This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0463 Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE	Provider CCN: 315057	Worksheet S
COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY		Parts I, II & III
		Date/Time Prepared:
		5/29/2024 9:09 am

				J/ Z 7	7/2024 7	. 0 7 aiii
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	ort		Date: 5/29/2024	Ti me:	9:09 am
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report ent	ter the number	of times the provider	resubmitted this cos	st repor	t
	3.01 [] No Medicare Utilization. Enter "	'Y" for yes or	leave blank for no.			
Contractor	4. [1] Cost Report Status	6. Contractor	No	<u></u>		
use only	(1) As Submitted	7.[N] First	Cost Report for this	Provider CCN		
	(2) Settled without audit	8.[N] Last	Cost Report for this F	Provider CCN		
	(3) Settled with audit	9. NPR Date:				
	(4) Reopened	10.[0]If Ii	ne 4, column 1 is "4":	 Enter number of time	es reope	ned
	(5) Amended	11. Contractor	Vendor Code	4	•	
	5. Date Received:	12.[F] Medi	care Utilization. Ente	 r "F" for full, "L" f	or low,	or "N"
		for	no utilization.			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MERRY HEART SUCCASUNNA (315057) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Wil	jun Sunga	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Wiljun Sunga			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-5, 485	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	-5, 485	0	0	100. 00

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

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

Health Financial Systems MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315057 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/29/2024 9:09 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: Street: 200 ROUTE 10 1.00 PO Box: 1.00 2.00 City: SUCCASUNNA State: NJ Zi p Code: 07876 2.00 3.00 County: MORRIS CBSA Code: 35084 Urban/Rural: U 3.00 CBSA Code: 3. 01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF MERRY HEART SUCCASUNNA 315057 01/01/1967 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 469, 194 20.00 Straight Line 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 469, 194 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38, 00 39.00 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 0 41 00

Heal th	Financial Systems	MERRY HEART SUCC	ASUNNA	In Lieu	u of Form CMS-2	2540-10
SKI LLE	SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315057 Period:					
COMPLE	X INDENTIFICATION DATA			From 01/01/2023	Part I	
				To 12/31/2023	Date/Time Pre	
					5/29/2024 9:0	9 am
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrativ	ve and General cost	N	42. 00
	center? Enter Y or N. If yes, check box	κ, and submit supporting s	schedule listing c	cost centers and		
	amounts.		-			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	pter 10?		N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and addr	ress of the home		44.00
	office on lines 45, 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the name	and address of t	the home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Con	tractor's Number:		45. 00
46. 00	Street:	PO Box:				46, 00
47.00	Ci tv:	State:	Zip	Code:		47. 00
	1" "3	The state of the s	-			1

Health Financial Systems MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315057 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2023 5/29/2024 9:09 am Date 1. 00 2.00 General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see 1.00 N 1.00 instructions) Y/N Date V/I 1. 00 2. 00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν column 1 is ves. enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary Is the provider involved in business transactions, including management 3.00 Υ 3.00 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 Type Date 1 00 2.00 3.00 Financial Data and Reports 4 00 4 00 Column 1: Were the financial statements prepared by a Certified Public C Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If column 1 is "Y", submit reconciliation. Y/N Legal Oper. 1.00 2.00 Approved Educational Activities Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the 6.00 N Ν 6.00 legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Programs? (Y/N) see instructions Ν 7.00 8.00 Were approvals and/or renewals obtained during the cost reporting period for Nursing 8.00 School and/or Allied Health Program? (Y/N) see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? (Y/N) see instructions. 9.00 9.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting 10.00 Ν 10.00 period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. 11.00 Ν Bed Complement 12.00 Have total beds available changed from prior cost reporting period? If "Y" Ν see instructions 12.00 Part B Y/N Date Description Y/N 1.00 3.00 0 2.00 PS&R Data 13.00 Was the cost report prepared using the PS&R Υ 05/01/2024 Υ 13.00 only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R Ν Ν 14 00 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 If line 13 or 14 is "Y", were adjustments 15.00 Ν Ν 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were 16.00 16.00 Ν Ν adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were Ν Ν 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. N Ν 18.00

Financial Systems MERRY H	EART S	SUCCASUNNA		In Lieu	u of Form CMS-2	2540-10
	CARE	Provi der No.				
A KEI MIDONGEMENT QUESTI ONNAI KE					Date/Time Pre	
		1. 00		2. (00	
Cost Report Preparer Contact Information						
Enter the first name, last name and the title/position	ı S	SLAVKA		PARTI LOVA		19. 00
held by the cost report preparer in columns 1, 2, and	3,					
respecti vel y.						
Enter the employer/company name of the cost report	H	IEALTH CARE RESOU	RCES			20. 00
preparer.						
Enter the telephone number and email address of the co	st 6	09-987-1440		SLAVKA. PARTI LOV	/A@HCRNJ. NET	21.00
report preparer in columns 1 and 2, respectively.						
	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost.	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost	Provider No. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report Enter the telephone number and email address of the cost 609-987-1440	ED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE EX REIMBURSEMENT QUESTIONNAIRE 1.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost Provider No.: 315057 Facility HEALTH CARE Provider No.: 315057 Facility HEALTH CARE No.: 315057 Facility HEALTH	ED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE EX REIMBURSEMENT QUESTIONNAIRE Provider No.: 315057 Period: From 01/01/2023 To 12/31/2023 1.00 2.0 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost 609-987-1440 Period: From 01/01/2023 To 12/31/2023 Period: From 01/01/2023 To 12/31/2023 PARTILOVA PARTILOVA SLAVKA PARTILOVA SLAVKA PARTILOVA SLAVKA PARTILOVA SLAVKA PARTILOVA SLAVKA PARTILOVA SLAVKA PARTILOVA	ED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE EX REIMBURSEMENT QUESTIONNAIRE Provider No.: 315057 Period: From 01/01/2023 To 12/31/2023 Part II Date/Time Provider to 12/31/2024 Provider No.: 315057 Period: From 01/01/2023 To 12/31/2023 Part II Date/Time Provider to 12/31/2024 Part II Date/Time Provider to 12/31/2024 SLAVKA PARTILOVA PARTILOVA PERTILOVA PER

 Heal th Financial
 Systems
 MERRY HEART

 SKILLED NURSING
 FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10 Provi der No.: 315057

Peri od: Worksheet S-2 From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/29/2024 9:09 am COMPLEX REIMBURSEMENT QUESTIONNAIRE

				5/29/2024 9:0	19 alli
		Part B			
		Date			
		4.00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R	05/01/2024			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and				
	4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				14. 00
	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.				
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00
13.00	made to PS&R data for additional claims that				15.00
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
	see Instructions.				
16.00	If line 13 or 14 is "Y", then were				16. 00
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17. 00					17. 00
	adjustments made to PS&R data for Other?				
	Describe the other adjustments:				
18. 00	Was the cost report prepared only using the				18. 00
	provider's records? If "Y" see Instructions.				
			3.00		
	Cost Report Preparer Contact Information		3.00		
19. 00	Enter the first name, last name and the title	/nosition	PREPARER		19. 00
19.00	held by the cost report preparer in columns		I KEI AKEK		17.00
	respectively.	i, 2, and 5,			
20. 00	Enter the employer/company name of the cost i	report			20.00
	preparer.	-1			
21. 00	Enter the telephone number and email address	of the cost			21. 00
	report preparer in columns 1 and 2, respective				
	· · · · · · · · · · · · · · · · · · ·	-	•	•	•

Health Financial Systems MERRY HEART STAND SKILLED NURSING FACILITY HEALTH CARE In Lieu of Form CMS-2540-10 MERRY HEART SUCCASUNNA

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315057 COMPLEX STATISTICAL DATA

				To	12/31/2023	Date/Time Prep 5/29/2024 9:09	
				I npa	atient Days/Vis		
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	113	1		5, 550		1. 00
2.00	NURSING FACILITY	0	0	1		0	2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0	0		0	0	3. 00 4. 00
5. 00	Other Long Term Care	0	0		O		5. 00
6. 00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	113		0	5, 550	13, 092	8. 00
		Inpatient L	Days/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	T	6.00	7. 00	8. 00	9. 00	10.00	
1. 00 2. 00	SKILLED NURSING FACILITY	13, 814	32, 456 0		248	15 0	1. 00 2. 00
3.00	NURSING FACILITY	0		٥		0	3. 00
4. 00	HOME HEALTH AGENCY COST	0	٥			Ĭ	4. 00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0	00.45	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	13, 814 Di sch			age Length of	15 Stay	8. 00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1. 00	SKILLED NURSING FACILITY	11. 00	12. 00 530	13.00	14. 00 22. 38	15. 00 872. 80	1. 00
2. 00	NURSING FACILITY	0	0		22. 30	0.00	2. 00
3. 00	ICF/IID	0	Ō			0.00	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00 7. 00	SNF-Based CMHC HOSPI CE			0.00	0. 00	0.00	6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	267	0 530		22. 38		8. 00
0.00	Tretai (dam er Trines I 7)	Average Length		Admi s		072100	0.00
		of Stay					
	Component	Total 16.00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
1. 00	SKILLED NURSING FACILITY	61. 24	17.00		19.00	20.00	1. 00
2. 00	NURSING FACILITY	0.00			0		2. 00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4. 00
5.00	Other Long Term Care	0.00				0	5. 00
6. 00 7. 00	SNF-Based CMHC HOSPI CE	0. 00	0	0	0	ol	6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	61. 24	Ö	268	24	242	8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
	oomponom:	1014.	Payrol I	Workers			
		21.00	22. 00	23. 00			
1.00	SKILLED NURSING FACILITY	534					1.00
2. 00 3. 00	NURSING FACILITY	0					2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST		0.00				4. 00
5. 00	Other Long Term Care	0					5. 00
6.00	SNF-Based CMHC		0.00				6. 00
7. 00	HOSPI CE	0					7. 00
8. 00	Total (Sum of lines 1-7)	534	120. 10	0.00			8. 00

Provi der No.: 315057

In Lieu of Form CMS-2540-10
Period: Worksheet S-3
From 01/01/2023 Part II

				Ť	o 12/31/2023	Date/Time Prep 5/29/2024 9:09	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES		_				
1.00	Total salaries (See Instructions)	6, 424, 415	0	6, 424, 415	· ·		1. 00
2.00	Physician salaries-Part A	0	0	0	0.00		2. 00
3.00	Physician salaries-Part B	0	0	0	0.00		3. 00
4.00	Home office personnel	0	0	0	0.00		4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	6, 424, 415	0	6, 424, 415	· ·		6. 00
7.00	Other Long Term Care	0	0	0	0.00		7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		8. 00
9.00	CMHC	0	0	0	0.00		9. 00
10. 00	HOSPI CE	0	0	0	0.00		
11. 00	Other excluded areas	0	0	0	0.00		
12. 00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12. 00
40.00	through 11)				050 400 00	05.40	40.00
13. 00	Total Adjusted Salaries (line 6 minus line	6, 424, 415	0	6, 424, 415	250, 122. 00	25. 69	13. 00
	12) OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	426, 197		426, 197	10, 311. 00	41, 33	14. 00
15. 00	Contract Labor: Physician services-Part A	420, 197	0	420, 197	0.00		15.00
16. 00	Home office salaries & wage related costs	0	0		0.00		
10.00	WAGE-RELATED COSTS	0	0		0.00	0.00	10.00
17. 00	Wage-related costs core (See Part IV)	1, 040, 336		1, 040, 336			17. 00
18. 00	Wage-related costs core (See Part IV)	1,040,330		1, 040, 330			18. 00
19. 00	Wage related costs other (see rait 17)	0					19. 00
20. 00	Physician Part A - WRC	0					20.00
21. 00	Physician Part B - WRC	0					21. 00
21.00	Total Adjusted Wage Related cost (see	1, 040, 336		1, 040, 336			22.00
22.00	instructions)	1,040,330	١	1, 040, 330			22.00
	Thisti dott ons)	l .	I	I	T.	1 !	I

Health Financial Systems
SNF WAGE INDEX INFORMATION MERRY HEART SUCCASUNNA

Provi der No.: 315057

				Т	o 12/31/2023	Date/Time Prep 5/29/2024 9:09	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1. 00
2.00	Administrative & General	488, 559	0	488, 559	20, 873. 00	23. 41	2. 00
3.00	Plant Operation, Maintenance & Repairs	209, 141	0	209, 141	10, 058. 00	20. 79	3. 00
4.00	Laundry & Li nen Servi ce	98, 762	0	98, 762	5, 998. 00	16. 47	4. 00
5.00	Housekeepi ng	236, 286	0	236, 286	13, 450. 00	17. 57	5. 00
6.00	Di etary	495, 725	0	495, 725	25, 635. 00	19. 34	6. 00
7.00	Nursing Administration	742, 041	0	742, 041	16, 099. 00	46. 09	7. 00
8.00	Central Services and Supply	30, 498	0	30, 498	718. 00	42. 48	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	41, 416	0	41, 416	2, 422. 00	17. 10	10.00
11.00	Soci al Servi ce	238, 146	0	238, 146	7, 748. 00	30. 74	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	338, 852	0	338, 852	10, 863. 00	31. 19	13.00
14. 00	Total (sum lines 1 thru 13)	2, 919, 426	o	2, 919, 426	113, 864. 00	25. 64	14. 00

Health Financial Systems	MERRY HEART SUCCASUNNA	In Lie	u of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315057	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2024 9:09 am

	To 12/31/2023	Date/Time Prep 5/29/2024 9:0	pared: 9 am
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	102, 994	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	o	3. 00
4.00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	_	
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	Ö	6. 00
7. 00	Employee Managed Care Program Administration Fees	Ö	7. 00
7.00	HEALTH AND INSURANCE COST		7.00
8.00	Heal th Insurance (Purchased or Self Funded)	312, 475	8. 00
9. 00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	6, 789	
11. 00	Life Insurance (If employee is owner or beneficiary)	0, 707	11. 00
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14. 00		0	14. 00
	Workers' Compensation Insurance	136, 607	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	130,007	16. 00
16.00	Non cumulative portion)	U	16.00
	TAXES		
17 00	FI CA-Employers Portion Only	475, 213	17 00
	Medicare Taxes - Employers Portion Only	473, 213	18. 00
19. 00	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	6, 258	
20.00	OTHER	0, 200	20.00
21 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22.00
	Tuition Reimbursement	0	22.00
		-	
24. 00	Total Wage Related cost (Sum of lines 1 - 23)	1, 040, 336 Amount	24. 00
		Reported	
		1. 00	
	Part B - Other than Core Related Cost	1.00	
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	TOTHER WAGE RELATED COSTS (SPECITI)	ا	25.00

				T.	01/01/2023	Date/Time Prep 5/29/2024 9:0	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	7 aiii
	occupational outegoly	Reported		Sal ari es (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				'	3	,	
		1.00	2. 00	3.00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	890, 853	144, 260				1. 00
2.00	Licensed Practical Nurses (LPNs)	568, 743	92, 099				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 576, 349	255, 266	1, 831, 615	76, 395. 00	23. 98	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 035, 945	491, 625				4. 00
5.00	Physical Therapists	216, 494	35, 058				5. 00
6.00	Physical Therapy Assistants	72, 260	11, 701				6. 00
7.00	Physical Therapy Aides	119, 582	19, 365		·		7. 00
8.00	Occupational Therapists	99, 027	16, 036		·		8. 00
9.00	Occupational Therapy Assistants	63, 081	10, 215	73, 296	·		9. 00
10. 00	Occupational Therapy Aides	0	0	0	0. 00		10. 00
11. 00	Speech Therapists	0	0	0	0. 00		11. 00
12. 00	Respi ratory Therapi sts	0	0	0	0.00		12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13. 00
	Contract Labor						
44.00	Nursing Occupations	100 700		100 700	0.007.00		
14.00	Registered Nurses (RNs)	130, 709		130, 709			
15. 00	Li censed Practical Nurses (LPNs)	0		0	0.00		15.00
16. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	67, 984		67, 984	3, 207. 00	21. 20	16. 00
17. 00	Total Nursing (sum of lines 14 through 16)	198, 693		198, 693	6, 033. 00	32. 93	17. 00
18. 00	Physical Therapists	87, 715		87, 715	·		
19. 00	Physical Therapy Assistants	25, 124		25, 124	·		
20. 00	Physical Therapy Aides	20, 121		20, 121	0.00		
21. 00	Occupational Therapists	79, 827		79, 827			21. 00
22. 00	Occupational Therapy Assistants	5, 081		5, 081	·		
23. 00	Occupational Therapy Aides	0,001		0,001	0.00		23. 00
24. 00	Speech Therapists	29, 757		29, 757			
25. 00	Respiratory Therapists	27,737		27,707	0.00		
26. 00	Other Medical Staff	l ol		l o	0.00		
	1	-1		-			

			0 12/31/2023	Date/lime Prep 5/29/2024 9:09	
1.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 3				Days	
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3.00					
4.00					
Book British	1				
7.00 MAX	5. 00		RHX		5.00
8.00 9.00 10					
9.00 11.00 12.00 13.00 14.00 15.00 16.00 16.00 17.00 18.00 18.00 17.00 18.00 1	1				
10.00					
11.00 RIJA 11.00 RIJA 11.00 RIJA 12.00 RIJA 13.00 RIJA 15.00 RIJA 15.0	1				
13.00 RWC					
14.00 RV8					
15 00					
10.00 RHC					
17.00	1				
19,00 RMC					
20.00 RNB 20.00 RNB 22.00 RNB					
21.00 RIMA 21.00 RIMA 22.00 RIMA 22.00 RIMA 23.00 RIMA 23.0					
RLB					
23.00 RIA 23.00 ES3 24.00 ES3 24.00 ES5 25.00 ES5 25.00 ES5 25.00 ES5 25.00 ES5 25.00 ES5 26.00 ES5 25.00 ES5 26.00 ES5 26					
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33.00 34.00 35.00 36.00 37.00 38.00 39.00 4.101 38.00 39.00 4.1.00 4.1.00 4.1.00 4.1.00 4.2.00 4.3.00 4.4.00 4.4.00 4.4.00 4.5.00 4.5.00 4.6.00 4.7.00 4.6.00 4.7.00 4.8.00 4.9.00 4.0.00 4.9.00 4.9.00 4.9.00 4.9.00 4.9.00 4.9.00 4.9.00 4.9.00 4.0.0					
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49.00 CB2					
50. 00 CB1 50. 00 51. 00 CA2 51. 00 52. 00 CA1 52. 00 53. 00 SE3 53. 00 55. 00 SE2 54. 00 55. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 IB2 59. 00 60. 00 IB1 60. 00 61. 00 IA2 61. 00 62. 00 IA1 62. 00 64. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA1 66. 00 67. 00 PE2 67. 00 68. 00 PP1 68. 00 69. 00 PD2 69. 00 70. 00 PD1 70. 00 71. 00 PC2 71. 00 72. 00 PB2 73. 00 74. 00 PB1 74. 00					
51. 00 CA2 51. 00 52. 00 SE3 52. 00 53. 00 SE3 53. 00 54. 00 SE2 54. 00 55. 00 SE1 55. 00 56. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 SSA 58. 00 60. 00 I B2 59. 00 60. 00 I B1 60. 00 61. 00 I A1 62. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 BA1 66. 00 67. 00 BA1 66. 00 69. 00 PE1 68. 00 69. 00 PD2 69. 00 70. 00 PD1 70. 00 71. 00 PC2 71. 00 72. 00 PB2 73. 00 74. 00 PB1 74. 00					
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54. 00 SE2 54. 00 55. 00 SE1 55. 00 56. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 IB2 59. 00 60. 00 IB1 60. 00 61. 00 IA2 61. 00 62. 00 IA1 62. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 BA2 65. 00 67. 00 BA1 66. 00 67. 00 PE1 68. 00 69. 00 PD2 69. 00 70. 00 PD2 69. 00 71. 00 PC2 71. 00 72. 00 PB2 73. 00 74. 00 PB1 74. 00					52.00
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57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 IB2 59. 00 60. 00 IB1 60. 00 61. 00 IA2 61. 00 62. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 BA1 66. 00 67. 00 PE2 67. 00 68. 00 PE1 68. 00 69. 00 PD1 70. 00 70. 00 PC2 71. 00 72. 00 PR1 72. 00 73. 00 PR2 73. 00 74. 00 PB1 74. 00					
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69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB2 PC2 PC1 PC1 PC2 PC1 PC2 PC3 PC3 PC1 PC2 PC3					
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72. 00 73. 00 74. 00 PB1 72. 00 PB1 74. 00					
73. 00 74. 00 PB1 73. 00 74. 00					
74. 00 PB1 74. 00					
75. 00 PA2 75. 00	74. 00		PB1		74.00
	75. 00		PA2		75. 00

Health Financial Systems	MERRY HEART SUCCA	ASUNNA		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315057	Period: From 01/01/2023 To 12/31/2023	Worksheet S- Date/Time Pr 5/29/2024 9:	epared:
				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 Vopayments beginning 10/01/2003. Congress expect expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fow ith direct patient care and related expenses (See instructions)	cted this increase to a column 1 the amour acch category to to ar yes or "N" for no	to be used nt of the total SNF oif the s	for direct pexpense for expense for expense from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related Iter in Part I, Esociated	
101. 00 Staffi ng						101. 00
102.00 Recrui tment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105. 00 OTHER (SPECI FY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, lir	ne 1, column 3)					106. 00

Health Financial Systems	MERRY HEART SU	CCASUNNA		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	5/29/2024 9: 0 Reclassi fi ed	9 am
cost center bescription	Sai ai i es	other	+ col . 2)	ons	Trial Balance	
			+ COI. 2)	Increase/Decre		
				ase (Fr Wkst	col . 4)	
				A-6)	COI. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00 O0100 CAP REL COSTS - BLDGS & FLXTURES		1, 315, 397	1, 315, 397	7	1, 315, 397	1. 00
2. 00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT		1, 313, 377	1, 313, 371		0	2. 00
3. 00 00300 EMPLOYEE BENEFITS	0	1, 204, 848	1, 204, 848	-	1, 204, 848	3. 00
4. 00 00400 ADMI NI STRATI VE & GENERAL	488, 559	1, 373, 138	1, 861, 697		1, 861, 697	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	209, 141	386, 548	595, 689		595, 689	5. 00
	1	30, 793				6. 00
	98, 762		129, 555		129, 555	
7. 00 00700 HOUSEKEEPI NG	236, 286	84, 538	320, 824		320, 824	7.00
8. 00 00800 DI ETARY	495, 725	387, 766	883, 491		883, 491	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	742, 041	0	742, 041		742, 041	9. 00
10. 00 01000 CENTRAL SERVI CES & SUPPLY	30, 498	275, 646	306, 144	1 0	306, 144	10.00
11. 00 01100 PHARMACY	0	0	(0	0	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	41, 416	0	41, 416		41, 416	12. 00
13. 00 O1300 SOCIAL SERVICE	238, 146	0	238, 146		238, 146	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(0	0	14. 00
15. 00 O1500 PATIENT ACTIVITIES	338, 852	37, 541	376, 393	0	376, 393	15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	3, 035, 945	298, 565	3, 334, 510	0	3, 334, 510	30. 00
31.00 03100 NURSING FACILITY	0	0	(0	0	31. 00
32. 00 03200 I CF/I I D	0	0	(0	0	32. 00
33.00 O3300 OTHER LONG TERM CARE	0	0	(0	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0	7, 943	7, 943	0	7, 943	40. 00
41. 00 04100 LABORATORY	0	37, 856	37, 85 <i>6</i>	0	37, 856	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	0	0	(0	0	42. 00
43.00 O4300 OXYGEN (INHALATION) THERAPY	0	0	(0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	306, 936	112, 839	419, 775	0	419, 775	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	162, 108	84, 908	247, 016	0	247, 016	45. 00
46. 00 04600 SPEECH PATHOLOGY	O	29, 757	29, 757	0	29, 757	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	(0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	351, 077	351, 077	0	351, 077	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	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0	0	(0		60.00
61.00 06100 RURAL HEALTH CLINIC	0	0	(0	0	61. 00
62. 00 06200 FQHC						62. 00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000 HOME HEALTH AGENCY COST	0	0	(0	0	70. 00
71. 00 07100 AMBULANCE	0	0	(0	0	71. 00
73. 00 07300 CMHC	0	0	(0	0	73. 00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	(0	0	
81.00 08100 INTEREST EXPENSE		0	(0	0	81. 00
82.00 08200 UTILIZATION REVIEW - SNF	0	0	(0	0	82. 00
83. 00 08300 HOSPI CE	0		(0	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	6, 424, 415	6, 019, 160	12, 443, 575	0	12, 443, 575	89. 00
NONREI MBURSABLE COST CENTERS			_			
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	10.01	-	0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP	0	12, 216	12, 216	0	12, 216	
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	(0	92.00
93. 00 09300 NONPAL ENTS AUNIDRY		0	(0	93. 00
94. 00 09400 PATIENTS LAUNDRY 100. 00 TOTAL	4 424 415	4 021 27/	10 455 704		0 12, 455, 791	94.00
100. 00 TOTAL	6, 424, 415	6, 031, 376	12, 455, 791	ı _l 0	12, 455, 791	100.00

MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 MERRY HE

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315057

				То	12/31/2023	Date/Time Prepared: 5/29/2024 9:09 am
	Cost Center Description	Adjustments to	Net Expenses			372772024 7:07 dill
			For Allocation			
		Wkst A-8)	(col. 5 +-			
		/ 00	col . 6) 7.00			
	GENERAL SERVICE COST CENTERS	6. 00	7.00			
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES	-199, 745	1, 115, 652			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	0			2. 00
3.00	00300 EMPLOYEE BENEFITS	o	1, 204, 848			3.00
4.00	00400 ADMINISTRATIVE & GENERAL	41, 708	1, 903, 405			4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	595, 689			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	129, 555			6. 00
7.00	00700 HOUSEKEEPI NG	0	320, 824			7.00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	0	883, 491 742, 041			8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY		306, 144			10.00
11. 00	01100 PHARMACY	o	0			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	41, 416			12. 00
13.00	01300 SOCIAL SERVICE	O	238, 146			13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			14. 00
15. 00	01500 PATIENT ACTIVITIES	0	376, 393			15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 224 510			20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	3, 334, 510			30. 00 31. 00
32. 00	03200 CF/IID		0			32.00
33. 00	03300 OTHER LONG TERM CARE		0			33.00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>			55. 55
40.00	04000 RADI OLOGY	0	7, 943			40. 00
41.00	04100 LABORATORY	0	37, 856			41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0			42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0			43.00
44. 00	04400 PHYSI CAL THERAPY	0	419, 775			44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	247, 016 29, 757			45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY		27, 737			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	o			48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	351, 077			49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	O	0			50.00
51.00	05100 SUPPORT SURFACES	0	0			51.00
	OUTPATIENT SERVICE COST CENTERS	T al	ما			(0.00
60.00	O6000 CLINIC O6100 RURAL HEALTH CLINIC	0	0			60.00
61. 00 62. 00	06200 FQHC	٩	U			61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS					02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0			70. 00
71.00	07100 AMBULANCE	O	0			71. 00
73.00	07300 CMHC	0	0			73. 00
	SPECIAL PURPOSE COST CENTERS					
	I I	0	0			80.00
	O8100 INTEREST EXPENSE O8200 UTILIZATION REVIEW - SNF	0	0			81. 00 82. 00
83. 00	08300 HOSPI CE		0			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-158, 037				89. 00
200	NONREI MBURSABLE COST CENTERS		:=, ===, ===			57.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			90.00
	09100 BARBER AND BEAUTY SHOP	0	12, 216			91. 00
	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0			92. 00
	09300 NONPAI D WORKERS	0	0			93.00
94. 00 100. 00	O9400 PATIENTS LAUNDRY TOTAL	-158, 037	12, 297, 754			94. 00 100. 00
100.00) TOTAL	-100,037	12, 291, 754			[100.00

Health Financial Systems	MERRY HEART SUCCASUNNA In Lieu of Form CMS-254					
RECLASSI FI CATI ONS	Pro	ovi der No.: 315057	Peri od:	Worksheet A-6		
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared: 9 am	
		Increases				
	Cost Center	Li ne #	Sal ary	Non Salary		
	2. 00	3. 00	4. 00	5. 00		
TOTALS						
100. 00	Total Reclassifications	ns (Sum	0	0	100.00	
	of columns 4 and 5 must	st				
	equal sum of columns 8	3 and				
	9)					

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	MERRY HEART SUCC	ASUNNA		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315057	Peri od:	Worksheet A-6	·)
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/29/2024 9:0	09 am
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
TOTALS						
100.00				0	C	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10 Provi der No.: 315057

Peri od: Worksheet A-7 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

				-	To 12/31/2023	Date/Time Prep 5/29/2024 9:09	oared: 9 am
			<u> </u>	Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0	(0	0	1. 00
2.00	Land Improvements	0	0	(0	0	2. 00
3.00	Buildings and Fixtures	0	0	(0	0	3. 00
4.00	Building Improvements	529, 437	138, 694	(138, 694	0	4. 00
5.00	Fi xed Equi pment	0	0	(0	0	5. 00
6.00	Movable Equipment	2, 364, 224	331, 988		331, 988	l .	6. 00
7. 00	Subtotal (sum of lines 1-6)	2, 893, 661	470, 682	(470, 682	0	7. 00
8.00	Reconciling Items	0	0	(0	0	8. 00
9. 00	Total (line 7 minus line 8)	2, 893, 661	470, 682	(470, 682	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	ANALYSIS OF SUMMOSS IN CARLEY ASSET BALANCES	6.00	7. 00				
4 00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES) 	0				4 00
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	668, 131	0				4.00
5.00	Fi xed Equipment	0 (0)	0				5. 00
6.00	Movable Equipment	2, 696, 212	0				6. 00
7.00	Subtotal (sum of lines 1-6)	3, 364, 343	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	3, 364, 343	0				9. 00

From 01/01/2023 | Worksheet A-8 | To 12/31/2023 | Date/Time Prepared:

				10 12/31/2023	5/29/2024 9:0	
				Expense Classification on		9 alli
				To/From Which the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Line No.	
		Adjustment				
		1.00	2.00	3. 00	4. 00	
1.00	Investment income on restricted funds		0		0.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter		l o		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		1		0.00	3. 00
4. 00	Rental of provider space by suppliers		Ö		0.00	4. 00
4.00	(chapter 8)		٥		0.00	4.00
5.00	Tel ephone services (pay stations excluded)		0		0.00	5. 00
3.00	(chapter 21)		٦		0.00	3.00
	1 ` ' '		,	J	0.00	6. 00
6.00	Television and radio service (chapter 21)		0	(1	
7.00	Parking lot (chapter 21)		0	1	0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0)		8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0	1	0.00	
10.00	Sale of scrap, waste, etc. (chapter 23)		0	1	1	10.00
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	-136, 128			12.00
	related organizations (chapter 10)					
13.00	Laundry and linen service		0)	0.00	13.00
14.00	Revenue - Employee meals		l o		0.00	14.00
15.00	Cost of meals - Guests		l		0.00	15. 00
16, 00	Sale of medical supplies to other than		0		l .	16. 00
	patients		_			
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		1	18. 00
19. 00	Vending machines			1	1	19. 00
20. 00	Income from imposition of interest, finance		l o		0.00	
20.00	or penalty charges (chapter 21)		·	1	0.00	20.00
21 00			l o		0.00	21 00
21. 00	Interest expense on Medicare overpayments		١	1	0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
				EQUI PMENT		
25.00	DONATIONS	A	-5, 980	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MEALS & ENTERTAINMENT	A	-15, 929	ADMINISTRATIVE & GENERAL	4.00	25. 01
100.00	Total (sum of lines 1 through 99) (Transfer		-158, 037			100. 00
	to Worksheet A, col. 6, line 100)					
(1) D-	comintion all chanter references in this co	Lump postoin te	CMC Dub. 1E 1	•	•	

⁽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 MERRY HEART STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME MERRY HEART SUCCASUNNA

| Peri od: | Worksheet A-8-1 | From 01/01/2023 | Parts I-II | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315057 OFFICE COSTS

PART I COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR	
CLAI MED HOME OFFI CE COSTS: 1. 00	1 00
1. 00 CAP REL COSTS - BLDGS & RENT 1 FIXTURES	1. 00
	2. 00
FI XTURES	
	3. 00
4.00 FIXTURES 1.00CAP REL COSTS - BLDGS & FEES 4	4 00
4. 00 1. 00 CAP REL COSTS - BLDGS & FEES 4	4. 00
	5. 00
6.00 4.00 ADMINISTRATIVE & GENERAL DUES & SUBSCRIPTIONS 6.00	5. 00
7.00 1.00 CAP REL COSTS - BLDGS & RENT 7.00	7. 00
FI XTURES	
	3. 00
	9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line	0. 00
12.	
Amount Amount Adjustments	
Allowable In Included in (col. 4 minus	
Cost Wkst. A, col. col. 5)	
5	
4.00 5.00 6.00 PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR	
CLAIMED HOME OFFICE COSTS:	
	1. 00
	2. 00
3.00 332,279 0 332,279 3	3. 00
4.000 0 4,000 4	4. 00
	5. 00
	5. 00
	7. 00
	3. 00
	9. 00 0. 00
6, line 100 to Worksheet A-8, column 3, line). 00
12.	

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

Provider No.: 315057
From 01/01/2023
To 12/31/2023
Parts I-II
Date/Time Prepared:

				5/29/2024 9:0	9 am
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/C	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	The state of the s	i i	1
1.00	A	B. BONIFACIO, ET. AL.	100.00	1.00
2. 00	A	B. BONIFACIO, ET. AL.	100.00	2. 00
3.00			0.00	3. 00
4.00			0.00	4. 00
5. 00			0.00	5. 00
6. 00			0.00	6. 00
7. 00			0.00	7. 00
8. 00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10. 00
100.00 G. Other (financial or non-financial)			0.00	100. 00
speci fy:				

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

	Rel ated Organi	zation(s) and/	or Home Office
	Name	Percentage of Ownership	Type of Business
DART LL LATERDE ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6. 00

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

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

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

rei parpeces er erarining reinibareenient ander er er	O 7		
1.00	200 ROUTE 10 LLC	100. 00 REALTY	1.00
2.00	MERRY HEART ASSISTED LIVING	100.00 AL FACILITY	2.00
	LLC		
3. 00		0. 00	3.00
4. 00		0. 00	4. 00
5. 00		0. 00	5.00
6. 00		0. 00	6.00
7. 00		0. 00	7.00
8. 00		0. 00	8.00
9. 00		0. 00	9.00
10. 00		0. 00	10.00
100.00 G. Other (financial or non-financial)		0. 00	100.00
speci fy:			

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

Health Financial Systems MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315057 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 9:09 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDGS & MOVABLE EMPLOYEE Subtotal for Cost **FLXTURES FOUL PMENT** BENEFITS Allocation (from Wkst A col. 7) 1.00 2.00 3. 00 ЗА GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1 00 1 00 1, 115, 652 1, 115, 652 2.00 0 2 00 3.00 00300 EMPLOYEE BENEFITS 1, 204, 848 0 1, 204, 848 3.00 00400 ADMINISTRATIVE & GENERAL 0 2, 180, 838 4 00 1, 903, 405 185 808 91, 625 4 00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 595, 689 28, 197 0 39, 223 663, 109 5.00 26, 036 6.00 00600 LAUNDRY & LINEN SERVICE 129, 555 18, 522 174, 113 6.00 7.00 00700 HOUSEKEEPI NG 320, 824 13,036 0 44, 314 378, 174 7.00 00800 DI ETARY 92 969 8 00 883 491 1, 060, 476 8 00 84, 016 9.00 00900 NURSING ADMINISTRATION 742,041 139, 164 881, 205 9.00 01000 CENTRAL SERVICES & SUPPLY 5, 720 10.00 10.00 306, 144 0 311, 864 01100 PHARMACY 11.00 0 0 11.00 Ω 01200 MEDICAL RECORDS & LIBRARY 41, 416 0 49, 183 12.00 7 767 12 00 13.00 01300 SOCIAL SERVICE 238, 146 0 44,662 286, 468 13.00 3,660 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 01500 PATIENT ACTIVITIES 0 15.00 376, 393 83, 197 63, 549 523, 139 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 3, 334, 510 0 569, 368 4, 570, 066 30.00 666, 188 31.00 03100 NURSING FACILITY 0 0 31.00 03200 | CF/IID 32.00 0 0 32.00 0 0 0 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 7, 943 C 7, 943 40.00 04100 LABORATORY 41.00 37.856 0 0 37, 856 41.00 0 04200 I NTRAVENOUS THERAPY 0 42.00 C 0 42.00 0 0 04300 OXYGEN (INHALATION) THERAPY 43.00 43.00 44.00 04400 PHYSI CAL THERAPY 419, 775 21, 331 0 57, 563 498, 669 44.00 04500 OCCUPATIONAL THERAPY 45.00 247, 016 0 30.402 277, 418 45.00 C 04600 SPEECH PATHOLOGY 29, 757 46.00 46.00 29, 757 04700 ELECTROCARDI OLOGY 47.00 0 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48 00 Ω C Λ 48 00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 351,077 0 351, 077 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 0 0 50.00 05100 SUPPORT SURFACES 51.00 0 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 62 00 06200 FQHC 62 00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 n 0 0 n 70.00 07100 AMBULANCE 71.00 0 0 0 0 0 71.00 07300 CMHC 73 00 0 O 0 73 00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82 00 83.00 08300 H0SPI CE 0 Ω 83.00 SUBTOTALS (sum of lines 1-84) 12, 285, 538 1, 204, 848 12, 281, 355 89.00 1, 111, 469 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 91.00 09100 BARBER AND BEAUTY SHOP 12, 216 4, 183 0 0 16, 399 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 92.00 0 C 0 09300 NONPALD WORKERS 93 00 0 0 93 00 0 Ω 0

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12, 297, 754

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1, 204, 848

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12, 297, 754 100. 00

98.00 0

99.00

94.00

98.00

99.00

100.00

09400 PATIENTS LAUNDRY

TOTAL

Cross Foot Adjustments

Negative Cost Centers

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315057

COST CENTER DESCRIPTION					T	o 12/31/2023	Date/Time Pre	
ENERAL SERVICE COST CENTERS		Cost Center Description	ADMI NI STRATI VE	PI ANT	LAUNDRY &	HOUSEKEEPI NG		9 am
SEPAIRS								
SENERAL SERVICE COST CENTERS								
GM.RAL SERVICE COST CENTERS			4.00		4 00	7.00	9.00	
1.00		GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	6.00	
0.0300 EMPLOYER FRIFFITS 2, 180, 838	1.00							1.00
4.00 0.0400 ADM INSTRATIVE & GENERAL 2.180, 838								•
5.00 00500 PLANT OPERATION, MAINT & REPAIRS 142, 942 806, 051 6.00 00500 LANDRY & LINEM SERVICE 37, 532 23, 276 234, 921 471, 348 7.00 7.00 7.00 00700 HOUSEKEEPING 81, 521 11, 653 0 471, 348 7.00 7.00 00700 HOUSEKEEPING 81, 521 11, 653 0 471, 348 7.00 7.00 00900 HETARY 228, 600 75, 100 0 0 45, 910 1, 410, 958 8.00 9.00 00900 USTRAR SERVICES & SUPPLY 67, 229 0 0 0 0 0 0 0 0 0								•
0.0000 LANDRY & LINEN SERVICE 37, 532 23, 276 234, 921 7, 00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.0000000 0.00000000			1	904 OE1				•
0.000 0.0000 0.001 0.0			1					•
0.000 0.0000 DIETARY 228, 500 75, 109 0 45, 910 1, 110, 095 8, 00 0.000 0.000 0.01000 0.01000 0.01000 0.			1			471, 348		1
10. 00 101000 CENTRAL SERVICES & SUPPLY	8.00		1				1, 410, 095	8. 00
11.00 01100 PHARMACY 0 0 0 0 0 0 0 11.00 13.00 13.00 13.00 03.00 MBICAL SERVICE 61,752 3.272 0 2.000 0 13.00 14.00 14.00 14.00 14.00 01500 MRSI NG AND ALLED HEALTH EDUCATION 0 0 0 0 0 0 14.00 15.00 15.00 MRSI NG AND ALLED HEALTH EDUCATION 0 0 0 0 0 0 14.00 15.00 15.00 MRSI NG AND ALLED HEALTH EDUCATION 12.770 74,376 0 45,463 0 15.00 MRSI NG THE SERVICE COST CENTERS			189, 956	0	0	0	0	1
12 00 01200 MEDICAL RECORDS & LIBRARY 10, 602 0 0 0 0 0 12, 00		1 1	67, 227	0	0	0	-	ł
13. 00 01300 SOCIAL SERVICE 61,752 3,272 0 2,000 0 13. 00 14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 NIPATE SERVICE COST CENTERS		1	10 403	0	0	0	-	ł
14. 00 01400 QUESTING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 0			1	3 272	0	2 000	ŭ	ł
15.00 OTSOO PATILENT ACTIVITIES SERVICE COST CENTERS			1	0, 2, 2		· ·		ł
30.00 03000 03000 0300 0310 04100 0310 0310 0310 0310 0310 0310 0310 0320 03200			112, 770	74, 376	0	45, 463	0	1
31.00 03100 NURSING FACILITY					,			
32.00 032.00 CORPITION 0 0 0 0 0 0 0 0 0			985, 138					ı
33.00 03300 OTHER LONG TERM CARE O O O O O O O O O			0					•
ANCILLARY SERVICE COST CENTERS			0	-				1
40.00	00.00		<u> </u>			<u> </u>		00.00
42.00 04200 04300 0X76QN (INRAVENOUS THERAPY 0 0 0 0 0 0 43.00	40.00		1, 712	0	0	0	0	40. 00
43.00 04300 DXYSEN (INHALATION) THERAPY		I I	8, 160	0	0	0	0	•
44. 00 04400 PHYSI CAL THERAPY 107, 495 19, 069 0 11, 656 0 44. 00 45. 00 04500 0CCUPATI ONAL THERAPY 59,801 0 0 0 0 0 0 45. 00 04500 SPEECH PATHOLOGY 6, 415 0 0 0 0 0 0 47. 00 04700 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 75,680 0 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 50. 00 05000 SUPPORT SURFACES 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 61. 00 06000 CLINIC COST 0 0 0 0 0 0 62. 00 06000 CLINIC COST 0 0 0 0 0 0 61. 00 06000 CLINIC COST 0 0 0 0 0 62. 00 06200 FOHC 0 0 0 0 0 0 63. 00 07000 MBLH FRALTH AGENCY COST 0 0 0 0 0 0 67. 00 07000 MBLH FRALTH AGENCY COST 0 0 0 0 0 0 67. 00 07000 MBLH FRACTI CE PREMI LIMS & PAID LOSSES 80. 00 08000 MALFRACTI CE PREMI LIMS & PAID LOSSES 80. 00 08000 MALFRACTI CE PREMI LIMS & PAID LOSSES 80. 00 08000 MALFRACTI CE PREMI LIMS & PAID LOSSES 80. 00 08000 MALFRACTI CE PREMI LIMS & PAID LOSSES 80. 00 08000 MALFRACTI CE PREMI LIMS & PAID LOSSES 80. 00 09000 00 0 0 0 0 0 80. 00 09000 00 00 0 0 0 80. 00 09000 00 00 0 0 0 80. 00 09000 00 00 0 0 80. 00 09000 00 00 0 0 0 80. 00 09000 00 00 0 0 0 80. 00 09000 00 00 0 0 0 80. 00 09000 09000 09000 00 00		1	0	0	1	0		•
45. 00 04500 OCCUPATI ONAL THERAPY 59,801 0 0 0 0 45. 00 46. 00 04600 SPEECH PATHOLOGY 6,415 0 0 0 0 0 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATI ENTS 75,680 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 60. 00 06000 CLI NI C 0 0 0 0 0 0 61. 00 06000 CLI NI C 0 0 0 0 0 0 62. 00 06200 FOHC 0 0 0 0 0 0 62. 00 06200 FOHC 0 0 0 0 0 0 71. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 71. 00 07300 HOME HEALTH AGENCY COST 0 0 0 0 0 0 71. 00 07300 MABULANCE 0 0 0 0 0 0 71. 00 07300 MABULANCE 0 0 0 0 0 0 71. 00 07300 MADULANCE 0 0 0 0 0 71. 00 07300 MADULANCE 0 0 0 0 0 71. 00 07300 MADULANCE 0 0 0 0 0 71. 00 07300 07300 MADULANCE 0 0 0 0 71. 00 07300 07300 07300 07300 07300 07300 71. 00 07300 07300 07300 07300 07300 07300 07300 71. 00 07300 07300 07300 07300 07300 07300 07300 71. 00 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 71. 00 07300			107 405	10.040	1	11 454	-	•
46. 00 04600 SPECH PATHOLOGY						,		•
47. 00 04700 LECTROCARDI OLOGY 0 0 0 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 75, 680 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 OSDOO DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 60. 00 06000 CLINIC 0 0 0 0 0 0 61. 00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 62. 00 06000 CLINIC 0 0 0 0 0 0 62. 00 07100 HOME HEALTH AGENCY COST 0 0 0 0 0 0 67. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 67. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 67. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 68. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 08100 INTEREST EXPENSE 81. 00 82. 00 08200 UTILIZATION REVIEW - SNF 81. 00 83. 00 08300 HOSPICE SUMFORM OF TIMES SUMFORM OF TIMES 80. 00 SUBTOTALS (Sum of Lines 1-84) 2, 177, 303 802, 312 234, 921 469, 062 1, 410, 095 89. 00 SUBTOTALS (Sum of Lines 1-84) 2, 177, 303 802, 312 234, 921 469, 062 1, 410, 095 89. 00 ONDREIMBURSABLE COST CENTERS 0 0 0 0 0 89. 00 O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 89. 00 O9000 O9000 PATIENTS LAUNDRY 0 0 0 0 0 89. 00 O9000 ONDREIMBURSABLE COST CENTERS 0 0 0 0 0 89. 00 O9000 ONDREIMBURSABLE COST CENTERS 0 0 0 0 0 89. 00 O9000 ONDREIMBURSABLE COST CENTERS 0 0 0 0 0 89. 00 O9000 ONDREIMBURSABLE COST CENTERS 0 0 0 0 0 89. 00 O9000 ONDREIMBURSABLE COST CENTERS 0 0 0 0 0 89. 00 ONDREIMBURSABLE COST CENTERS 0 0 0 0 0 89. 00 ONDREIMBURSABLE COST CENTERS 0 0 0 0 89. 00 ONDREIMBURSABLE COST CENTERS 0 0			1	0	Ö	-		•
49. 00 04900 DRUGS CHARGED TO PATIENTS 75,680 0 0 0 0 0 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 60. 00 06000 CLINIC 0 0 0 0 0 0 61. 00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 62. 00 06200 FOHC 071HER REI MBURSABLE COST CENTERS 77. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 78. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 79. 00 07300 CMHC SUPPORT SURFACES 0 0 0 0 0 0 79. 00 07300 CMHC SUPPORT SURFACES 0 0 0 0 0 80. 00 08000 MALPRACTICE PREMI UMS & PAID LOSSES 81. 00 81. 00 08300 HOSPICE SUBFORD SU	47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			0	0	0	0	-	•
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0			75, 680	0		· · · · · · · · · · · · · · · · · · ·		1
OUTPATIENT SERVICE COST CENTERS O		1	0	0		· ·	-	
60. 00	31.00		١	0	0	<u> </u>	0	31.00
62. 00 06200 FOHC OTHER REI MBURSABLE COST CENTERS	60.00		0	0	0	0	0	60.00
OTHER REIMBURSABLE COST CENTERS OTOOD ONE HEALTH AGENCY COST O O O O O O O O O O O O O O O O O O	61. 00		0	0	0	0	0	61. 00
70.00	62. 00							62. 00
71. 00	70.00				1 0	٥	0	70.00
73. 00			0			1		ł
80. 00			l o					1
81. 00								
82. 00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 0 0 0 0 83. 00 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 2,177,303 802,312 234,921 469,062 1,410,095 89. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I						•
83. 00 08300 HOSPI CE SUBTOTALS (sum of lines 1-84) 2,177,303 802,312 234,921 469,062 1,410,095 89.00 NONREI MBURSABLE COST CENTERS 90.00 09100 BARBER AND BEAUTY SHOP 3,535 3,739 0 2,286 0 91.00 92.00 992.00 99300 NONPAI D WORKERS 0 0 0 0 0 0 92.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 0 98.00 99.00 Nonpai D Workers 0 0 0 0 0 0 0 0 0								1
89. 00 SUBTOTALS (sum of lines 1-84) 2,177,303 802,312 234,921 469,062 1,410,095 89.00			0	0	0	0	0	
NONRE MBURSABLE COST CENTERS		I I	2, 177, 303					1
91. 00 09100 BARBER AND BEAUTY SHOP 3,535 3,739 0 2,286 0 91.00 92.00 92.00 94.00 95.0			, , , , , , , , , , , , , , , , , , , ,			.5.,502	,,	
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92. 00 93. 00 93. 00 094. 00			0	0				l
93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 93. 00 94. 00 94. 00 94. 00 95. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3, 535	3, 739	0	2, 286		
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 94. 00 98. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00 0 0 99. 00 0 0 0 0 0 0 0 0 0			0	0	0	0		
98.00 Cross Foot Adjustments				0		1		
99.00 Negative Cost Centers 0 0 0 0 99.00				0	1	-		ł
100. 00 TOTAL 2, 180, 838 806, 051 234, 921 471, 348 1, 410, 095 100. 00				0	0	0		ł
	100.00	D TOTAL	2, 180, 838	806, 051	234, 921	471, 348	1, 410, 095	100. 00

Provi der No.: 315057

In Lieu of Form CMS-2540-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5//9/2024 9:09 am	

				' \	12/31/2023	5/29/2024 9: 0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	•	ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	1, 071, 161					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	379, 091				10.00
11. 00	01100 PHARMACY	0	0	0			11.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		0	Ō	59, 785		12.00
13. 00	01300 SOCIAL SERVICE		0	0	0,7,700	353, 492	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		0	Ö	0	0	14. 00
15. 00	01500 PATIENT ACTIVITIES		0	0	0	Ö	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>			10.00
30. 00	03000 SKILLED NURSING FACILITY	1, 071, 161	182, 227	0	59, 785	353, 492	30.00
31. 00	03100 NURSING FACILITY	0	0	Ö	07, 700	0 0 0	31.00
32. 00	03200 CF/11D		0	Ö	0	1	32.00
33. 00	03300 OTHER LONG TERM CARE		0	Ö	0	Ö	33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	١	0		33.00
40. 00	04000 RADI OLOGY	O	0	O	0	0	40. 00
41. 00	04100 LABORATORY		0		0	1	41. 00
42. 00	04200 I NTRAVENOUS THERAPY		0	0	0	Ö	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0		44. 00
45. 00	04500 OCCUPATIONAL THERAPY		0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY		0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	48.00
49. 00	04900 DRUGS CHARGED TO PATTENTS		196, 864	0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		190, 604	0	0	0	50.00
51. 00	05100 SUPPORT SURFACES		0	0	0	0	51.00
31.00	OUTPATIENT SERVICE COST CENTERS	ı o	U	U	0	0	31.00
60. 00	06000 CLINIC	O	0	O	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0	0	0	1	61. 00
62. 00	06200 FQHC	٩	U	U	0	0	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00	07000 HOME HEALTH AGENCY COST	l ol	0	0	0	0	70. 00
71. 00	07100 AMBULANCE		0	o	0	-	71.00
73.00	07300 CMHC		0	0	0	0	73.00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		U U		0	73.00
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	0	0	
	1	-1	379, 091	0	59, 785		
89. 00	SUBTOTALS (sum of lines 1-84)	1, 071, 161	379, 091	l U	39, 783	353, 492	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	T ol	ما	0	^	0	90.00
		-1	0	- 1	0		
91.00	09100 BARBER AND BEAUTY SHOP	0	0	- 1	0		91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0	0	0	0	92. 00 93. 00
93.00	09400 PATIENTS LAUNDRY		0		0	0	93.00
98. 00			0		Ü		98.00
	Cross Foot Adjustments		0		^	0	98.00
99. 00 100. 00	Negative Cost Centers TOTAL	1, 071, 161	379, 091	0	59, 785		
100.00) IOTAL	1,0/1,101	3/7, 091	I 이	37, 783	303, 492	100.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315057

				Т	o 12/31/2023	Date/Time Pre 5/29/2024 9:0	
			OTHER GENERAL			3/24/2024 4.0	7 alli
			SERVI CE				
	Cost Center Description	NURSING AND	PATI ENT	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH EDUCATI ON	ACTI VI TI ES		Adjustments		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3. 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 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY						9. 00 10. 00
11. 00	01100 PHARMACY						11.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY						12. 00
13.00	01300 SOCIAL SERVICE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 PATIENT ACTIVITIES	0	755, 748				15. 00
30. 00	O3000 SKILLED NURSING FACILITY	0	755, 748	10, 582, 223	ol	10, 582, 223	30.00
31. 00	03100 NURSING FACILITY	0	755, 740			10, 302, 223	31.00
32. 00	03200 CF/IID	0	0		_	0	1
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	_	_				
40.00	04000 RADI OLOGY	0	0	, , , , , , , , , , , , , , , , , , , ,	-	9, 655	
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	46, 016 0		46, 016 0	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	Ö	-	0	1
44.00	04400 PHYSI CAL THERAPY	0	0	636, 889	o	636, 889	1
45.00	04500 OCCUPATI ONAL THERAPY	0	0	337, 219		337, 219	1
46. 00	04600 SPEECH PATHOLOGY	0	0	36, 172		36, 172	1
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	-	0	1
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	623, 621	_	623, 621	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			0	1
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	1	ام		l al		
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0			0	60. 00 61. 00
62. 00	06200 FOHC	0	U	0	, o	Ü	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0			0	1
73. 00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	73. 00
80 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
							81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0			0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	0	755, 748	12, 271, 795	0	12, 271, 795	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	O	0	ol	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	25, 959		25, 959	
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	o	0	_	0	1
93. 00	09300 NONPALD WORKERS	0	0	0	o o	0	
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0		0	
100.00		0	755, 748	12, 297, 754	0	12, 297, 754	1
	•	'			, -1		

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315057

				Τ	o 12/31/2023	Date/Time Prep 5/29/2024 9:00	oared:
			CAPI TAL REL	ATED COSTS		372772024 7.0	7 dili
	Cost Contor Description	Directly	DI DCC 0	MOVABLE	Subtotal	EMDL OVEE	
	Cost Center Description	Assigned New	BLDGS & FIXTURES	EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal					
		Related Costs				2.22	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	3. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	-		0	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	185, 808		,	0	4. 00
5. 00 6. 00	00600 LAUNDRY & LINEN SERVICE		28, 197 26, 036			0	5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG	o	13, 036				7. 00
8.00	00800 DI ETARY	0	84, 016	C	84, 016	0	8. 00
9.00	00900 NURSING ADMINISTRATION	0	0	C	0	0	9. 00
10.00		0	0		0	0	10.00
11. 00 12. 00			0		0	0	11. 00 12. 00
13. 00		0	3, 660		3, 660	-	13. 00
14.00		0	0	C		0	14. 00
15. 00		0	83, 197	(83, 197	0	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		/// 100		/// 100	0	20.00
30. 00 31. 00		0	666, 188 0			0	30. 00 31. 00
32. 00	1	0	0			Ö	32. 00
33. 00	1	0	0	C	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS			_	_		
40. 00 41. 00		0	0	_		-	40. 00 41. 00
41.00			0			0	41.00
43. 00		o	Ö		1	Ö	43. 00
44. 00		0	21, 331	C	21, 331	0	44. 00
45. 00		0	0	C	0	0	45. 00
46. 00 47. 00		0	0		0	0	46. 00 47. 00
48. 00		0	0		0	0	48. 00
49. 00		0	0	d	0	0	49. 00
50.00		0	0	C	0	0	50. 00
51. 00		0	0		0	0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0		0	0	60. 00
61. 00		0	0				61. 00
62.00							62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00		0	0				70.00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC		0				71. 00 73. 00
70.00	SPECIAL PURPOSE COST CENTERS	9			,	0	70.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00							81. 00
82. 00			0	,		0	82. 00
83. 00 89. 00		0	1, 111, 469			0	83. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	1, 111, 107		1, 111, 107	0	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			-	90. 00
91.00		0	4, 183	(4, 183		91.00
92. 00 93. 00			0		0	0	92. 00 93. 00
94.00			0) 0	0	93.00
98. 00			J		0		98. 00
99. 00	1 9		0	C	0	0	99. 00
100.00	0 TOTAL	0	1, 115, 652	(1, 115, 652	0	100. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315057

				T	0 12/31/2023	Date/Time Pre 5/29/2024 9:0	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7 CIII
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	4 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	6. 00	7.00	8.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	185, 808					4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	12, 179	40, 376	1			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	3, 198	1, 166				6.00
7.00	00700 HOUSEKEEPI NG	6, 946	584	1			7.00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	19, 477	3, 762	1			1
10. 00	01000 CENTRAL SERVICES & SUPPLY	16, 184 5, 728	0	1	0	0	1
11. 00	01100 PHARMACY	3, 720	0		0	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	903	0		0	0	12. 00
13. 00	01300 SOCIAL SERVICE	5, 261	164	Ö	87	ő	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1	0	Ō	1
15. 00	01500 PATIENT ACTIVITIES	9, 608	3, 726	0	1, 984	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS]
30. 00	03000 SKILLED NURSING FACILITY	83, 933	29, 832	30, 400	15, 883	109, 258	30. 00
31. 00	03100 NURSING FACILITY	0	0				1
32. 00	03200 CF/IID	0	0	1	_	_	
33. 00	03300 OTHER LONG TERM CARE] 0	0	0	0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	444			0		40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	146 695	0	1	_		
41.00	04200 I NTRAVENOUS THERAPY	095	0	1	0	0	1
43. 00	04300 OXYGEN (INHALATION) THERAPY		0	1	0	0	1
44. 00	04400 PHYSI CAL THERAPY	9, 159	955	1	509		1
45. 00	04500 OCCUPATI ONAL THERAPY	5, 095	0	1	0		1
46.00	04600 SPEECH PATHOLOGY	547	O	o o	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	6, 448	0	0	0	0	
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1	0	0	
51. 00	05100 SUPPORT SURFACES] 0	0	0	0	0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC		0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC		0				
62. 00	06200 FQHC		O		0		62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	C	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	O	0	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS			_			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF				0		82.00
83. 00	08300 HOSPI CE	105 507	40. 100		0	100.250	1
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	185, 507	40, 189	30, 400	20, 466	109, 258	89. 00
90. 00		O	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	301	187		_		1
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0		1
93. 00	09300 NONPALD WORKERS		0	Ö	Ō	Ō	1
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	1
98. 00	Cross Foot Adjustments			0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	
100.00	TOTAL	185, 808	40, 376	30, 400	20, 566	109, 258	100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315057

				T	o 12/31/2023	Date/Time Pre 5/29/2024 9:0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	, diii
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
	T	9. 00	10. 00	11. 00	12. 00	13.00	
4 00	GENERAL SERVICE COST CENTERS					I	1 4 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						6.00
7. 00 8. 00	00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	16, 184					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	10, 104	5, 728				10.00
11. 00	01100 PHARMACY		3, 720	0		•	11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0		903		12.00
13. 00	01300 SOCIAL SERVICE		0	Ŏ	0		13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		0	ő	0	1	14. 00
15. 00	01500 PATIENT ACTIVITIES		0				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-		-		
30.00	03000 SKILLED NURSING FACILITY	16, 184	2, 754	0	903	9, 172	30.00
31.00	03100 NURSING FACILITY	o	0	0	0	0	31. 00
32.00	03200 CF/IID	O	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	o	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0				40. 00
41. 00	04100 LABORATORY	0	0	_	0		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44.00
45. 00	04500 OCCUPATIONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0		0	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS		2, 974		0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY		2, 7,4		0		50.00
51. 00	05100 SUPPORT SURFACES		0				51. 00
	OUTPATIENT SERVICE COST CENTERS	-1		_			
60.00	06000 CLI NI C	0	0	0	0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	T		ı		T	
70. 00	07000 HOME HEALTH AGENCY COST	0	0				70.00
71.00	07100 AMBULANCE	0	0				71.00
73. 00	07300 CMHC] 0	0	0	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES					I	80. 00
81. 00	08100 INTEREST EXPENSE						81. 00
	1 1						82. 00
	08300 HOSPI CE		0	0	0	0	•
89. 00	SUBTOTALS (sum of lines 1-84)	16, 184	5, 728			_	
	NONREI MBURSABLE COST CENTERS	,,	2, . 20		, , ,	,.,,	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	0	0	_	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00	Cross Foot Adjustments	0	0	0			98. 00
99. 00	Negative Cost Centers	0	0	0			
100.00	TOTAL	16, 184	5, 728	0	903	9, 172	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315057

				1	To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
			OTHER GENERAL			372772024 7.0	7 dili
			SERVI CE				
	Cost Center Description	NURSI NG AND	PATI ENT	Subtotal	Post Step-Down	Total	
		ALLI ED HEALTH	ACTI VI TI ES		Adjustments		
		EDUCATI ON					
		14.00	15. 00	16.00	17.00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						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	98, 515				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	98, 515	1		1, 063, 022	30. 00
31. 00	03100 NURSING FACILITY	0	0			0	31. 00
32. 00	03200 CF/IID	0	0			0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	(0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	_	-	1			
40.00	04000 RADI OLOGY	0	0			146	
41. 00	04100 LABORATORY	0	0	695		695	
42.00	04200 I NTRAVENOUS THERAPY	0	0		-	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	04.05	-	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	31, 954		31, 954	1
45. 00	04500 OCCUPATIONAL THERAPY	0	0	5, 095		5, 095	ı
46. 00	04600 SPEECH PATHOLOGY	0	0	547		547	46.00
47. 00	04700 ELECTROCARDI OLOGY	0	0			0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9, 422	-	0 422	48. 00
50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0	1		9, 422 0	49. 00 50. 00
51.00	05100 SUPPORT SURFACES	0				0	1
31.00	OUTPATIENT SERVICE COST CENTERS			1	<u>) </u>	U	31.00
60. 00	06000 CLINIC	0	0		0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	1			0	61.00
62. 00	06200 FQHC		0	1		0	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
71. 00	07100 AMBULANCE	0	Ö			0	71. 00
	07300 CMHC	0	0			0	1
70.00	SPECIAL PURPOSE COST CENTERS			1	,		70.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 NTEREST EXPENSE						81. 00
	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 H0SPI CE	0	0	l (0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	98, 515	1, 110, 881			89. 00
	NONREI MBURSABLE COST CENTERS				<u>'</u>		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	4, 771	0	4, 771	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	(0	0	
94.00	09400 PATIENTS LAUNDRY	0	0	(0	0	
98. 00	Cross Foot Adjustments	0	0) c	0	0	
99. 00	Negative Cost Centers	0	0	(0	0	
100.00	TOTAL	0	98, 515	1, 115, 652	2 0	1, 115, 652	100. 00

Hoal th	Financial Systems	MERRY HEART	SUCCASUNNA		In lie	eu of Form CMS-:	2540-10
	ALLOCATION - STATISTICAL BASIS	WERRY HEART		No.: 315057	Peri od:	Worksheet B-1	
0001 7	ELEGOTII SIL BIOLO		110VI del	110 010007	From 01/01/2023 To 12/31/2023		
		CARLTAL BEI	ATED COCTO			5/29/2024 9:0	9 am
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FIXTURES	EQUI PMENT	BENEFITS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
				SALARI ES)			
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3.00	4A	4. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES	64, 018					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	04,010					2. 00
3. 00	00300 EMPLOYEE BENEFITS	0		6, 424, 4	15		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	10, 662	l c	488, 5		10, 116, 916	1
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 618	0	209, 1			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 494	O	98, 7	62 0	174, 113	6. 00
7.00	00700 HOUSEKEEPI NG	748	0	236, 2	36 0	378, 174	7. 00
8.00	00800 DI ETARY	4, 821	0	1,			1
9. 00	00900 NURSI NG ADMI NI STRATI ON	0	0	,, 0		881, 205	1
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	30, 4	98 0	311, 864	1
11.00	01100 PHARMACY	0		11 1	14	0	
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	210		41, 4 238, 1		49, 183 286, 468	1
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	210		1	0 0		1
15. 00	01500 PATIENT ACTIVITIES	4,774		1			1
	INPATIENT ROUTINE SERVICE COST CENTERS	.,,,,		000,0	52	020/10/	1
30.00	03000 SKILLED NURSING FACILITY	38, 227	C	3, 035, 9	45 0	4, 570, 066	30.00
31.00	03100 NURSING FACILITY	0	0)	0 0	0	31.00
32. 00	03200 I CF/I I D	0	0	1	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	Ι ο				7.042	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0	1	0 0		1
42.00	04200 I NTRAVENOUS THERAPY	0			0 0		1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0			0 0	0	1
44. 00	04400 PHYSI CAL THERAPY	1, 224		306, 9	36 0	498, 669	1
45.00	04500 OCCUPATI ONAL THERAPY	0	0	162, 1	0 80	277, 418	1
46.00	04600 SPEECH PATHOLOGY	0	0)	0 0	29, 757	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0	0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0		1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0		
51. 00	O5100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	0	51.00
60. 00	06000 CLINIC	0	0		0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC			1	0 0		
62. 00	06200 FQHC					Ĭ	62. 00
	OTHER REIMBURSABLE COST CENTERS			1			1
70.00	07000 HOME HEALTH AGENCY COST	0	C)	0 0	0	70. 00
71. 00	07100 AMBULANCE	0	0)	0	0	71. 00
73. 00	07300 CMHC	0	0		0 0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS			1		I	
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF	-					81. 00 82. 00
82. 00 83. 00	+ I					0	1
89. 00	SUBTOTALS (sum of lines 1-84)	63, 778	-	1	15 -2, 180, 838		1
57.00	NONREI MBURSABLE COST CENTERS	. 33,770		0, 727, 4	2, 100, 000	10, 100, 317	1 57.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	О		0 0	0	90.00
04 00	DOMOG DARRED AND DEALTY CHOR	1 040	1 .	.1		1 44 000	1 04 00

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1, 115, 652

17. 427161

16, 399

0

2, 180, 838 102. 00

0. 215564 103. 00 185, 808 104. 00

0. 018366 105. 00

0

0

1, 204, 848

0. 187542

0.000000

91.00

92.00

93.00 0

94.00

98.00

99.00

91.00 09100 BARBER AND BEAUTY SHOP

09300 NONPALD WORKERS

Part I)

Part II)

11)

09400 PATIENTS LAUNDRY

93.00

94. 00

98.00 99.00

102.00

103.00

104.00

105.00

92.00 09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments Negative Cost Centers

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315057 Period:

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/29/2024 9:09 am Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG OPERATI ON, LINEN SERVICE (SQUARE FEET) (MEALS SERVED) ADMINISTRATION MAINT. & (PATIENT DAYS) REPAI RS (DI RECT (SQUARE FEET) NURSI NG) 7. 00 5.00 6.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 51, 738 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 1, 494 32, 456 6.00 7.00 00700 HOUSEKEEPI NG 748 49, 496 7.00 8.00 00800 DI ETARY 4,821 4,821 97, 368 8.00 00900 NURSING ADMINISTRATION 130, 209 9 00 0 C 0 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 0 0 0 0 10.00 01100 PHARMACY 0 0 0 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 C 0 12.00 0 01300 SOCIAL SERVICE 0 13 00 210 Ω 210 13 00 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C C 0 0 14.00 01500 PATIENT ACTIVITIES 15.00 4,774 4,774 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 38, 227 32, 456 38, 227 97, 368 130, 209 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 0 32.00 0 0 03300 OTHER LONG TERM CARE 33.00 0 Ω 0 0 33 00 Ω ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40.00 C 0 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 43.00 04400 PHYSI CAL THERAPY 0 0 44.00 1, 224 1, 224 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 45.00 C 0 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 0 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 r 0 0 50.00 51.00 05100 SUPPORT SURFACES 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 61.00 0 C 0 Ω 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω \cap 0 Λ 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83 00 Λ 83 00 89.00 SUBTOTALS (sum of lines 1-84) 51, 498 32, 456 49, 256 97, 368 130, 209 89.00 NONREIMBURSABLE COST CENTERS 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 C 91.00 09100 BARBER AND BEAUTY SHOP 240 C 240 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 C 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 93.00 94 00 09400 PATIENTS LAUNDRY 0 O ol 94 00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 806, 051 471, 348 1, 410, 095 1, 071, 161 102. 00 102.00 234, 921 Part I) 8. 226474 103. 00 103 00 Unit cost multiplier (Wkst. B, Part I) 15 579477 9 522951 7. 238138 14. 482119 104.00 Cost to be allocated (per Wkst. B, 109, 258 16, 184 104. 00 40, 376 30, 400 20, 566 105.00 Unit cost multiplier (Wkst. B, Part 0.780394 0.936653 0.415508 1.122114 0. 124292 105. 00 11)

Heal th	Financial Systems	MERRY HEART S	UCCASUNNA		In Lie	u of Form CMS-	2540-10
COST A	ILLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Pre 5/29/2024 9:0	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
	OFNEDAL CEDIUSE COCT CENTERS	10.00	11. 00	12.00	13. 00	14. 00	
1. 00 2. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION						3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY	676, 051					10.00
11. 00	01100 PHARMACY	0	0				11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	32, 45			12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1	0 32, 456 0 0	0	13.00
	01500 PATIENT ACTIVITIES	0	0		0 0		1
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		'	0 0		13.00
30.00	03000 SKILLED NURSING FACILITY	324, 974	0	32, 45	6 32, 456	0	30.00
31.00	03100 NURSING FACILITY	0	0)	0 0	0	31.00
32. 00	03200 CF/IID	0	0	1	0	0	0 - 1 - 0 - 0
33. 00	03300 OTHER LONG TERM CARE	0	0	1	0 0	0	33. 00
40. 00	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY	O	0	ı	0 0	0	40. 00
41. 00	04100 LABORATORY		0	1	0 0	0	
	04200 I NTRAVENOUS THERAPY	0	0	1	o o	Ö	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0)	0 0	0	43. 00
	04400 PHYSI CAL THERAPY	0	0)	0	0	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	1	0	0	
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0		0	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	351, 077	0		o o	Ö	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0)	0 0	0	50. 00
51.00	05100 SUPPORT SURFACES	0	0)	0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS			1			
60. 00 61. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C	0	0		0 0		
62. 00	06200 FQHC		0	'	0	0	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	l .	0		
73. 00	07300 CMHC	0	0		0 0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			1			80. 00
81. 00	08100 INTEREST EXPENSE			•			81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83.00	08300 H0SPI CE	O	0	l .	0 0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	676, 051	0	32, 45	6 32, 456	0	89. 00
00.00	NONREI MBURSABLE COST CENTERS						00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	1	0 0	0 0	
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0	1	0	0	
93. 00	09300 NONPALD WORKERS	o	0	,	o o	Ō	
94.00	09400 PATIENTS LAUNDRY	0	0	1	0 0	0	
98. 00	Cross Foot Adjustments						98. 00
99.00	Negative Cost Centers	270 001	0	F0 70	252 402		99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	379, 091	U	59, 78	5 353, 492	0	102. 00
103.00	1 1 1	0. 560743	0. 000000	1. 84203	2 10. 891422	0. 000000	103. 00
104.00		5, 728	0	90			104. 00
	Part II)						
105.00	1 1	0. 008473	0. 000000	0. 02782	2 0. 282598	0. 000000	105. 00
	11)	I I		I		I	I

MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315057

			0 12/31/2023	Date/Time Prepared: 5/29/2024 9:09 am
		OTHER GENERAL		
		SERVI CE		
	Cost Center Description	PATI ENT		
		ACTI VI TI ES		
		(PATIENT DAYS) 15.00		
	GENERAL SERVICE COST CENTERS	15.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			6.00
7.00	00700 HOUSEKEEPI NG			7.00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON			8. 00 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			14. 00
15.00	01500 PATIENT ACTIVITIES	32, 456		15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 1		
30.00	03000 SKILLED NURSING FACILITY	32, 456		30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0		31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0		33.00
33. 00	ANCILLARY SERVICE COST CENTERS	<u> </u>		33.00
40.00		0		40. 00
41.00	04100 LABORATORY	0		41.00
42.00	04200 I NTRAVENOUS THERAPY	0		42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0		43. 00
44. 00	04400 PHYSI CAL THERAPY	0		44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0		45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	o		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51.00	05100 SUPPORT SURFACES	0		51.00
	OUTPATIENT SERVICE COST CENTERS			(0.00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0		60.00
62. 00	06200 FOHC	U		62.00
02.00	OTHER REIMBURSABLE COST CENTERS			02.00
70.00		0		70.00
71.00	07100 AMBULANCE	0		71. 00
73.00	07300 CMHC	0		73. 00
00.00	SPECIAL PURPOSE COST CENTERS			00.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE			80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF			82.00
83. 00	08300 HOSPI CE	0		83. 00
89.00	SUBTOTALS (sum of lines 1-84)	32, 456		89. 00
	NONREI MBURSABLE COST CENTERS			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0		91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0		92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY			93. 00 94. 00
98.00	Cross Foot Adjustments			98.00
99. 00	Negative Cost Centers			99. 00
102.00		755, 748		102. 00
	Part I)			
103.00		23. 285309		103. 00
104.00		98, 515		104. 00
105. 00	Part II) Unit cost multiplier (Wkst. B, Part	3. 035340		105. 00
100.00		3. 033340		103.00
		1		ı

Health Financial Systems	MERRY HEART SUCCA	ASUNNA		In Lie	eu of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY A	AND OUTPATIENT COST CENTERS	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet C Date/Time Prep 5/29/2024 9:09	
Cost Center Description			Total (from Wkst. B, Pt I col. 18) 1.00	Total Charges		
ANCILLARY SERVICE COST CENTERS						

Total (from Wist. B, Pt I col . 18)					5/29/2024 9:0	7 am
Col. 18 Col. 2	Cost Center Description		Total (from	Total Charges	Ratio (col. 1	
ANCI LLARY SERVICE COST CENTERS		N	Wkst. B, Pt I,		di vi ded by	
ANCILLARY SERVICE COST CENTERS 9, 655 11, 577 0. 833981 40. 00			col . 18)		col. 2	
40. 00 04000 RADI OLOGY 9,655 11,577 0.833981 40. 00 41. 00 04100 LABORATORY 46,016 20,375 2.258454 41. 00 42. 00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42. 00 43. 00 04300 OXYGEN (INHALATION) THERAPY 0 2,791 0.000000 43. 00 44. 00 04400 PHYSI CAL THERAPY 636, 889 483, 479 1.317304 44. 00 45. 00 04500 OCCUPATI ONAL THERAPY 337, 219 458, 842 0.734935 45. 00 46. 00 04600 SPEECH PATHOLOGY 36, 172 66, 225 0. 546199 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0.000000 47. 00 49. 00 04900 DRUGS CHARGED TO PATI ENTS 623, 621 177, 558 3.512210 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0.000000 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 0.000000 51. 00			1. 00	2. 00	3. 00	
41. 00	ANCILLARY SERVICE COST CENTERS					
42. 00 04200 INTRAVENOUS THERAPY 0 0 0. 000000 42. 00 43. 00 04300 0XYGEN (INHALATION) THERAPY 0 2, 791 0. 000000 43. 00 44. 00 04400 PHYSI CAL THERAPY 636, 889 483, 479 1. 317304 44. 00 45. 00 04500 0CCUPATI ONAL THERAPY 337, 219 458, 842 0. 734935 45. 00 04500 050	40. 00 04000 RADI OLOGY		9, 655	11, 577	0. 833981	40.00
43. 00 04300 0XYGEN (INHALATION) THERAPY 0.000000 43. 00 44. 00 04400 PHYSI CAL THERAPY 0.317304 44. 00 45. 00 04500 0CCUPATIONAL THERAPY 0.734935 45. 00 04500 0CCUPATIONAL THERAPY 0.734935 45. 00 04600 SPEECH PATHOLOGY 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	41. 00 04100 LABORATORY		46, 016	20, 375	2. 258454	41.00
44. 00 04400 PHYSI CAL THERAPY 1. 317304 44. 00 45. 00 04500 0CCUPATI ONAL THERAPY 337, 219 458, 842 0. 734935 45. 00 04600 SPEECH PATHOLOGY 36, 172 66, 225 0. 546199 46. 00 04700 ELECTROCARDI OLOGY 0 0 0. 000000 47. 00 04700 ELECTROCARDI OLOGY 0 0 0. 000000 48. 00 04900 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 623, 621 177, 558 3. 512210 49. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0. 000000 50. 00 05100 SUPPORT SURFACES 0 0 0. 000000 51. 00 000000 51. 00 000000 000000 000000 0000000	42. 00 04200 I NTRAVENOUS THERAPY		C	0	0.000000	42.00
45. 00	43.00 04300 OXYGEN (INHALATION) THERAPY		C	2, 791	0.000000	43.00
46. 00	44. 00 04400 PHYSI CAL THERAPY		636, 889	483, 479	1. 317304	44.00
47. 00 04700 CALTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	45. 00 04500 OCCUPATI ONAL THERAPY		337, 219	458, 842	0. 734935	45.00
48. 00	46. 00 04600 SPEECH PATHOLOGY		36, 172	66, 225	0. 546199	46.00
49. 00 04900 DRUGS CHARGED TO PATIENTS 623, 621 177, 558 3. 512210 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0. 0000000 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 0. 0000000 51. 00 OUTPATIENT SERVICE COST CENTERS 60. 00 06100 RURAL HEALTH CLINIC 62. 00 62. 00 06200 FOHC 62. 00 71. 00 07100 AMBULANCE 0 0 0 0. 000000 71. 00	47. 00 04700 ELECTROCARDI OLOGY		C	0	0.000000	47.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0.000000 50. 00 51. 00 05100 SUPPORT SURFACES 0 0.000000 51. 00 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 60. 00 61. 00 06100 RURAL HEALTH CLINIC 61. 00 62. 00 06200 FQHC 62. 00 71. 00 07100 AMBULANCE 0 0.000000 71. 00	48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		C	0	0.000000	48.00
51. 00 05100 SUPPORT SURFACES 0 0.000000 51. 00 0UTPATI ENT SERVI CE COST CENTERS 0 0 0.000000 60.00 61. 00 06100 RURAL HEALTH CLINIC 61. 00 61. 00 62. 00 06200 FQHC 62. 00 71. 00 07100 AMBULANCE 0 0.000000 71. 00	49.00 04900 DRUGS CHARGED TO PATIENTS		623, 621	177, 558	3. 512210	49.00
OUTPATIENT SERVICE COST CENTERS	50.00 05000 DENTAL CARE - TITLE XIX ONLY		C	0	0.000000	50.00
60. 00 06000 CLI NI C 0 0.000000 60. 00 61. 00 61. 00 62. 00 62. 00 71. 00 07100 AMBULANCE 0 0 0.000000 71. 00 71	51.00 05100 SUPPORT SURFACES		C	0	0.000000	51.00
61. 00 06100 RURAL HEALTH CLINIC 61. 00 62. 00 71. 00 07100 AMBULANCE 0 0. 000000 71. 00	OUTPATIENT SERVICE COST CENTERS					
62. 00 06200 FQHC 62. 00 71. 00 07100 AMBULANCE 0 0 0. 000000 71. 00	60. 00 06000 CLI NI C		C	0	0.000000	60.00
71. 00 07100 AMBULANCE 0 0 0. 000000 71. 00	61.00 06100 RURAL HEALTH CLINIC					61.00
	62. 00 06200 FQHC					62.00
100. 00 Total 1, 689, 572 1, 220, 847 100. 00	71. 00 07100 AMBULANCE		C	0	0.000000	71.00
	100. 00 Total		1, 689, 572	1, 220, 847		100. 00

Health Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	eu of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
		Title	XVIII (1)	Skilled Nursing		77 alli
		11 11 0	XVIII (1)	Facility	113	
		Heal th Care Pr	rogram Charges		Program Cost	
			3 3		J	
	Ratio of Cost	Part A	Part B		Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
DART I CALCULATION OF ANOLITARY AND OUTDAY	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	ITENI COST					-
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY	0.022001	11 577	<u> </u>	0 0 455		40.00
40. 00 04000 RADI 0LOGY 41. 00 04100 LABORATORY	0. 833981 2. 258454			0 9, 655	•	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0 46, 016	0	
43. 00 04200 TNTRAVENOUS THERAPY 43. 00 04300 0XYGEN (INHALATION) THERAPY	0. 000000			0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 317304			0 609, 187	0	1
45. 00 04500 OCCUPATI ONAL THERAPY	0. 734935			0 329, 003	0	1
46. 00 04600 SPEECH PATHOLOGY	0. 734433			0 30, 082	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 30,002	0	1
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	l .			0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	3. 512210	l .		0 623, 621	0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			020,021	Ŭ	50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	l		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>		1 00
60. 00 06000 CLINIC	0.000000	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, 177, 489		0 1, 647, 564	0	100.00
(1) For title Ward VIV was religions 1 2 and 4 and						

⁽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.

	Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	u of Form CMS-2	2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315057	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/29/2024 9:0	
	Title XVIII Skilled Nursing Facility						
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	3. 512210	1.00
2.00	Program vaccine charges (From your reco					0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health (From Wkst. B,		Cost (From	& Allied Health Costs	
		18		Costs to Tota		for Pass	
		10		Costs to Tota		Through (Col.	
			17)	(Col. 2 / Col		3 x Col . 4)	
				1)		,	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	9, 655	l e				
41.00	04100 LABORATORY	46, 016	0	0.00000			41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0	0. 00000 0. 00000		0	
44. 00	04400 PHYSI CAL THERAPY	636, 889		0.00000		0	
45. 00	04500 OCCUPATI ONAL THERAPY	337, 219		0.00000		0	
	04600 SPEECH PATHOLOGY	36, 172	l e	0. 00000		0	
	04700 ELECTROCARDI OLOGY	00,172		0. 00000		Ö	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l o	0.00000		0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	623, 621	0	0. 00000	623, 621	0	49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000		0	
	05100 SUPPORT SURFACES	0	0	0.00000		0	
100.00	Total (Sum of lines 40 - 52)	1, 689, 572	0		1, 647, 564	0	100. 00

leal th	Financial Systems MERRY HEART SUCC	ASUNNA	In Lie	u of Form CMS-2	2540-10	
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315057	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prep 5/29/2024 9:09	pared:	
		Title XVIII	Skilled Nursing Facility	PPS		
				1. 00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00		
	I NPATI ENT DAYS				İ	
1.00	Inpatient days including private room days			32, 456	1.00	
2. 00	Private room days			0	2. 00	
3. 00	Inpatient days including private room days applicable to the Pr			5, 550	3.00	
4. 00	Medically necessary private room days applicable to the Program	1		0	4. 00	
5. 00	Total general inpatient routine service cost			10, 582, 223	5. 00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			12 041 004	, ,,,	
6. 00 7. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 di	vided by Line 4)		12, 841, 884 0. 824040	6. 00 7. 00	
7. 00 B. 00	Enter private room charges from your records	vided by Title 6)		0. 824040	8.00	
9. 00	Average private room per diem charge (Private room charges line	0.00				
7. 00	2)					
10. 00	Enter semi-private room charges from your records	0	10.00			
11. 00	Average semi-private room per diem charge (Semi-private room c	0.00				
	semi -pri vate room days)					
12. 00	Average per diem private room charge differential (Line 9 minus	0.00	12.00			
13. 00	Average per diem private room cost differential (Line 7 times I	0. 00	13.00			
14. 00	Private room cost differential adjustment (Line 2 times line 13			0	14. 00	
15. 00	General inpatient routine service cost net of private room cost	differential (Line 5	minus line 14)	10, 582, 223	15. 00	
16. 00	PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divi	dod by Line 1)		326. 05	l 16. 00	
16.00	Program routine service cost (Line 3 times line 16)	ded by line i)		326. 05 1, 809, 578		
18.00	Medically necessary private room cost applicable to program (I	ine / times line 13)		1, 609, 376	18.00	
19. 00	Total program general inpatient routine service cost (Line 17			1, 809, 578		
20. 00	Capital related cost allocated to inpatient routine service cos		t II column 18.	1, 063, 022	1	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			.,,		
21. 00	Per diem capital related costs (Line 20 divided by line 1)			32. 75	21.00	
22. 00	Program capital related cost (Line 3 times line 21)			181, 763		
23. 00	Inpatient routine service cost (Line 19 minus line 22)			1, 627, 815		
24. 00	Aggregate charges to beneficiaries for excess costs (From prov			0	24. 00	
25. 00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	1, 627, 815		
26. 00	Enter the per diem limitation (1)		0() (4)		26.00	
27. 00	Inpatient routine service cost limitation (Line 3 times the per				27. 00	
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)	: resser of time 25 or	11110 21)		28. 00	
(1) :	nes 26 and 27 are not applicable for title XVIII, but may be use	ad for title V and or t	itla VIV		I	
() LI	100 20 and 27 are not approcable for title Aviii, but may be use		THE AIA			
				1. 00		
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS			1. 00		

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	32, 456	1.00
2.00	Program inpatient days (see instructions)	5, 550	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. 171001	4. 00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	MERRY HEART SUCC	ASUNNA	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII	Provi der No.: 315057	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/29/2024 9:09 am
		Title XVIII	Skilled Nursing	PPS

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1.00 Inpatient PPS amount (See Instructions) 2.00 Nursing and Allied Health Education Activities (pass through payments) 3.00 Subtotal (Sum of lines 1 and 2) 4.00 Primary payor amounts 5.00 Coinsurance 6.00 Allowable bad debts (From your records) 7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8.00 Adjusted reimbursable bad debts. (See instructions) 9.00 Recovery of bad debts - for statistical records only	0 2.00 280 3.00 0 4.00 5.00 433 6.00 0 7.00 031 8.00 0 9.00 0 10.00 211 11.00
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1. 00 Inpatient PPS amount (See Instructions) 2. 00 Nursing and Allied Health Education Activities (pass through payments) 3. 00 Subtotal (Sum of lines 1 and 2) 4. 00 Primary payor amounts 5. 00 Coinsurance 6. 00 Allowable bad debts (From your records) 7. 00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8. 00 Adjusted reimbursable bad debts. (See instructions) 62,	0 2.00 280 3.00 0 4.00 400 5.00 433 6.00 0 7.00 031 8.00 0 9.00 0 10.00 277 12.00
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1. 00 Inpatient PPS amount (See Instructions) 2. 00 Nursing and Allied Health Education Activities (pass through payments) 3. 00 Subtotal (Sum of lines 1 and 2) 4. 00 Primary payor amounts 5. 00 Coinsurance 6. 00 Allowable bad debts (From your records) 7. 00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8. 00 Adjusted reimbursable bad debts. (See instructions) 62,	0 2.00 280 3.00 0 4.00 400 5.00 433 6.00 0 7.00 031 8.00 0 9.00 0 10.00 277 12.00
1.00 Inpatient PPS amount (See Instructions) 2.00 Nursing and Allied Health Education Activities (pass through payments) 3.00 Subtotal (Sum of lines 1 and 2) 4.00 Primary payor amounts 5.00 Coinsurance 6.00 Allowable bad debts (From your records) 7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8.00 Adjusted reimbursable bad debts. (See instructions) 3, 646, 9, 346, 9, 466, 9, 466, 9, 476, 9, 487, 9, 487, 9, 487, 9, 487, 9, 487, 9, 9, 9, 9, 9, 9, 9, 9, 9, 9, 9, 9, 9, 9	0 2.00 280 3.00 0 4.00 400 5.00 433 6.00 0 7.00 031 8.00 0 9.00 0 10.00 277 12.00
2.00 Nursing and Allied Health Education Activities (pass through payments) 3.00 Subtotal (Sum of lines 1 and 2) 4.00 Primary payor amounts 5.00 Coinsurance 6.00 Allowable bad debts (From your records) 7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8.00 Adjusted reimbursable bad debts. (See instructions) 62,	0 2.00 280 3.00 0 4.00 400 5.00 433 6.00 0 7.00 031 8.00 0 9.00 0 10.00 271 11.00
3.00 Subtotal (Sum of lines 1 and 2) 4.00 Primary payor amounts 5.00 Coinsurance 6.00 Allowable bad debts (From your records) 7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8.00 Adjusted reimbursable bad debts. (See instructions) 62,	0 4.00 400 5.00 433 6.00 0 7.00 031 8.00 0 9.00 0 10.00 011 11.00 077 12.00
4.00 Primary payor amounts 5.00 Coinsurance 6.00 Allowable bad debts (From your records) 7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8.00 Adjusted reimbursable bad debts. (See instructions) 62,	0 4.00 400 5.00 433 6.00 0 7.00 031 8.00 0 9.00 0 10.00 011 11.00 077 12.00
5.00 Coinsurance 337, 6.00 Allowable bad debts (From your records) 95, 7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 62, 8.00 Adjusted reimbursable bad debts. (See instructions) 62,	433 6.00 0 7.00 031 8.00 0 9.00 0 10.00 911 11.00 977 12.00
7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8.00 Adjusted reimbursable bad debts. (See instructions) 62,	0 7.00 031 8.00 0 9.00 0 10.00 911 11.00 977 12.00
7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 8.00 Adjusted reimbursable bad debts. (See instructions) 62,	0 7.00 031 8.00 0 9.00 0 10.00 911 11.00 977 12.00
8.00 Adjusted reimbursable bad debts. (See instructions) 62,	0 9.00 0 10.00 911 11.00 977 12.00
	0 9.00 0 10.00 911 11.00 977 12.00
	911 11.00 977 12.00
10.00 Utilization review	911 11.00 977 12.00
11.00 Subtotal (See instructions) 3,370,	777 12.00
12.00 Interim payments (See instructions) 3,308,	0 13.00
13.00 Tentative adjustment	
14.00 OTHER adjustment (See instructions)	0 14.00
14.50 Demonstration payment adjustment amount before sequestration	0 14.50
14.55 Demonstration payment adjustment amount after sequestration	0 14.55
	241 14. 75
14.99 Sequestration amount (see instructions) 66,	178 14. 99
15.00 Balance due provider/program (see Instructions) -5,	185 15.00
16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0 16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY	
17.00 Ancillary services Part B	0 17.00
18.00 Vaccine cost (From Wkst D, Part II, line 3)	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 Cost of covered services (Lesser of line 19 or line 20)	0 21.00
22.00 Primary payor amounts	0 22.00
23.00 Coinsurance and deductibles	0 23.00
24.00 Allowable bad debts (From your records)	0 24.00
24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions)	0 24. 01
24.02 Adjusted reimbursable bad debts (see instructions)	0 24. 02
25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	0 25.00
26.00 Interim payments (See instructions)	0 26.00
27.00 Tentative adjustment	0 27.00
28.00 Other Adjustments (See instructions) Specify	0 28. 00
28.50 Demonstration payment adjustment amount before sequestration	0 28. 50
28.55 Demonstration payment adjustment amount after sequestration	0 28. 55
28.99 Sequestration amount (see instructions)	0 28. 99
29.00 Balance due provider/program (see instructions)	0 29.00
30.00 Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0 30.00

Provi der No.: 315057 Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 9:09 am Title XVIII Skilled Nursing PPS

		11 (1)	e Aviii	Facility	FF3	
		Inpatien	t Part A		t B	
		·				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 322, 881		0	
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	enter zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			o		o o	
3. 03			0		0	3. 03
3. 04			0		0	1
3.05			0		0	3. 05
	Provider to Program				•	
3.50	ADJUSTMENTS TO PROGRAM	06/21/2023	13, 904		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	
3.54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-13, 904		0	3. 99
	- 3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 308, 977		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		o o	
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)		_		_	
6. 01	PROGRAM TO PROVIDER		0		0	6. 01
6. 02	PROVI DER TO PROGRAM		5, 485		0	
7. 00	Total Medicare program liability (see instructions)		3, 303, 492 Contract	or Nama	Contractor	7. 00
			Contract	or maile	Number	
			1. (20	2. 00	
8. 00	Name of Contractor		1.		2.00	8. 00
3.00	1				ı	. 5. 55

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

In Lieu of Form CMS-2540-10 MERRY HEART SUCCASUNNA Provi der No.: 315057

Health Financial Systems

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

| Peri od: | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 9:09 am

oni y)		Canaral Fund	Consi fi o	-ndowmon+ Fund	5/29/2024 9:0	9 am
		General Fund	Purpose Fund	Endowment Fund	Plant Fund	
	Assets	1. 00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	1, 586, 447	0	0	0	
2.00	Temporary investments	0	0	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	834, 872	0	0	0	
4. 00 5. 00	Other receivables	034, 072	0	0	0	
6. 00	Less: allowances for uncollectible notes and accounts	0	0	o	0	
	recei vabl e				_	
7. 00	Inventory	0	0	0	0	
8.00	Prepaid expenses	15, 096	0	0	0	
9. 00 10. 00	Other current assets Due from other funds	2, 972, 636	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	5, 409, 051	0	0	0	
11.00	FIXED ASSETS	3, 407, 031	<u> </u>	<u> </u>		1 ''' 6
12. 00	Land	0	0	0	0	12.0
13. 00	Land improvements	0	0	0	0	13.0
14. 00	Less: Accumulated depreciation	0	0	0	0	
15.00	Buildings	0	0	0	0	
16. 00 17. 00	Less Accumulated depreciation Leasehold improvements	0	0	O O	0	
18.00	Less: Accumulated Amortization		0	0	0	
19. 00	Fi xed equipment	0	0	0	0	
20. 00	Less: Accumulated depreciation	0	0	0	0	
21. 00	Automobiles and trucks	0	0	0	0	21.0
22. 00	Less: Accumulated depreciation	0	0	0	0	1
23. 00	Major movable equipment	3, 909, 059	0	0	0	
24. 00	Less: Accumulated depreciation	-1, 865, 796	0	0	0	1
25. 00 26. 00	Minor equipment - Depreciable Minor equipment nondepreciable	0	0	O O	0	
27. 00	Other fixed assets	0	0	0	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	2, 043, 263	ő	0	0	
	OTHER ASSETS		·	-		
29. 00	Investments	0	0	0	0	29.0
30. 00	Deposits on Leases	0	0	0	0	
31. 00	Due from owners/officers	0	0	0	0	
32. 00 33. 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	0	0	0	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	7, 452, 314	0	0	0	
	Liabilities and Fund Balances	., ., ., .,	-			1
	CURRENT LIABILITIES	_				
35. 00	Accounts payable	112, 438		0	0	
36.00	Salaries, wages, and fees payable	625, 749	0	0	0	1
37. 00 38. 00	Payroll taxes payable Notes & Loans payable (Short term)	207, 006	0	0	0	
39. 00	Deferred income	127, 271	0	0	0	
40. 00	Accel erated payments	0		Ĭ	· ·	40.0
41. 00	Due to other funds	0	0	0	0	41.0
42. 00	Other current liabilities	0	0	0	0	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 072, 464	0	0	0	43.0
44.00	LONG TERM LIABILITIES				0	1440
44. 00 45. 00	Mortgage payable Notes payable	0	0	0	0	1
46. 00	Unsecured Loans	0	0	0	0	
47. 00	Loans from owners:	0	ő	0	0	
48. 00	Other long term liabilities	0	0	0	0	
49. 00	OTHER (SPECIFY)	0	0	0	0	49.0
50. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	1, 072, 464	0	0	0	51.0
52. 00	CAPITAL ACCOUNTS General fund balance	6, 379, 850		T		52. C
52.00	Specific purpose fund	0,379,000	0			53.0
54. 00	Donor created - endowment fund balance - restricted			o		54.0
55. 00	Donor created - endowment fund balance - unrestricted			o		55.0
56. 00	Governing body created - endowment fund balance			О		56.0
57. 00	Plant fund balance - invested in plant				0	
-0 00	Plant fund balance - reserve for plant improvement,				0	58.0
58. 00	replacement, and expansion	1				
	1 .	4 270 OFO	^	ΔI	^	1 50 7
58. 00 59. 00 60. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	6, 379, 850 7, 452, 314		0	0	

MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der No.: 315057

Peri od: Worksheet G-1 From 01/01/2023

General Fund Special Purpose Fund Endowment Fund	
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) 6,040,370 579,477 6,619,847 0	
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) 6,040,370 579,477 6,619,847 0	
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) 579, 477 6, 619, 847 0	
3.00 Total (sum of line 1 and line 2) 6,619,847 0 4.00 Additions (credit adjustments)	1.00
4.00 Additions (credit adjustments)	2. 00 3. 00
	4. 00
	5. 00
6.00	6. 00
7. 00 0 0 0 0 0 0 0 0 0	7. 00 8. 00
9.00	9. 00
10.00 Total additions (sum of line 5 - 9)	10.00
11. 00 Subtotal (line 3 plus line 10) 6,619,850 0	11.00
12.00 Deductions (debit adjustments) 13.00 0 0	12. 00 13. 00
14.00	14. 00
15. 00 OTHER DEDUCTIONS 240,000 0	15. 00
16.00	16.00
17.00 0 0 0 18.00 Total deductions (sum of lines 13 - 17) 240,000 0 0	17. 00 18. 00
19. 00 Fund balance at end of period per balance 6, 379, 850	19. 00
sheet (Line 11 - line 18)	
Endowment Fund Plant Fund	
6.00 7.00 8.00	
1.00 Fund balances at beginning of period 0	1. 00
2.00 Net income (loss) (from Wkst. G-3, line 31)	2.00
3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments)	3. 00 4. 00
5. 00 ROUNDI NG 0	5. 00
6. 00	6. 00
7. 00 8. 00	7. 00 8. 00
8.00	9. 00
10.00 Total additions (sum of line 5 - 9)	10. 00
11.00 Subtotal (line 3 plus line 10) 0	11. 00
12.00 Deductions (debit adjustments) 13.00 0	12. 00 13. 00
14. 00	14. 00
15. 00 OTHER DEDUCTIONS O	15. 00
16. 00	16.00
17.00 0 18.00 Total deductions (sum of lines 13 - 17) 0 0	17. 00 18. 00
18.00 Total deductions (sum of lines 13 - 17) 0 0 19.00 Fund balance at end of period per balance 0 0	18.00
sheet (Line 11 - line 18)	

Heal th	Financial Systems	MERRY HEART SUCCAS	SUNNA		In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315057	Period: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/29/2024 9:00	oared:
	Cost Center Description			Inpati ent	Outpati ent	Total	
				1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY			12, 841, 88	34	12, 841, 884	1. 00
2.00	NURSING FACILITY				0	0	2.00
3.00	ICF/IID				0	0	3.00
4. 00	OTHER LONG TERM CARE				0	0	4.00

4.00	OTHER LONG TERM CARE	0		0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	12, 841, 884		12, 841, 884	5. 00
	All Other Care Services				
6.00	ANCI LLARY SERVI CES	1, 220, 848	0	1, 220, 848	6. 00
7.00	CLI NI C		0	0	7. 00
8.00	HOME HEALTH AGENCY COST		0	0	8. 00
9.00	AMBULANCE		0	0	9. 00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10. 10	FQHC		0	0	10. 10
11.00	CMHC		0	0	11. 00
12.00	HOSPI CE	0	0	0	12.00
13.00	ROUTI NE CHARGES / BED HOLD	226, 271	0	226, 271	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to	14, 289, 003	0	14, 289, 003	14.00
	Worksheet G-3, Line 1)				
	Cost Center Description				
			1. 00	2. 00	
	PART II - OPERATING EXPENSES				
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			12, 455, 791	1. 00
2.00	Add (Specify)		0		2. 00
3.00			0		3. 00
4.00			0		4. 00
5. 00			0		5. 00
6.00			0		6. 00
7. 00			0		7. 00
8. 00	Total Additions (Sum of lines 2 - 7)			0	8. 00
9. 00	Deduct (Specify)		0		9. 00
10.00			0		10. 00
11. 00			0		11. 00
12.00			0		12. 00
13.00			0		13. 00
14.00	Total Deductions (Sum of Lines 9 - 13)			0	14. 00
15 00					
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			12, 455, 791	

Heal th	Financial Systems ME	ERRY HEART SUCCA	SUNNA		In Lie	u of Form CMS-	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES			Provi der No.: 315057	Peri od:		Worksheet G-3	
				From 01/ To 12/		Date/Time Pre 5/29/2024 9:0	
						1.00	
1.00	O Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)				14, 289, 003	1. 00	
2.00	Less: contractual allowances and discounts on patients accounts			1, 268, 957	2. 00		
3.00	Net patient revenues (Line 1 minus line 2)					13, 020, 046	3. 00
4.00	Less: total operating expenses (From Worksheet G-	-2, Part II, lir	ne 15)			12, 455, 791	4. 00
5.00	Net income from service to patients (Line 3 minus	s 4)				564, 255	5. 00
	Other income:						1

		5/29/2024 9:0	9 alli
		1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	14, 289, 003	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	1, 268, 957	2. 00
3.00	Net patient revenues (Line 1 minus line 2)	13, 020, 046	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	12, 455, 791	4. 00
5.00	Net income from service to patients (Line 3 minus 4)	564, 255	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	0	14. 00
15. 00	Revenue from rental of living quarters	0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17. 00
18. 00	Revenue from sale of medical records and abstracts	0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen	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	BARBER BEAUTY	15, 222	24. 00
24. 50	COVI D-19 PHE Funding	0	24. 50
25.00	Total other income (Sum of lines 6 - 24)	15, 222	25. 00
26.00	Total (Line 5 plus line 25)	579, 477	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)	579, 477	31. 00
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