	17, 103	0,000	14, 307	40,001	1.00.00

Cost Center Description NNRSING ANM STRUTO CINITRAL SUPPLY Processor (CINITRAL SUPPLY Processor (CINITRAL SUPPLY Social (CINITRAL SUPPLY Social (CINITRAL SUPP			JOSEPHS HEALTHO				u of Form CMS-	2540-10
ADMI IN ISTRATION SERVICES & ILBRARY 10 GENOLOSC COST CENTERS 9.00 10.00 11.00 12.00 13.00 10 GENOLOSC COST CENTERS MISS & FLYDERS 13.00 13.00 13.00 10.00 GODO CAP REL COSTS - MOVABLE EQUI PNENT 3.00	ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315194		Date/Time Pre	
CENERAL SERVICE COST CENTERS 1 1.00 OTOCO CAP REL COSTS - MOVABLE EQUIPMENT 2.4 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 3.1 4.00 00400 PHLYPE ERENT IS 4.4 5.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 3.1 4.00 00400 PHLYPE ERENT IS 4.4 5.00 00500 DELTARY 8.6 7.00 00700 DETARY 9.00 0 9.00 00700 DETARY 0.01100 PHARMACY 0 0 11.00 01100 PHARMACY 0 0 0 0 11.00 01100 PHARMACY 0 0 0 0 0 11.00 01300 SOLAL SERVICE 0 0 0 0 0 1 1 11.00 01300 SOLAL SERVICE OST CENTERS 0 0 0 0 1 1 1 12.00 03000 DITAR NO MAN ALLED THEACTHY 0 0 0 0 3 3 3 3 3 3 3		Cost Center Description		SERVICES &	PHARMACY	RECORDS &	SOCI AL SERVI CE	
1.00 00100 (CAP ELE, COSTS - BLIGS & FLXTURES 1.1 2.00 00200 (EMPLC) CAP ELE, COSTS - MUNABLE CUP NENT 3.1 3.00 00300 (EMPLCYE BEREFITS 3.1 0.00 00000 (EMPLCYE BEREFITS 5.1 0.00 00000 (INMINISTRATION, MAINT & REPAIRS 6.5 0.00 00000 (ENTAND SERVICE) 7.1 7.00 00000 (ENTAN, SERVICE) 9.0 1.00 01000 (ENTAN, SERVICE) 9.0 1.00 01000 (ENTAN, SERVICE) 0 0 1.00 01200 (MEDICAL, RECORDS & LIBRARY 0 0 0 1.10 01100 (INTER) KA CABURI (EF ALLIE) 0 0 0 1.1 1.10 01100 (INTER) KA CABURI (EF ALLIE) 0 0 0 0 1.1 1.10 01100 (INTER) KA CABURI (EF ALLIE) 0 0 0 0 1.1 1.10 01200 (MEDICAL, RECORDS & LIBRARY 0 0 0 0 1.1 1.10 01400 (INTER) KA CABURI (EF ALLIE) 0 0 0 1.2 <td></td> <td></td> <td>9.00</td> <td>10.00</td> <td>11.00</td> <td>12.00</td> <td>13.00</td> <td></td>			9.00	10.00	11.00	12.00	13.00	
2.00 00000 (CAP REL COSTS - MOVABLE FOULPMENT 2. 3.00 00000 DEPLOYCE BEREFIT IS 3. 4.00 00400 ADMI INSTRATIVE & GENERAL 5. 5.00 00500 (LAMORY & LINEN SERVICE 6.0 6.00 00600 (LAMORY & LINEN SERVICE 6.0 7.00 00000 (LAMORY & LINEN SERVICE 6.081 7.00 00000 (LAMORY & LINEN SERVICE 7.0 7.00 00000 (LAMORY & LINEN SERVICE 7.0 7.00 00000 (LAMORY & LINEN SERVICE 7.0 7.00 00000 (LAMARY & LINEN SERVICE 7.0 7.00 01100 (PARABARY & 0 0 0 7.10 01300 SOCIAL SERVICE 0 0 0 7.11 01300 SOCIAL SERVICE 0 0 0 1.1 7.10 01300 SOCIAL SERVICE 0 0 0 0 1.1 7.10 01300 SOCIAL SERVICE 0 0 0 0 1.1 7.10 0 0 0 0 0 1.1 1.1 <tr< td=""><td>1 00</td><td></td><td></td><td></td><td>1</td><td></td><td>1</td><td>1 1 00</td></tr<>	1 00				1		1	1 1 00
3.00 000000 EMPLOYEE ENERTITS 3.0 4.0 0400 4.0 4.4 4.4 5.00 00500 PLANT OPREATION, MAINT, & REPAIRS 5.0								2.00
4.00 00400 ADMINISTRATIVE & GENERAL 4.4 5.00 00500 PANT OPERATION, MAINT & REPAR RS 5.1 6.00 00500 LAUMDRY & LINEN SERVICE 5.1 7.00 0700 DISENCEPING 8.0 9.00 00500 LAUMDRY & LINEN SERVICE 8.0 9.00 00500 LAUMDRY & LINEN SERVICE 8.00 9.00 00500 LAUMDRY & LINEN SERVICE 8.00 9.00 00500 LETARY 0 0 9.00 00500 LETARY 0 0 0 11.00 01000 CENTRAL SERVICES & SUPPLY 0 0 0 0 11.00 01200 MEDICAL SERVICES & SUPPLY 0								3.00
6.00 000000 LAMADRY & LINEN SERVICE 6.0 7.00 00700 NURSI MS ADMINI STRATION 6.00 9.00 008000 DIETARY 0 11.00 01000 CENTRAL SERVICES & SUPPLY 0 10.00 01000 CENTRAL SERVICES & SUPPLY 0 0 11.00 01000 CENTRAL SERVICES & SUPPLY 0 0 0 11.00 01000 CENTRAL SERVICE 0 0 0 0 13.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 14.00 01400 NURSING AND ALLED REALTH EDUCATION 0 0 0 0 0 0 0 1 1 12.00 01400 NURSING FACILITY 0.00 <								4.00
7. 00 000700 PUSEREEPING 7. 00 PUSEREEPING 7. 00 PUSEREEPING 7. 00 PUSEREEPING 8. 8 9. 00 000000 PUSEREEPING 6. 081 9. 00 PUSEREEPING 9. 00 PUSEREEPING 9. 00 <td< td=""><td>5.00</td><td>00500 PLANT OPERATION, MAINT. & REPAIRS</td><td></td><td></td><td></td><td></td><td></td><td>5.00</td></td<>	5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
8.00 000800 DETARY 6.081 8.081 9.00 007000 URSING ADMINISTRATION 6.081 9.1 10.00 01000 CENTROLES & SUPPLY 0 0 0 11.00 01100 DELAR SERVICES 0 0 0 11.1 12.00 01200 MEDICAL RECORDS & LIBRARY 0								6.00
9.00 000000 UNEX NO ADMINISTRATION 6.081 9.0 10.00 01000 CENTRAL SERVICES & SUPPLY 0 0 0 10.0 12.00 01200 PEOR ALLED HEALTH EDUCATION 0 0 0 0 11.0 13.00 01300 SCIAL SERVICE 0 0 0 0 0 14.1 14.00 01400 MIRSING ADA ALLED HEALTH EDUCATION 0 0 0 0 14.1 15.00 01300 SCIAL SERVICE 0 0 0 0 13.1 30.00 033000 SKILLED NURSING FACILITY 6.081 0 0 0 33.1 33.00 03300 OFFLID NURSING FACILITY 0 0 0 0 33.1 40.00 04000 OHENCID COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>7.00</td></t<>								7.00
10.00 01000 CENTRAL SERVICES & SUPPLY 0 0 10.0 11.00 01100 PHARMACY 0 0 0 11.1 12.00 01200 MEDICAL, RECORDS & LIBRARY 0 0 0 0 12.1 13.00 01300 SOCIAL SERVICE 0 0 0 0 14.1 15.00 01500 SOCIAL SERVICE COST CENTERS 0 0 0 0 15.1 10.00 0300 OSKILLED NURSING FACILITY 6.0811 0 0 2.721 3.1 32.00 02300 OFFLID 0 0 0 0 3.1 33.00 03300 OFFLID 0 0 0 0 3.1 40.00 04000 RACILLARY SERVICE COST CENTERS			4 001					8.00
11.00 0100 PHARACY 0 0 0 11.1 12.00 01300 SOCIAL SERVICE 0 0 0 2.721 13.1 13.00 01300 SOCIAL SERVICE 0 0 0 0 0 13.1 14.00 01400 NURSING ANALLED HEALTH EDUCATION 0 0 0 0 0 15.1 11.00 01500 PATIENT ACTIVITIES 0 0 0 0 0 0 0 15.1 11.00 01500 PATIENT ACTIVITIES 0				0				
12.00 01200 MEDICAL BECORDS & LI LERARY 0 0 0 12. 13.00 01300 SOLAL SERVICE 0 0 0 0 14. 14.00 01400 NURSING AND ALLICE HEALTH EDUCATION 0 0 0 0 0 14. 15.00 01500 SOLAL SERVICE COST CENTERS 0 0 0 0 0 0 0 0 31. 33.00 03000 OKILLED NURSING FACILITY 6.0811 0 0 0 0 33.1 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 33.1 33.00 03300 0 0 0 0 0 0 0 0 33.1 33.00 33.00 33.00 33.00 33.00 33.00 33.00 30.00 0.00 0			0	0		0		11.00
13.00 01300 SOCIAL SERVICE 0 0 0 2,721 13. 14.00 01400 NURSING AND ALLED NURSING FACILITY 0 0 0 0 14. 15.00 03000 SOCIAL SERVICE 0 0 0 0 0 14. 15.00 03000 SOCIAL SERVICE COST CENTERS 0 0 0 0 31. 30.00 03000 NERSING FACILITY 0 0 0 0 33. 30.00 03000 OTHER LONG TERM CARE 0 0 0 0 0 33. 30.00 03000 OTHER LONG TERM CARE 0			0	0		0 0		12.00
15.00 O O O O O O O O D <thd< th=""> D <thd< th=""> <thd< th=""></thd<></thd<></thd<>	13.00		0	0)	0 0	2, 721	13.00
INPATI ENT NOUTINE SERVICE COST CENTERS 0 1 1 0.0 0.00000000 SKULED NURSING FACLUTY 6.081 0 0 0 2.721 30.1 30.00 0.0000 SKULED NURSING FACLUTY 6.081 0 0 0 0 2.721 30.1 32.00 0.03000 CHT/LID 0 0 0 0 0 2.721 30.1 32.00 0.3000 CHT/LID 0 0 0 0 0 0 2.721 30.1 40.00 0.40000 RADIOLOSY 0 <td>14.00</td> <td>01400 NURSING AND ALLIED HEALTH EDUCATION</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>	14.00	01400 NURSING AND ALLIED HEALTH EDUCATION						•
30.00 00000 SKILLED NURSING FACILITY 6,081 0 0 2,721 30.01 31.00 0300 NURSING FACILITY 0 0 0 0 31.1 32.00 03200 ICF/I D 0 0 0 0 33.3 33.00 03300 OHER IN CARCLITY 0 0 0 0 33.3 33.00 0300 OHER IN CARCLITY 0 0 0 0 33.3 40.00 04000 RADIOLOGY 0 <td>15.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>15.00</td>	15.00		0	0		0 0	0	15.00
31.00 03100 NURSING FACILITY 0 0 0 0 31.0 32.00 03200 1/1 0 0 0 0 0 33.0 33.00 03300 0THER LONG TERM CARE 0 0 0 0 0 33.0 40.00 04000 RADI LLARY SERVICE COST CENTERS	20.00		(001			0	0 701	1 20 00
32.00 03200 1CF /1 ID 0 0 0 32.00 33.00 03200 1CF /1 ID 0 0 0 0 33.1 33.00 03200 1CF /1 ID 0 0 0 0 0 33.1 40.00 04000 RADIOLOGY 0								•
33.00 OIDER LONG TERM CARE O <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
ANCI LLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td></td><td></td><td>1</td><td>-</td><td></td><td></td></t<>					1	-		
41.00 0d100 LABORATORY 0 0 0 0 0 1 42.00 04300 INTRAVENUST HERAPY 0 0 0 0 42. 43.00 04300 OXYGEN (1NHALATION) THERAPY 0 0 0 0 43. 44.00 04400 PHYSICAL THERAPY 0 0 0 0 44. 45.00 04500 OCUPATIONAL THERAPY 0 0 0 0 44. 45.00 04500 SEECH PATHOLOGY 0 0 0 0 0 45. 44.00 DABOD BRUGS CHARGED TO PATIENTS 0					1	-1, -	-	1
42.00 04200 INTRAVENOUS THERAPY 0 0 0 0 42.0 43.00 04300 DYGEN (I NHALATION) THERAPY 0 0 0 0 43.1 44.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 43.1 45.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 44.1 45.00 04600 SPECEH PATHOLOGY 0 0 0 0 45.1 46.00 04600 BECLATROCARDI OLOGY 0 0 0 0 47.1 48.00 04900 DRUICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 48.1 50.00 05000 DENTAL CARE - TITLE XI X ONLY 0 0 0 0 0 50.1 51.00 5100 SUPPORT SURFACES 0 0 0 0 0 0 0 51.1 60.00 6100 RURAL HEALTH CLINIC 0 0 0 0 0 0 61.1 62.00 0 0	40.00		0	0		0 0	0	40.00
43.00 04300 0XYGEN (I NHALATION) THERAPY 0 0 0 0 43.4 44.00 04400 PHYSI CAL THERAPY 0								
44.00 04400 PHYSI CAL THERAPY 0<			-					
45.00 04500 OCCUPATIONAL THERAPY 0 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td>-</td><td></td><td></td></td<>			0			-		
46.00 04600 SPEECH PATHOLOGY 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td>-</td> <td></td>			0	0		-	-	
47.00 04700 ELECTROCARDIOLOGY 0<			0	0		s s	-	
49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 49.0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>			0	0		0 0		
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0	48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 0	0	48.00
51.00 05100 SUPPORT SURFACES 0 <td>49.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>49.00</td>	49.00		0	0				49.00
OUTPATI ENT SERVICE COST CENTERS 0 <								
60.00 06000 CLINIC 0	51.00		0	0		0 0	0	51.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 61.0 0 62.0 07000 HOWE HEALTH AGENCY COST 0 0 0 0 0 70.0 71.00 07100 AMBULANCE 0 0 0 0 0 71.0 73.00 07300 CMHC 0 0 0 0 0 0 73.0 73.00 08000 MALPRACTICE PREMI UMS & PAID LOSSES 0 <	60.00		0	0		0 0	0	60.00
62.00 06200 FQHC 62.00 0THER REI MBURSABLE COST 0 0 0 0 0 70.00 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 70.0 71.00 07100 AMBULANCE 0 0 0 0 0 70.0 73.00 07300 CMHC 0 0 0 0 0 73.0 SPECIAL PURPOSE COST CENTERS 80.00 081000 INTEREST EXPENSE 80.1 81.0 81.1 81.0 81.1 82.00 8200 11.1 LZATI NO REVI EW - SNF 82.0 82.00 80.0 83.0 83.0 83.0 83.0 83.0 83.0 83.0 90.00 90.00 0 0 0 0 83.0 83.0 89.00 SUBTOTALS (sum of Lines 1-84) 6.081 0 0 0 2,721 89.0 90.00 09000 GIT, FLOWER, COFFE SHOPS & CANTEEN 0 0 0 0 90.0 91.0 92.0 9								
OTHER REI MBURSABLE COST CENTERS 70.00 O7000 HOME HEALTH AGENCY COST 0 <t< td=""><td></td><td></td><td>Ŭ</td><td>0</td><td></td><td>0</td><td>0</td><td>62.00</td></t<>			Ŭ	0		0	0	62.00
71.00 07100 AMBULANCE 0 0 0 0 0 71.0 73.00 07300 CMHC 0 0 0 0 0 0 73.0 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.0 81.00 08100 INTEREST EXPENSE 80.0 81.0 82.00 08200 UT L LI ZATI ON REVI EW - SNF 82.0 83.0 83.0 83.0 83.00 08300 HOSPI CE 0 0 0 0 83.4 89.00 SUBTOTALS (sum of Lines 1-84) 6, 081 0 0 0 83.4 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92.0 93.00 093000 NONPAI D WORKERS 0 0 0					•			1
73.00 OT300 CMHC 0 0 0 0 0 73.0 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 80.0 80.00 8000 MALPRACTICE PREMIUMS & PAID LOSSES 80.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90								
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.0 81.00 08100 I NTEREST EXPENSE 81.0 82.00 08200 UTI LI ZATI ON REVI EW - SNF 82.0 83.00 08300 HOSPI CE 0 0 0 82.0 89.00 SUBTOTALS (sum of lines 1-84) 6,081 0 0 2,721 89.00 SUBTOTALS (sum of Lines 1-84) 6,081 0 0 2,721 90.00 O9000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.0 90.00 09000 OFFEE SHOPS & CANTEEN 0 0 0 90.0 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 91.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92.0 93.00 09300 NONPAI D WORKERS 0 0 0 0 93.0 94.00 09400 PATI ENTS LAUNDR								
80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.0 81.00 08100 INTEREST EXPENSE 81.0 81.0 82.00 08200 UTI LI ZATI ON REVI EW - SNF 82.0 83.00 08300 HOSPI CE 0 0 0 82.0 89.00 SUBTOTALS (sum of lines 1-84) 6,081 0 0 2,721 89.0 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 91.0 93.00 09300 NONPAI D WORKERS 0 0 0 92.0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.0 98.00 Cross Foot Adj ustments 0 0 0 94.0 90.00 99.0 99.00 Negative Cost Centers 0 0 0 0 99	73.00		0	0		0 0	0	73.00
81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTI LI ZATI ON REVIEW - SNF 0 0 0 82.0 83.00 08300 HOSPI CE 0 0 0 0 83.0 89.00 SUBTOTALS (sum of lines 1-84) 6,081 0 0 2,721 83.0 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.0 93.00 09300 NONREH BURSABLE 0 0 0 0 93.0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 93.0 98.00 Cross Foot Adj ustments 0 0 0 94.00 90.00 99.00 99.00 99.00 99.00 90.00 99.00 99.00 99.00 99.00 99.00	<u>00 00</u>				1			00 00
82.00 08200 UTI LI ZATI ON REVIEW - SNF 82.0 83.00 08300 HOSPI CE 0 0 0 83.0 89.00 SUBTOTALS (sum of lines 1-84) 6,081 0 0 0 2,721 89.0 NONREL MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.0 93.00 09300 NONPAI D WORKERS 0 0 0 0 93.0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.0 99.00 Negative Cost Centers 0 0 0 94.0 99.0 99.0 99.0 99.0 99.0 99.0 99.0 99.0 99.0 99.00 99.0 99.00 99.00 9								81.00
83.00 08300 HOSPICE 0 0 0 0 83.0 89.00 SUBTOTALS (sum of lines 1-84) 6,081 0 0 0 2,721 89.0 NONREL MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92.0 93.00 09300 NONPAID WORKERS 0 0 0 93.0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.0 98.00 Cross Foot Adj ustments 0 0 0 94.0 99.0 99.0 0 0 90.0 99.0								82.00
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.0 93.00 09300 NONPAI D WORKERS 0 0 0 93.0 94.00 0 0 0 93.0 94.00 94.00 94.00 94.00 94.00 90.00 94.00 96.00 94.00 96.00 97.00 98.00 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 98.00 99.00 99.00 99.00 99.00 99.00 90.00			0	0)	0 0	0	
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.0 93.00 09300 NONPAID WORKERS 0 0 0 93.0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.0 98.00 Cross Foot Adj ustments 0 0 0 98.0 99.00 Negative Cost Centers 0 0 0 0 99.0	89.00	SUBTOTALS (sum of lines 1-84)	6, 081	0		0 0	2, 721	89.00
91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.0 93.00 09300 NONPAI D WORKERS 0 0 0 0 93.0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94.0 98.00 Cross Foot Adjustments 0 0 0 98.0 99.00 0 0 0 99.00			1 1			-		
92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92.0 93.00 00300 NONPAI D WORKERS 0 0 0 0 93.00 94.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94.00 94.00 0 0 0 94.00 <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td>•</td>			1					•
93.00 09300 NONPAI D WORKERS 0 0 0 93.0 94.00 94.00 94.00 0 0 0 94.00 94.00 0 0 0 94.00 94.00 94.00 94.00 90.00 0 0 0 94.00								
94.00 09400 PATIENTS LAUNDRY 0 0 0 94.0 98.00 Cross Foot Adjustments 0 0 0 98.0 99.00 0 0 99.00 0 0 0 99.00 0 0 0 0 99.00 0 0 0 0 99.00 0 0 0 0 99.00 0 0 0 0 0 0 0 99.00 0 </td <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>-</td> <td>-</td> <td></td>			-	-		-	-	
98.00 Cross Foot Adjustments 0 0 98.0 99.00 Negative Cost Centers 0 0 0 0 99.0			Ŭ			-		
99.00 Negative Cost Centers 0 0 0 0 0 99.0			Ű				l	98.00
		3	-			-	0	
	100.00		6, 081	0		0 0	2, 721	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider	F	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/16/2022 3:0	
Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	OTHER GENERAL SERVI CE PATI ENT ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS	1	F	Т	1		
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMI NI STRATI VE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE						5.00 6.00
7. 00 00700 HOUSEKEEPING						7.00
8. 00 00800 DI ETARY						8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON						9.00
10. 00 01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00 01100 PHARMACY						11.00
12.00 01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00 01300 SOCIAL SERVICE						13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00 01500 PATIENT ACTIVITIES	0	36, 393	3			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 SKILLED NURSING FACILITY	0	36, 393	3 381, 935	5 0	381, 935	1
31.00 03100 NURSING FACILITY	0		1	0 0	0	
32.00 03200 I CF/I I D	0			0 0	0	
33.00 03300 OTHER LONG TERM CARE	0) (0 0	0	33.00
ANCI LLARY SERVI CE COST CENTERS	0			-		40.00
40. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY	0				55 19	1
41.00 04100 LABORATORY 42.00 04200 I NTRAVENOUS THERAPY	0				0	
43. 00 04300 0XYGEN (INHALATION) THERAPY	0				0	•
44. 00 04400 PHYSI CAL THERAPY	0		3, 654	4 0	3, 654	•
45. 00 04500 OCCUPATI ONAL THERAPY	0	(4, 27		4, 271	1
46.00 04600 SPEECH PATHOLOGY	0	C	1, 202		1, 202	1
47.00 04700 ELECTROCARDI OLOGY	0	C			0	1
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	228	з 0	228	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	C	1,634	4 0	1, 634	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	C		0 0	0	50.00
51.00 05100 SUPPORT SURFACES	0) (0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS	-			-		
60. 00 06000 CLINIC	0			0 0	0	
61. 00 06100 RURAL HEALTH CLINIC	0	C		0 0	0	
62. 00 06200 FQHC OTHER REI MBURSABLE COST CENTERS						62.00
70. 00 07000 HOME HEALTH AGENCY COST	0	(0 0	0	70.00
71. 00 07100 AMBULANCE	0			0 0	0	
73. 00 07300 CMHC	0			0 0	0	
SPECIAL PURPOSE COST CENTERS			·	-		
80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 08100 INTEREST EXPENSE						81.00
82.00 08200 UTILIZATION REVIEW - SNF						82.00
83. 00 08300 HOSPI CE	0			0 0	0	
89.00 SUBTOTALS (sum of lines 1-84)	0	36, 393	392, 998	3 0	392, 998	89.00
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			-	0	1
91.00 09100 BARBER AND BEAUTY SHOP	0		2,658	8 0	2, 658	
92. 00 09200 PHYSI CLANS PRI VATE OFFICES 93. 00 09300 NONPALD WORKERS	0				0	
93. 00 109300 NUNPATE WORKERS 94. 00 109400 PATI ENTS LAUNDRY	0				0	1
98.00 Cross Foot Adjustments	0				0	•
99.00 Negative Cost Centers	0				0	1
100.00 TOTAL	0		395, 656	-	395, 656	
1 1						

ST. JOSEPHS HEALTHCARE & REHAB CTR Provi der No. : 315194 Peri od:

In Lieu of Form CMS-2540-10 Worksheet B-1

	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2021	Worksheet B-1	
					o 12/31/2021		
		CAPITAL REL	ATED COSTS			5/16/2022 3:0	5 pm
	Cost Conton Description						
	Cost Center Description	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE FEET)		(GROSS		(ACCUM COST)	
		(*	(*) ,	SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	56, 314					1 1. C
. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	30, 314	56, 314				2.0
. 00	00300 EMPLOYEE BENEFITS	0	0		8	l I	3.0
. 00	00400 ADMINISTRATIVE & GENERAL	8, 974	8, 974				
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	1,804	1,804			923, 893	
. 00 . 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	1, 012 1, 492	1, 012 1, 492		-	114, 998 684, 812	
. 00	00800 DI ETARY	4, 950	4, 950			1, 590, 423	
. 00	00900 NURSI NG ADMI NI STRATI ON	0	0	996, 789		1, 246, 453	
0. 00	01000 CENTRAL SERVICES & SUPPLY	0	0	C	0	0	10.0
1.00	01100 PHARMACY	0	0	C	0	0	
2.00 3.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	243	0 243	136, 554	0	0 172, 463	
4.00	01400 NURSING AND ALLIED HEALTH EDUCATION	243	243	130, 334		172,403	
5.00	01500 PATIENT ACTIVITIES	4, 523	4, 523	193, 160	0	-	
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 SKI LLED NURSI NG FACI LI TY	32, 238	32, 238			6, 800, 808	
1.00	03100 NURSING FACILITY	0	0		-	0	
2.00 3.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0	0		-	-	
5.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		<u> </u>	0	1 55.0
0. 00	04000 RADI OLOGY	0	0	C	0 0	11, 279	40.0
1.00	04100 LABORATORY	0	0	C	0 0	3, 879	
2.00	04200 I NTRAVENOUS THERAPY	0	0	C	0	0	
3.00 4.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	270	0 270	-		0 320, 687	
5.00	04500 OCCUPATIONAL THERAPY	335	335		0	344, 199	
6.00	04600 SPEECH PATHOLOGY	67	67	C	0	140, 122	
7.00	04700 ELECTROCARDI OLOGY	0	0	-	0		47.0
8.00	04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	-	0	46, 816	
9.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	64	64 0			233, 386 0	
1.00	05100 SUPPORT SURFACES	0	0	-			51.0
	OUTPATIENT SERVICE COST CENTERS	· · ·					
0. 00	06000 CLI NI C	0	0	C	0	0	
1.00	06100 RURAL HEALTH CLINIC	0	0	C	0 0	0	
2.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS					<u> </u>	62.0
0. 00	07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70.0
	07100 AMBULANCE	0	0			0	71.0
3.00	07300 CMHC	0	0	C	0	0	73.0
0 00	SPECIAL PURPOSE COST CENTERS	1					
0.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 0 81. 0
2.00	08200 UTILIZATION REVIEW - SNF						82.0
	08300 H0SPI CE	0	0	C	0	0	
3.00		55, 972	55, 972	8, 002, 688	-2, 060, 948	12, 920, 401	89.0
	SUBTOTALS (sum of lines 1-84)						
9.00	NONREI MBURSABLE COST CENTERS						
9. 00 0. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				
9.00 0.00 1.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 342 0	342	C	0	2, 403	91. (
9.00 0.00 1.00 2.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	342		C			91. (92. (
9.00 0.00 1.00 2.00 3.00 4.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CI ANS PRI VATE OFFI CES 09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	342 0	342 0	C C		2, 403 0	91. (92. (93. (94. (
9.00 0.00 1.00 2.00 3.00 4.00 8.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CI ANS PRIVATE OFFICES 09300 NONPAI D WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments	342 0	342 0	C C		2, 403 0 0	91.0 92.0 93.0 94.0 98.0
9.00 0.00 1.00 2.00 3.00 4.00 8.00 9.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers	342 0 0 0	342 0 0 0			2, 403 0 0 0	91.0 92.0 93.0 94.0 98.0 99.0
9.00 0.00 1.00 2.00 3.00 4.00 9.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	342 0	342 0			2, 403 0 0	91. (92. (93. (94. (98. (99. (
 39.00 90.00 91.00 92.00 93.00 94.00 99.00 02.00 	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	342 0 0 0	342 0 0 0	C C C 2, 004, 414		2, 403 0 0 2, 060, 948	91. 0 92. 0 93. 0 94. 0 98. 0 99. 0 102. 0
 39.00 90.00 91.00 92.00 93.00 94.00 99.00 02.00 03.00 	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	342 0 0 0 395, 656	342 0 0 0	2, 004, 414		2, 403 0 0 0	91. (92. (93. (94. (98. (99. (102. (103. (
 33.00 39.00 39.00 39.00 30.00 30.00 40.00 30.00 40.00 <	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	342 0 0 0 395, 656	342 0 0 0	C C C 2, 004, 414		2, 403 0 0 2, 060, 948 0. 159481	91. (92. (93. (94. (98. (99. (102. (103. (104. (

COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2021	Worksheet B-1	2540-
					o 12/31/2021	Date/Time Pre 5/16/2022 3:0	
	Cost Center Description	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (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	
. 00 2. 00 3. 00 5. 00 5. 00 7. 00 3. 00 9. 00 0. 00 0. 00		45, 536 1, 012 1, 492 4, 950 0 0	43, 043 0	43, 032 4, 950 0 0	129, 129 0 0	152, 944 0	10.
2.00 3.00 4.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES	0 0 243 0 4, 523	0	0 0 243 0 4, 523	0 0 0 0	0 0 0 0	12. 13. 14.
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	32, 238	43,043	32, 238	129, 129	152, 944	30.
32.00	03100 NURSING FACILITY 03200 ICF/IID		0	0 0 0	0	0	31. (32. (
0. 00	ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	40.
1. 00	04100 LABORATORY	0	0	0	0	0	41.
		0	0	0	0	0	
4.00		270	0	270	0	0	43.
		335		335	0	0	
		67	0	67 0	0	0	
8. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENT	s j o	0	0	0	0	
		64		64	0	0	
		0	0	0	0	0	
1.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>	0	0	0	1 31.
0.00		0		0		0	
		0	0	0	0	0	61. 62.
	07000 HOME HEALTH AGENCY COST	0		0		0	
	07100 AMBULANCE	0	0	0	-	0	
3.00	07300 CMHC SPECIAL PURPOSE COST CENTERS		<u> </u>	0	0	0	73.
0.00 1.00 2.00 3.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF	0	0	0	0	0	80. 81. 82. 83.
9.00		45, 194	43, 043	42, 690	129, 129	152, 944	
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEE			0	0	0	
		342	0	342	0	0	
2.00			0	0	0	0	
4.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.
8.00 9.00	5						98. 99.
9.00 02.00	5	1, 071, 236	157, 145	829, 126	2, 055, 889	1, 445, 239	
03. 00 04. 00	0 Unit cost multiplier (Wkst. B, Part	I) 23. 525035 17, 183		19. 267661 14, 387	15. 921203 46, 061	9. 449465 6, 081	
		1	1	1			1

		JOSEPHS HEALTHC				u of Form CMS-2	2540-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S)	PHARMACY (COSTED REQUIS)	RECORDS & LIBRARY (TIME SPENT)	SOCI AL SERVI CE (PATI ENT DAYS)	5/16/2022 3:0 NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED TI ME)	5 pm
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
12.00 13.00 14.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 LANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	798, 491 0 0 0 0 0	0 0 0 0 0 0	43, 043 0 0 0	43, 043 0 0	0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
30, 00	03000 SKILLED NURSING FACILITY	518, 739	0	43, 043	43, 043	0	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0 0 0	0 0 0	0	0 0 0	31.00 32.00 33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	40.00
41.00 42.00 43.00	04000 RADIOLOGY 04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 0 0	0 0 0 0 0	0 0 0 0 0		0 0 0 0 0	40.00 41.00 42.00 43.00 44.00
46. 00 47. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0 46, 816	0 0 0	000000000000000000000000000000000000000	0 0 0	0 0 0 0	45.00 46.00 47.00 48.00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	232, 936 0 0	0 0 0	0	0	0	49.00 50.00 51.00
61.00	OUTPATI ENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC	0 0	0	0	0	0	60. 00 61. 00 62. 00
71.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	70.00 71.00 73.00
81.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						80.00 81.00 82.00
83. 00 89. 00	08300 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 798, 491	0 0	0 43, 043		0	83.00 89.00
91.00 92.00 93.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 210, 367	0 0 0 0 0	90.00 91.00 92.00 93.00 94.00 98.00 99.00 102.00
103.00 104.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 000000 0	0. 000000 0	0. 000000 0	4. 887368 2, 721	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part)	0. 000000	0. 000000	0. 000000	0. 063216	0. 000000	105.00

	CATION - STATISTICAL BASIS		Provider No.: 315194	Period: From 01/01/2021	Worksheet B-1
				To 12/31/2021	Date/Time Prepar 5/16/2022 3:05 p
		OTHER GENERAL		· · · · · · · · · · · · · · · · · · ·	
	Cast Contor Description	SERVI CE			
	Cost Center Description	PATI ENT ACTI VI TI ES			
		(PATIENT DAYS)			
		15.00			
	ERAL SERVICE COST CENTERS				
	00 CAP REL COSTS - BLDGS & FIXTURES				1
	COO CAP REL COSTS - MOVABLE EQUI PMENT				2
					3
	00 ADMINISTRATIVE & GENERAL 000 PLANT OPERATION, MAINT. & REPAIRS				2
	00 LAUNDRY & LINEN SERVICE				
	100 HOUSEKEEPI NG				
	BOO DI ETARY				8
	NURSI NG ADMI NI STRATI ON				q
	000 CENTRAL SERVICES & SUPPLY				10
	00 PHARMACY				11
	200 MEDICAL RECORDS & LIBRARY				12
	00 SOCIAL SERVICE				13
	ON NURSING AND ALLIED HEALTH EDUCATION	42 042			14
	00 PATIENT ACTIVITIES ATIENT ROUTINE SERVICE COST CENTERS	43,043			15
	000 SKILLED NURSING FACILITY	43, 043			30
	00 NURSING FACILITY	43, 043			31
		0			32
	OO OTHER LONG TERM CARE	0			33
	ILLARY SERVICE COST CENTERS				
	000 RADI OLOGY	0			40
	00 LABORATORY	0			41
	200 INTRAVENOUS THERAPY	0			42
	OOOOXYGEN (INHALATION) THERAPY	0			43
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0			44
	00 SPEECH PATHOLOGY	0			46
	OO ELECTROCARDI OLOGY	0			47
	BOO MEDICAL SUPPLIES CHARGED TO PATIENTS	0			48
00 049	DOO DRUGS CHARGED TO PATIENTS	0			49
00 050	DOO DENTAL CARE - TITLE XIX ONLY	0			50
	00 SUPPORT SURFACES	0			51
	PATIENT SERVICE COST CENTERS				
		0			60
	00 RURAL HEALTH CLINIC	0			61
	ER REIMBURSABLE COST CENTERS				02
	00 HOME HEALTH AGENCY COST	0			70
	OO AMBULANCE	0			71
	000 CMHC	0			73
	CIAL PURPOSE COST CENTERS				
	000 MALPRACTICE PREMIUMS & PAID LOSSES				80
	00 INTEREST EXPENSE				81
	200 UTILIZATION REVIEW - SNF				82
00 083	SUBTOTALS (sum of Lines 1-84)	0 43, 043			83
	SUBTOTALS (sum of lines 1-84) REIMBURSABLE COST CENTERS	43,043			
	00 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90
	OO BARBER AND BEAUTY SHOP	0			91
	00 PHYSICIANS PRIVATE OFFICES	0			92
00 093	OO NONPAID WORKERS	0			93
	OO PATIENTS LAUNDRY	0			94
00	Cross Foot Adjustments				98
00	Negative Cost Centers				99
2.00	Cost to be allocated (per Wkst. B,	525, 376			102
2 00	Part I)	12 2050/1			10
3.00 4.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	12. 205841 36, 393			103
T. UU	Part II)	30, 373			102
5.00	Unit cost multiplier (Wkst. B, Part	0. 845503			105

Heal th	Financial Systems ST. JOSEPHS HEALTHCARE	& REHAB C	TR	In Lie	u of Form CMS-2	2540-10
RATI 0	OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der		Peri od:	Worksheet C	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narad.
				10 12/31/2021	5/16/2022 3:0	pareu. 5 pm
	Cost Center Description		Total (from	Total Charges		
			Wkst. B, Pt I	,	di vi ded by	
			col. 18)		col. 2	
			1.00	2.00	3.00	
	ANCI LLARY SERVI CE COST CENTERS					
	04000 RADI OLOGY		13, 07			
	04100 LABORATORY		4, 49	8 0	0.00000	
	04200 I NTRAVENOUS THERAPY			0 0	0.00000	
	04300 OXYGEN (INHALATION) THERAPY			0 0	0.00000	
	04400 PHYSI CAL THERAPY		383, 38		0. 424504	
	04500 OCCUPATI ONAL THERAPY		413, 42		0. 425832	45.00
	04600 SPEECH PATHOLOGY		165, 33	6 383, 832	0. 430751	
	04700 ELECTROCARDI OLOGY			0 0	0.00000	
	04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		54, 28		1. 159475	48.00
	04900 DRUGS CHARGED TO PATIENTS		273, 34	6 258, 519		
	05000 DENTAL CARE - TITLE XIX ONLY			0 0	0.00000	
51.00	05100 SUPPORT SURFACES			0 0	0. 000000	51.00
	OUTPATIENT SERVICE COST CENTERS			-1		
	06000 CLI NI C			0 0	0.00000	60.00
	06100 RURAL HEALTH CLINIC					61.00
	06200 FQHC					62.00
	07100 AMBULANCE			0 0	0. 000000	
100.00	Total		1, 307, 35	2 2, 574, 452		100. 00

Health Financial Systems ST	. JOSEPHS HEALTH	ICARE & REHAB C	TR	In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315194	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/16/2022 3:0	
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Health Care Pr	rogram Charge	s Health Care	Program Cost	
Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	1. 159500	11, 279		0 13, 078	0	40.00
41. 00 04100 LABORATORY	0. 000000	0		0 0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	43.00
44.00 04400 PHYSI CAL THERAPY	0. 424504	337, 095		0 143, 098	0	44.00
45.00 04500 OCCUPATIONAL THERAPY	0. 425832	375, 921		0 160, 079	0	45.00
46.00 04600 SPEECH PATHOLOGY	0. 430751	139, 742		0 60, 194	0	46.00
47.00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 159475	46, 816		0 54, 282	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1.057354	258, 519		0 273, 346	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						1
60. 00 06000 CLINIC	0.00000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 000000			0	0	71.00
100.00 Total (Sum of lines 40 - 71)		1, 169, 372		0 704, 077		100.00
(1) For title V and VIV was columned 1. 2 and 4 a	. '					

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

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

Health Financial Systems ST.	JOSEPHS HEALTH	ICARE & REHAB C	TR	In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315194	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/16/2022 3:0	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST						
1.00 Drugs charged to patients - ratio of co	ost to charges	(From Workshee	t C. column 3	line 49)	1.057354	1.00
2.00 Program vaccine charges (From your reco			,		0	2.00
3.00 Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet	0	3.00
E, Part I, line 18)	·····, ··· p···				-	
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	(From Wkst. B,		Nursing &	Cost (From	& Allied	
	Part I, Col.	(From Wkst. B,	Allied Healt	h Wkst. D Part	Health Costs	
	18	Part I, Col.	Costs to Tota	I I, Col. 4)	for Pass	
		14)	Costs - Part	A	Through (Col.	
			(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						
40. 00 04000 RADI OLOGY	13, 078	0	0.00000		0	40.00
41. 00 04100 LABORATORY	4, 498	0	0.0000	0 0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0.00000	0 0	0	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY	0	0	0.0000	0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	383, 384	0	0.00000	0 143, 098	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	413, 428	0	0.00000	160, 079	0	45.00
46.00 04600 SPEECH PATHOLOGY	165, 336	0	0.00000	60, 194	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0.0000	0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	54, 282	0	0.0000	0 54, 282	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	273, 346	0	0.00000		0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000	0 0	0	50.00
51.00 05100 SUPPORT SURFACES	0	0	0.00000	0 0	0	51.00
100.00 Total (Sum of lines 40 - 52)	1, 307, 352	C		704, 077	0	100.00

OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315194	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 5/16/2022 3:0	parec
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
. 00	Inpatient days including private room days			43, 043	1.0
. 00	Private room days			0	2.
. 00	Inpatient days including private room days applicable to the Pr	rogram		4, 717	3.
. 00	Medically necessary private room days applicable to the Program	1		0	4.
. 00	Total general inpatient routine service cost		13, 658, 978	5.	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00	General inpatient routine service charges		14, 873, 973	6.	
00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)				7.
00	Enter private room charges from your records	0	8		
00	Average private room per diem charge (Private room charges line 2)	0.00	9		
. 00	Enter semi-private room charges from your records		0	10	
. 00	Average semi-private room per diem charge (Semi-private room c semi-private room days)	0.00	11		
2. 00	Average per diem private room charge differential (Line 9 minus	s line 11)		0.00	12.
8.00	Average per diem private room cost differential (Line 7 times I	ine 12)		0.00	13
. 00	Private room cost differential adjustment (Line 2 times line 13	3)		0	14
. 00	General inpatient routine service cost net of private room cost PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 5	minus line 14)	13, 658, 978	15
6. 00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		317.33	16.
. 00	Program routine service cost (Line 3 times line 16)			1, 496, 846	17
. 00	Medically necessary private room cost applicable to program (I	ine 4 times line 13)		0	18
9.00	Total program general inpatient routine service cost (Line 17	plus line 18)		1, 496, 846	19
0. 00	Capital related cost allocated to inpatient routine service cos line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	sts (From Wkst. B, Par	t II column 18,	381, 935	20
. 00	Per diem capital related costs (Line 20 divided by line 1)			8.87	21
2. 00	Program capital related cost (Line 3 times line 21)			41, 840	22
. 00	Inpatient routine service cost (Line 19 minus line 22)			1, 455, 006	23
. 00	Aggregate charges to beneficiaries for excess costs (From prov	/ider records)		0	24
. 00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	1, 455, 006	25
. 00	Enter the per diem limitation (1)				26
. 00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27
3. 00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, Line 4) (See instructions)	e lesser of line 25 or	line 27)		28.

		1.00	1
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		1
1.00	Total SNF inpatient days	43, 043	1.00
2.00	Program inpatient days (see instructions)	4, 717	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 109588	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

		ICARE & REHAB CTR		u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315194	Peri od:	Worksheet E	
			From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	pared:
				5/16/2022 3:0	5 pm
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIN	IBURSEMENT		1100	
1.00	Inpatient PPS amount (See Instructions)			3, 081, 126	1.00
2.00	Nursing and Allied Health Education Activities (pass throug	gh payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			3, 081, 126	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			428, 691	5.00
6.00	Allowable bad debts (From your records)			0	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See ir	nstructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			0	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			2, 652, 435	11.00
12.00	Interim payments (See instructions)			2, 679, 609	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestration	on		0	14.50
14.55	Demonstration payment adjustment amount after sequestration			0	14.55
14.75	Sequestration for non-claims based amounts (see instruction	าร)		0	14.75
14.99	Sequestration amount (see instructions)			0	14.99
15.00	Balance due provider/program (see Instructions)			-27, 174	
16.00	Protested amounts (Nonallowable cost report items in accord			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LES	SSER OF COST OR CHARGES - I	TILE XVIII ONLY		
17.00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)			0	19.00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21.00 22.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00 22.00
22.00	Primary payor amounts Coinsurance and deductibles			0	22.00
23.00	Allowable bad debts (From your records)			0	23.00
24.00	Allowable Bad debts for dual eligible beneficiaries (see ir	estructions)		0	24.00
24.01	Adjusted reimbursable bad debts (see instructions)	istructrons)		0	24.01
24.02	Subtotal (Sum of Lines 21 and 24, minus Lines 22 and 23)			0	25.00
26.00	Interim payments (See instructions)			0	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50	Demonstration payment adjustment amount before sequestration	n		0	28.50
28.55	Demonstration payment adjustment amount after sequestration			0	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 accor			0	

NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provi der	Provider No.: 315194		Worksheet E-1 Date/Time Pre 5/16/2022 3:0	pared
		Ti tl	e XVIII	Skilled Nursing Facility		0 pm
		Inpatien	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero List separately each retroactive lump sum adjustment 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)		2, 652, 4	36 0	0	
	Program to Provider		1			
01	ADJUSTMENTS TO PROVIDER	08/09/2021	27, 1	73	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	
)5				0	0	3
	Provider to Program		1	-	-	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	-
53 54				0		
99 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		27, 1	-	0	
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)		2, 679, 6	609	0	4
	TO BE COMPLETED BY CONTRACTOR		1		Т	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider		1		1	
)1	TENTATI VE TO PROVI DER			0	0	
)2				0	0	
)3	Provider to Program		1	0	0	5
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
2				0	0	
9	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0	0	
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER			0	0	6
)2	PROVIDER TO PROGRAM		27, 1	74	0	6
0	Total Medicare program liability (see instructions)		2, 652, 4		0	7
			Contr	actor Name	Contractor	
				1 00	Number	
				1.00	2.00	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet G Date/Time Pre 5/16/2022 3:0	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	Assets	•	•			
2	CURRENT ASSETS	20 601 000		0 0	0	1
))	Cash on hand and in banks Temporary investments	30, 601, 000 412, 210, 000		0 0	0	
5	Notes receivable	0		0 0	0	
C	Accounts receivable	81, 731, 000		0 0	0	4
C	Other receivables	0		0 0	0	
C	Less: allowances for uncollectible notes and accounts	0		0 0	0	6
C	recei vabl e I nventory	0		0 0	0	7 10
5	Prepaid expenses	52, 755, 000		0 0	0	
5	Other current assets	22, 420, 000		0 0	0	
00	Due from other funds	0		0 0	0	10
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	599, 717, 000		0 0	0	11
~~	FIXED ASSETS				0	1 40
00 00	Land Land improvements	0		0 0	0	
)0)0	Less: Accumulated depreciation			0 0	0	
00	Buildings	372, 904, 000		0 0	0	
00	Less Accumulated depreciation	0		0 0	0	
00	Leasehold improvements	0		0 0	0	17
00	Less: Accumulated Amortization	0		0 0	0	
	Fixed equipment	0		0 0	0	
	Less: Accumulated depreciation Automobiles and trucks	0		0 0	0	
00 00	Less: Accumulated depreciation	0			0	
00	Major movable equipment	0		0 0	0	
	Less: Accumulated depreciation	0		0 0	0	
00	Minor equipment - Depreciable	0		0 0	0	25
	Minor equipment nondepreciable	0		0 0	0	
	Other fixed assets	0		0 0	0	
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	372, 904, 000		0 0	0	28
00	Investments	0		0 0	0	29
00	Deposits on Leases	0		0 0	0	
00	Due from owners/officers	0		0 0	0	31
	Other assets	133, 610, 000		0 0	0	
00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	133, 610, 000		0 0	0	
00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	1, 106, 231, 000		0 0	0	34
	CURRENT LI ABI LI TI ES					
00	Accounts payable	80, 815, 000		0 0	0	35
00	Salaries, wages, and fees payable	201, 009, 000		0 0	0	
		0		0 0	0	1 0 /
	Notes & loans payable (Short term)	45, 645, 000		0 0	0	
00 00	Deferred income Accelerated payments			0 0	0	39
	Due to other funds			0 0	0	
00	Other current liabilities	127, 530, 000		0 0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	454, 999, 000		0 0	0	43
	LONG TERM LIABILITIES			-		
00	Mortgage payable	304, 182, 000		0 0	0	
	Notes payable			0 0	0	
00 00	Unsecured Loans Loans from owners:				0	
)0)0	Other long term liabilities	17, 270, 000		0 0	0	
00	OTHER (SPECIFY)	0		0 0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	321, 452, 000		0 0	0	50
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	776, 451, 000		0 0	0	51
	CAPI TAL ACCOUNTS					1
00	General fund balance	329, 780, 000		0		52
00 00	Specific purpose fund Donor created - endowment fund balance - restricted			0		53
)0)0	Donor created - endowment fund balance - restricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					_
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	329, 780, 000 1, 106, 231, 000		0 0	0	
0C						

	JOSEPHS HEALTHC				eu of Form CMS-2	
STATEMENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315194	Period: From 01/01/2021 To 12/31/2021	Worksheet G-1 Date/Time Pre 5/16/2022 3:0	pared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
<pre>1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 31) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) 5.00 ADDITIONS 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 ROUNDING 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17)</pre>	80, 374, 381 0 0 0 0 1 0 0 0 0 0 0	250, 821, 000 -1, 415, 380 249, 405, 620 80, 374, 381 329, 780, 001			0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 Fund balance at end of period per balance sheet (Line 11 - Line 18)		329, 780, 000		0		19.00
	Endowment Fund	PI ant	Fund		1	
	6.00	7.00	8.00			
1.00 Fund balances at beginning of period	0.00	7.00	8.00	0	-	1.00
2.00 Net income (Loss) (from Wkst. G-3, line 31) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) 5.00 ADDITIONS 6.00 7.00 8.00 9.00	0	0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 ROUNDING 14.00 15.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance 	0 0 0	0 0 0 0 0		0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems ST. JOSEPHS HEALTHCARE	& RFHAB C	TR		Inlie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		No.: 315194		ri od:	Worksheet G-2	
				To	om 01/01/2021 12/31/2021	Parts I-II Date/Time Pre	
	Cast Canton Description		1		Outrationt	5/16/2022 3:0	5 pm
	Cost Center Description		Inpatient 1.00		Outpatient 2.00	Total 3.00	
	PART I – PATIENT REVENUES		1.00		2.00	5.00	
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY		14, 873, 9	73		14, 873, 973	1.00
2.00	NURSING FACILITY			0		0	2.00
	ICF/IID			0		0	3.00
	OTHER LONG TERM CARE			0		0	4.00
	Total general inpatient care services (Sum of lines 1 - 4)		14, 873, 9	73		14, 873, 973	5.00
	All Other Care Services		T]			
	ANCI LLARY SERVI CES		2, 574, 4	53	0	2, 574, 453	6.00
					0	0	7.00
	HOME HEALTH AGENCY COST				0	0	8.00
					0	0	9.00
	RURAL HEALTH CLINIC FOHC				0	0	10. 00 10. 10
					0	0	10.10
				0	0	0	12.00
			9, 2	25	0	9, 235	12.00
	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	to	17, 457, 6		0	⁹ , 233 17, 457, 661	14.00
14.00	Worksheet G-3, Line 1)	10	17,437,00		0	17, 437, 001	14.00
	Cost Center Description						
	•				1.00	2.00	
	PART II - OPERATING EXPENSES						
	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					14, 717, 180	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 10. 00	Deduct (Specify)				0		9.00 10.00
10.00					0		10.00
12.00					0		12.00
12.00					0		12.00
	Total Deductions (Sum of Lines 9 - 13)				0	0	14.00
	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)					14, 717, 180	
10.00				I	I	11, 717, 100	.0.00

Heal th	Financial Systems ST. JOSEPHS HEALTHCAR	E & REHAB CTR	In Lie	u of Form CMS-2	2540-10	
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315194	Peri od:	Worksheet G-3		
	Date/Time Pre					
	To 12/31/2021					
	· · · · · · · · · · · · · · · · · · ·			5/16/2022 3:0	o pm	
				1.00		
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		17, 457, 661	1.00	
2.00	Less: contractual allowances and discounts on patients account	IS .		4, 160, 525	2.00	
3.00	Net patient revenues (Line 1 minus line 2)			13, 297, 136	3.00	
4.00	Less: total operating expenses (From Worksheet G-2, Part II, I	ine 15)		14, 717, 180	4.00	
5.00	Net income from service to patients (Line 3 minus 4)			-1, 420, 044	5.00	
	Other income:					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			0	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			4, 664	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 th	nan patients		0	16.00	
17.00	Revenue from sale of drugs to other than patients			0	17.00	
18.00	Revenue from sale of medical records and abstracts			0	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00	
20.00	Revenue from gifts, flower, coffee shops, canteen			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	Other miscellaneous revenue (specify)			0	24.00	
24.50	COVI D-19 PHE Funding			0	24.50	
25.00	Total other income (Sum of lines 6 - 24)			4, 664	25.00	
26.00	Total (Line 5 plus line 25)			-1, 415, 380	26.00	
27.00	Other expenses (specify)			0	27.00	
28.00				0	28.00	
29.00				0	29.00	
30.00	Total other expenses (Sum of Lines 27 - 29)			0	30.00	
31.00	Net income (or loss) for the period (Line 26 minus line 30)			-1, 415, 380	31.00	