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 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315057	From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 5/26/2022 11:46 am

				37.207	2022 II. 40 alli
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically prepared cost rep	oort		Date: 5/26/2022	Time: 11:46 an
use only	2. [ ] Manually prepared cost report				
	3. [ 0 ] If this is an amended report ent	ter the numbe	of times the provide	r resubmitted this cost	t report
	3.01 [ ] No Medicare Utilization. Enter "	'Y" for yes o	leave blank for no.		
Contractor	4. [ 1 ] Cost Report Status	6. Contractor	No		
use only	(1) As Submitted	7.[ N ] Firs	t Cost Report for this	Provider CCN	
	(2) Settled without audit	8.[ N ] Last	Cost Report for this I	Provider CCN	
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened	10.[ 0 ]If I	ne 4, column 1 is "4":	 Enter number of times	s reopened
	(5) Amended	11.Contracto	r Vendor Code	4	
	5. Date Received:	12.[ F ] Medi	care Utilization. Ente	r "F" for full, "L" fo	rlow, 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 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1			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	2, 799	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	2, 799	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 01/01/2021 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2021 5/26/2022 11:46 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 1.00 2.00 3. 00 4.00 5.00 6.00 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) 12/31/2021 01/01/2021 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 N 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 20.00 Straight Line 439, 824 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 00 439, 824 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) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 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 N 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 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: 41 00 0

Heal th	Financial Systems	MERRY HEART SUCC	ASUNNA	In Lie	u of Form CMS-	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31505	57 Peri od:	Worksheet S-2	
COMPLE	X INDENTIFICATION DATA			From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre	pared:
					5/26/2022 11:	46 am_
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrative	and General cost	N	42. 00
	center? Enter Y or N. If yes, check box	k, and submit supporting s	schedule listing cos	st centers and		
	amounts.		-			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	apter 10?		N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and address	ss 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	e and address of the	e home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Contr	ractor's Number:		45. 00
46. 00	Street:	PO Box:				46, 00
47.00	Ci tv:	State:	Zi p C	Code:		47. 00
	15					

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 01/01/2021 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2021 5/26/2022 11:46 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 03/31/2022 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

S-2540-10
1-2
repared: 1:46 am
19. 00
20.00
21. 00
5

Health Financial Systems MERRY HEART STATE OF THE PROPERTY OF MERRY HEART SUCCASUNNA Provi der No.: 315057

COMPLEX REIMBURSEMENT QUESTIONNAIRE

OOMI EE	A REFINDORSEMENT GOESTFORWARE			To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Part B				
		Date				
		4.00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R	03/31/2022				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					
45.00	4.					45.00
15. 00	If line 13 or 14 is "Y", were adjustments					15. 00
	made to PS&R data for additional claims that					
	have been billed but are not included on the PS&R used to file this cost report? If "Y",					
	see Instructions.					
16. 00	If line 13 or 14 is "Y", then were					16. 00
10.00	adjustments made to PS&R data for					10.00
	corrections of other PS&R Report					
	information? If yes, see instructions.					
17 00	If line 13 or 14 is "Y", then were					17. 00
.,, 00	adjustments made to PS&R data for Other?					177.00
	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					
19. 00	Enter the first name, last name and the title		PREPARER			19. 00
	held by the cost report preparer in columns 1	, 2, and 3,				
20.00	respectively.					20.00
20.00	Enter the employer/company name of the cost r	eport				20. 00
21 00	preparer.	of the cost				21. 00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respective					21.00
	Frebori brebarer ili corumnis ranu 2, respectiv	cıy.		T .		I

MERRY HEART SUCCASUNNA

Health Financial Systems MERRY HEART STAND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315057 COMPLEX STATISTICAL DATA

COMPL	LA STATISTICAL DATA			To	12/31/2021	Date/Time Prep 5/26/2022 11:4	
				I npa	atient Days/Vis		+0 alli
	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 2. 00 3. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID	113 0 0	41, 245 0 0	0	8, 721	10, 005 0 0	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	0	0	О	0	0	4. 00 5. 00 6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	0 113	0 41, 245	0	0 8, 721	0 10, 005	7. 00 8. 00
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	I	6. 00	7.00	8. 00	9. 00	10.00	
1. 00 2. 00 3. 00 4. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	12, 331 0 0 0	31, 057 0 0	0	341	24 0 0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00	Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	0 0 12, 331	0	0	0 341	0	5. 00 6. 00 7. 00
8.00	Total (sum of fines 1-7)	Di scha	31, 057 arges		age Length of		8. 00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12. 00	13.00	14. 00	15. 00	
1. 00 2. 00 3. 00 4. 00 5. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	275 0 0	640 0 0	0. 00 0. 00	25. 57	416. 88 0. 00 0. 00	1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00	SNF-Based CMHC HOSPICE	0	0	0.00	0.00		6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	275 Average Length of Stay	640	0.00 Admis	25. 57 si ons	416. 88	8. 00
	Component	Total	Title V	Title XVIII	Title XIX	Other	
	·	16. 00	17. 00	18. 00	19. 00	20.00	
1. 00 2. 00 3. 00 4. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	48. 53 0. 00 0. 00	0	386	37 0 0	246 0 0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00	Other Long Term Care SNF-Based CMHC HOSPICE	0. 00	0	0	0	0	5. 00 6. 00 7. 00
8.00	Total (Sum of lines 1-7)	48. 53 Admi ssi ons	O Full Time	386 Faui val ent	37	246	8. 00
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I 22. 00	Workers 23.00			
1. 00 2. 00 3. 00 4. 00 5. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	669 0 0	119. 10 0. 00 0. 00 0. 00 0. 00	0. 00 0. 00 0. 00 0. 00			1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00	SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	0 669	0. 00 0. 00 119. 10	0.00			6. 00 7. 00 8. 00

					o 12/31/2021	Date/Time Prep 5/26/2022 11:4	
	·	Amount	Reclass. of	Adjusted	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)	5, 855, 048	0	5, 855, 048	· ·		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		
4.00	Home office personnel	0	0	0	0.00		
5.00	Sum of lines 2 through 4	0	0	0	0.00		
6.00	Revised wages (line 1 minus line 5)	5, 855, 048	0	5, 855, 048	· ·		
7. 00	Other Long Term Care	0	0	0	0.00	0. 00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	C	0.00		8. 00
9.00	CMHC	0	0	C	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	C	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	C	0.00	0.00	11. 00
12. 00	Subtotal Excluded salary (Sum of lines 7	0	0	C	0. 00	0. 00	12. 00
12 00	through 11)	E 0EE 040	_	E 0EE 040	247 722 00	22 (2	13. 00
13. 00	Total Adjusted Salaries (line 6 minus line 12)	5, 855, 048	0	5, 855, 048	247, 732. 00	23. 03	13.00
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	660, 847	0	660, 847	12, 871. 00	51 34	14. 00
	Contract Labor: Physician services-Part A	000,047	0	000, 047	0.00		
	Home office salaries & wage related costs	0	0		0.00		
10.00	WAGE-RELATED COSTS		0		0.00	0.00	10.00
17. 00	Wage-related costs core (See Part IV)	1, 121, 958	0	1, 121, 958			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	C			18. 00
19.00	Wage related costs (excluded units)	0	0				19. 00
20.00	Physician Part A - WRC	0	0				20. 00
21. 00	Physician Part B - WRC	0	0				21.00
22. 00	Total Adjusted Wage Related cost (see	1, 121, 958	0	1, 121, 958			22. 00
	instructions)						

Period: Worksheet S-3
From 01/01/2021 Part III
To 1/21/2021 Part VIII Propagate Health Financial Systems
SNF WAGE INDEX INFORMATION MERRY HEART SUCCASUNNA

Provider No.: 315057

				Т	o 12/31/2021	Date/Time Prep 5/26/2022 11:	
		Amount	Reclass. of	Adjusted	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 III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1. 00
2.00	Administrative & General	602, 838	0	602, 838	20, 657. 00	29. 18	2. 00
3.00	Plant Operation, Maintenance & Repairs	94, 937	0	94, 937	4, 591. 00	20. 68	3. 00
4.00	Laundry & Linen Service	96, 262	0	96, 262	6, 887. 00	13. 98	4. 00
5.00	Housekeepi ng	151, 239	0	151, 239	10, 920. 00	13. 85	5. 00
6.00	Di etary	378, 626	0	378, 626	21, 030. 00	18. 00	6. 00
7.00	Nursing Administration	596, 528	0	596, 528	16, 050. 00	37. 17	7. 00
8.00	Central Services and Supply	0	0	O.	0.00	0.00	8. 00
9.00	Pharmacy	0	0	O.	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	39, 923	0	39, 923	2, 520. 00	15. 84	10.00
11. 00	Soci al Servi ce	207, 146	0	207, 146	7, 553. 00	27. 43	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	322, 848	0	322, 848	10, 300. 00	31. 34	13.00
14.00	Total (sum lines 1 thru 13)	2, 490, 347	0	2, 490, 347	100, 508. 00	24. 78	14.00

Health Financial Systems	MERRY HEART SUCCASUNNA	In Lie	u of Form CMS-2	2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315057	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Pre 5/26/2022 11:	pared:
			Amount Reported	

PART IV - WAGE RELATED COSTS		10 12/31/2021	Date/lime Prep 5/26/2022 11:4	
PART IV - WAGE RELATED COSTS   Part A - Core List			1'	
PART IV - WAGE RELATED COSTS   Part A - Core List   RETIREMENT COST   401K Employer Contributions   80,948   1.00   2.00   7   7   7   7   7   7   7   7   7			Reported	
Part A - Core List   RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00	1.00	401K Empl oyer Contributions	80, 948	1. 00
Prior Year Pension Service Cost   Q   4.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAM ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA Pl an Administration Fees   0   0   5.00	3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
5.00   401K/TSA Plan Administration fees   0   5.00   6.00   Legal Accounting/Management Fees-Pensi on Plan   0   6.00   Complete Accounting/Management Fees-Pensi on Plan   0   7.00   Employee Managed Care Program Administration Fees   0   7.00   Fees   1.00   Fees	4.00	Prior Year Pension Service Cost	0	4. 00
Column   C		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
To   Employee Managed Care Program Administration Fees   0   7.00	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST   8. 00   Heal th Insurance (Purchased or Self Funded)   313,391   8. 00   9. 00   10. 00	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
Real th Insurance (Purchased or Self Funded)   313, 391   8.00   9.00   Prescription Drug Plan   0   9.00   10.00	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00       Prescription Drug Plan       0       9.00         10.00       Dental, Hearing and Vision Plan       7,756       10.00         11.00       Life Insurance (If employee is owner or beneficiary)       0       11.00         12.00       Accident Insurance (If employee is owner or beneficiary)       0       12.00         13.00       Disability Insurance (If employee is owner or beneficiary)       0       13.00         14.00       Long-Term Care Insurance (If employee is owner or beneficiary)       0       14.00         15.00       Workers' Compensation Insurance       278,519       15.00         16.00       Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.       0       16.00         Non cumulative portion)       TAXES       0       16.00         17.00       FICA-Employers Portion Only       0       18.00         18.00       Medicare Taxes - Employers Portion Only       0       19.00         20.00       State or Federal Unemployment Taxes       6,336       20.00         0THER         21.00       Executive Deferred Compensation       0       21.00         22.00       Tuition Reimbursement       0       22.00         23.00       Tuition Reimbursement       0<		HEALTH AND INSURANCE COST		
9.00       Prescription Drug Plan       0       9.00         10.00       Dental, Hearing and Vision Plan       7,756       10.00         11.00       Life Insurance (If employee is owner or beneficiary)       0       11.00         12.00       Accident Insurance (If employee is owner or beneficiary)       0       12.00         13.00       Disability Insurance (If employee is owner or beneficiary)       0       13.00         14.00       Long-Term Care Insurance (If employee is owner or beneficiary)       0       14.00         15.00       Workers' Compensation Insurance       278,519       15.00         16.00       Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.       0       16.00         Non cumulative portion)       TAXES       0       16.00         17.00       FICA-Employers Portion Only       0       18.00         18.00       Medicare Taxes - Employers Portion Only       0       19.00         20.00       State or Federal Unemployment Taxes       6,336       20.00         0THER         21.00       Executive Deferred Compensation       0       21.00         22.00       Tuition Reimbursement       0       22.00         23.00       Tuition Reimbursement       0<	8.00	Health Insurance (Purchased or Self Funded)	313, 391	8. 00
11. 00	9.00	Prescription Drug Plan		9. 00
11. 00	10.00	Dental, Hearing and Vision Plan	7, 756	10. 00
13.00   Disability Insurance (If employee is owner or beneficiary)   0   13.00     14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   278,519   15.00     16.00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0   16.00     Non cumulative portion)   17.00   FICA-Employers Portion Only   435,008   17.00     18.00   Modicare Taxes - Employers Portion Only   0   18.00     19.00   Unemployment Insurance   0   0   19.00     20.00   State or Federal Unemployment Taxes   6,336   20.00     OTHER   21.00   Executive Deferred Compensation   0   21.00     22.00   Day Care Cost and Allowances   0   22.00     23.00   Tuition Reimbursement   0   0   23.00     24.00   Total Wage Related cost (Sum of lines 1 - 23)   1,121,958   24.00     Part B - Other than Core Related Cost	11. 00		0	11. 00
14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00   Workers' Compensation Insurance   278,519   15.00   16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   Non cumul ative portion)   TAXES	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only  18.00 Medicare Taxes - Employers Portion Only  Unemployment Insurance  20.00 State or Federal Unemployment Taxes  OTHER  21.00 Executive Deferred Compensation  Day Care Cost and Allowances  Tuition Reimbursement  24.00 Total Wage Related cost (Sum of lines 1 - 23)  Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
Non cumulative portion   TAXES   TAX	15.00	Workers' Compensation Insurance	278, 519	15. 00
TAXES   17.00   FI CA-Employers Portion Only   435,008   17.00   18.00   18.00   18.00   18.00   19.	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00   FI CA-Employers Portion Only   435,008   17. 00     18. 00   Medicare Taxes - Employers Portion Only   0   18. 00     19. 00   Unemployment Insurance   0   19. 00     20. 00   State or Federal Unemployment Taxes   6, 336     20. 00   OTHER		Non cumulative portion)		
18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 0 19.00  21.00 Executive Deferred Compensation 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23)  Part B - Other than Core Related Cost				
19.00   Unempl oyment Insurance   0   19.00   20.00   State or Federal Unempl oyment Taxes   6,336   20.00	17.00	FICA-Employers Portion Only	435, 008	17. 00
20.00   State or Federal Unemployment Taxes   6, 336   20.00   OTHER	18.00	Medicare Taxes - Employers Portion Only	0	18. 00
OTHER   21.00   Executive Deferred Compensation   0   21.00	19.00	Unempl oyment Insurance	0	19. 00
21.00   Executive Deferred Compensation   0   21.00	20.00		6, 336	20. 00
22.00 Day Care Cost and Allowances  23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23)  Part B - Other than Core Related Cost  0 23.00 1,121,958 24.00 Amount Reported 1.00				
23.00 Tui tion Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23)  1,121,958 24.00  Amount Reported 1.00  Part B - Other than Core Related Cost	21.00	Executive Deferred Compensation	0	21. 00
24.00       Total Wage Related cost (Sum of lines 1 - 23)       1,121,958       24.00         Amount Reported         1.00       1.00	22.00	Day Care Cost and Allowances	0	22. 00
Amount Reported 1.00  Part B - Other than Core Related Cost	23.00	Tuition Reimbursement	0	23. 00
Part B - Other than Core Related Cost	24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 121, 958	24.00
Part B - Other than Core Related Cost			Amount	
Part B - Other than Core Related Cost				
			1.00	
25.00 OTHER WAGE RELATED COSTS (SPECIFY)				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part V | To 12/31/2021 | Date/Time Prepared:

				T	o 12/31/2021	Date/Time Prep 5/26/2022 11:4	
	Occupational Category	Amount	Fri nge	Adj usted	Paid Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
		'			Salary in col.		
				, i	3	ŕ	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	796, 533	152, 633				1.00
2.00	Licensed Practical Nurses (LPNs)	591, 328	113, 311				2.00
3.00	Certified Nursing Assistant/Nursing	1, 478, 209	283, 257	1, 761, 466	93, 211. 00	18. 90	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	2, 866, 070	549, 201				4. 00
5.00	Physical Therapists	232, 142	44, 484				5. 00
6.00	Physical Therapy Assistants	88, 058	16, 874				6. 00
7.00	Physical Therapy Aides	0	0		0.00	1	
8.00	Occupational Therapists	86, 112	16, 501		i i	1	
9.00	Occupational Therapy Assistants	92, 319	17, 690	110, 009		1	9. 00
10. 00	Occupational Therapy Aides	0	0	0	0.00	1	
11. 00	Speech Therapists	0	0	0	0.00		
12. 00	Respi ratory Therapi sts	0	0	0	0.00		
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	368, 737		368, 737	6, 467. 00		
15. 00	Licensed Practical Nurses (LPNs)	0		0	0.00		
16. 00	Certified Nursing Assistant/Nursing	10, 899		10, 899	414. 00	26. 33	16. 00
17 00	Assistants/Aides	270 (2)		270 (2)	/ 001 00	FF 47	17. 00
17. 00	Total Nursing (sum of lines 14 through 16)	379, 636		379, 636	i i	1	
18.00	Physical Therapists	98, 386		98, 386	· ·		
19.00	Physical Therapy Assistants	44, 228		44, 228			
20.00	Physical Therapy Aides	2, 740		2, 740			20. 00 21. 00
21. 00	Occupational Therapists	75, 177		75, 177	i i		
22. 00	Occupational Therapy Assistants	29, 446		29, 446			
23. 00	Occupational Therapy Aides Speech Therapists	21 222		1	0. 00 568. 00	1	
24. 00 25. 00	Respiratory Therapists	31, 233		31, 233	0.00		
	Other Medical Staff				0.00		25. 00 26. 00
20.00	Tother Medical Staff	ı Y		1	0.00	J 0.00	∠0. 00

Health Financial Systems MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10 PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provi der No.: 315057 Peri od: Worksheet S-7 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 11:46 am Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE2 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC<sub>2</sub> 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38, 00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB2 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 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 1 B2 59.00

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	Peri od:	Worksheet S-	7
				From 01/01/2021 To 12/31/2021		
,					5/26/2022 11	: 46 am
				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 experexpenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fowith direct patient care and related expenses (See instructions)	cted this increase to n column 1 the amoun reach category to or yes or "N" for no	to be used nt of the total SNF o if 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 (SPECIFY)	4 1 0)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, Iii	ne i, coiumn 3)		l			106. 00

Health Financial Systems	MERRY HEART SU	JCCASUNNA		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eri od:	Worksheet A	
				rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/26/2022 11:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	TO GIII
			+ col . 2)	ons	Trial Balance	
				Increase/Decre	•	
				ase (Fr Wkst	col. 4)	
	1.00	2.00	2.00	A-6)	F 00	
GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 00100 CAP REL COSTS - BLDGS & FLXTURES		1, 668, 655	1, 668, 655	0	1, 668, 655	1. 00
2. 00   00200 CAP REL COSTS - MOVABLE EQUIPMENT		0	1, 000, 000		0	2. 00
3. 00 00300 EMPLOYEE BENEFITS	0	1, 245, 975	1, 245, 975	_	1, 245, 975	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	602, 838	1, 347, 447	1, 950, 285		1, 950, 285	4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	94, 937	383, 967	478, 904	0	478, 904	5.00
6.00 00600 LAUNDRY & LINEN SERVICE	96, 262	7, 528	103, 790	0	103, 790	6.00
7. 00   00700   HOUSEKEEPI NG	151, 239	92, 487	243, 726		243, 726	7. 00
8. 00   00800   DI ETARY	378, 626	317, 422	696, 048		696, 048	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	596, 528	0	596, 528	0	596, 528	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	0	0	C	0	0	10.00
11. 00   01100   PHARMACY 12. 00   01200   MEDI CAL RECORDS & LI BRARY	20, 022	0	39, 923	0	20, 022	11. 00 12. 00
12. 00   01200   MEDI CAL RECORDS & LI BRARY 13. 00   01300   SOCI AL SERVI CE	39, 923 207, 146	0	207, 146		39, 923 207, 146	12.00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	207, 140	0	207, 140		207, 140	14. 00
15. 00 01500 PATIENT ACTIVITIES	322, 848	31, 410	_	_	354, 258	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	322,040	31, 410	334, 230		334, 230	13.00
30.00 03000 SKILLED NURSING FACILITY	2, 866, 071	699, 102	3, 565, 173	0	3, 565, 173	30.00
31.00 03100 NURSING FACILITY	0	0	· · ·	0	0	31.00
32. 00 03200 I CF/I I D	0	o	C	0	0	32.00
33.00 O3300 OTHER LONG TERM CARE	0	0	C	0	0	33.00
ANCI LLARY SERVI CE COST CENTERS						
40. 00   04000   RADI OLOGY	0	19, 961	19, 961	_	19, 961	40.00
41. 00   04100   LABORATORY	0	52, 407	52, 407		52, 407	41. 00
42. 00   04200   I NTRAVENOUS THERAPY 43. 00   04300   0XYGEN (I NHALATION) THERAPY		O O			0	42. 00 43. 00
44. 00   04400   PHYSI CAL THERAPY	320, 199	135, 944	456, 143	0	456, 143	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	178, 431	133, 238	311, 669		311, 669	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	12, 030	12, 030		12, 030	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	C	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	C	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	415, 940	415, 940	0	415, 940	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	0	0	50.00
51. 00 05100 SUPPORT SURFACES	0	25, 036	25, 036	0	25, 036	51. 00
OUTPATIENT SERVICE COST CENTERS  60. 00 06000 CLINIC	l	ما	C	0	0	60. 00
61. 00   06100   RURAL HEALTH CLINIC		0		0	0	61. 00
62. 00   06200 FQHC		Ğ			O	62. 00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70.00
71. 00   07100   AMBULANCE	0	193	193	0	193	71. 00
73. 00 07300 CMHC	0	0	C	0	0	73. 00
SPECIAL PURPOSE COST CENTERS		-				
80. 00   08000   MALPRACTI CE   PREMI UMS & PAI D LOSSES		0	C	0	0	80. 00
81.00   08100   INTEREST EXPENSE 82.00   08200   UTI LI ZATI ON REVI EW - SNF		0			0	81. 00 82. 00
83. 00   08300   HOSPI CE		0		0	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	5, 855, 048	6, 588, 742	12, 443, 790	0	12, 443, 790	89. 00
NONREI MBURSABLE COST CENTERS	0,000,010	0,000,712	12, 110, 170	<u> </u>	12, 110, 770	07.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	C	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	7, 391	7, 391	0	7, 391	
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	o	C	0	0	92.00
93. 00   09300   NONPALD   WORKERS	0	0	C	0	0	93. 00
94. 00   09400   PATI ENTS LAUNDRY	0	0	C	0	0	94.00
100. 00   T0TAL	5, 855, 048	6, 596, 133	12, 451, 181	0	12, 451, 181	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	12/31/2021	Date/Time Prepared: 5/26/2022 11:46 am
	Cost Center Description	Adjustments to	Net Expenses			37 207 2022 11. 40 dill
	<b>'</b>		For Allocation			
		Wkst A-8)	(col. 5 +-			
			col . 6)			
	GENERAL SERVICE COST CENTERS	6. 00	7. 00			
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES	-531, 086	1, 137, 569			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	0			2. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 245, 975			3.00
4.00	00400 ADMINISTRATIVE & GENERAL	107, 369	2, 057, 654			4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	478, 904	1		5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	103, 790			6. 00
7.00	00700 HOUSEKEEPI NG	0	243, 726	1		7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	0	696, 048 596, 528			8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0 390, 320	•		10.00
11. 00	01100 PHARMACY	0	0			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	39, 923			12. 00
13.00	01300 SOCIAL SERVICE	0	207, 146			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			14. 00
15.00	01500 PATIENT ACTIVITIES	0	354, 258			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		0.5/5.470	1		
30.00	03000 SKILLED NURSING FACILITY	0	3, 565, 173			30.00
31. 00 32. 00	03100 NURSING FACILITY 03200   CF/IID	0	0			31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0			33.00
33. 00	ANCI LLARY SERVI CE COST CENTERS		٩	1		33.00
40.00	04000 RADI OLOGY	0	19, 961			40.00
41.00	04100 LABORATORY	0	52, 407			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	456, 143	1		44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	311, 669 12, 030	1		45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	12,030	1		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	•		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	415, 940			49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			50.00
51.00	05100 SUPPORT SURFACES	0	25, 036			51.00
	OUTPATIENT SERVICE COST CENTERS			T		
60.00	06000 CLINIC	0	0	1		60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0			61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS					62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0			70.00
71. 00	07100 AMBULANCE	0	193	1		71. 00
73.00	07300 CMHC	0	0			73. 00
	SPECIAL PURPOSE COST CENTERS					
	I I	0	0	1		80.00
	08100   NTEREST EXPENSE	0	0			81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0	0			82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-423, 717				89.00
07.00	NONREI MBURSABLE COST CENTERS	-423, / 1 /	12, 020, 073	'L		07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			90.00
	09100 BARBER AND BEAUTY SHOP	0	7, 391	1		91. 00
	09200 PHYSICIANS PRIVATE OFFICES	0	0	1		92.00
	09300 NONPALD WORKERS	0	0			93. 00
	09400 PATIENTS LAUNDRY	0	0	1		94.00
100.00	TOTAL	-423, 717	12, 027, 464	1		100. 00

Health Financial Systems	MERRY HEART SUCCASU	UNNA		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS			Peri od:	Worksheet A-6		
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
	Increases					
	Cost Center		Li ne #	Sal ary	Non Salary	
	2. 00		3. 00	4. 00	5. 00	
TOTALS						
100.00	Total Reclassification	ons (Sum		0	0	100. 00
	of columns 4 and 5 mu	ust				
	equal sum of columns	8 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		Peri od:	Worksheet A-6	· )
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre	
					5/26/2022 11:	46 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

<sup>(1)</sup> 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 In Lieu of Form CMS-2540-10
Worksheet A-7 MERRY HEART SUCCASUNNA Provi der No.: 315057

Peri od: From 01/01/2021

				T	0 12/31/2021	Date/Time Prep 5/26/2022 11:4	oared: 46 am
	·		·	Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5	_1	_			
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fi xed Equi pment	0	0	0	0	0	5. 00
6.00	Movable Equipment	3, 030, 100	229, 008		229, 008	0	6. 00
7. 00	Subtotal (sum of lines 1-6)	3, 030, 100	229, 008	0	229, 008		7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	3, 030, 100	229, 008	0	229, 008	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
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	0	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	3, 259, 108	0				6. 00
7.00	Subtotal (sum of lines 1-6)	3, 259, 108	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	3, 259, 108	0				9. 00

From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				10 12/31/2021	5/26/2022 11:	
				Expense Classification or		70 diii
				To/From Which the Amount is		
				TO/TTOIL WITCH THE AMOUNT IS	to be Aujusteu	
					T	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne 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		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0	)	0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)		-			
6.00	Television and radio service (chapter 21)		Ó		0.00	6. 00
7. 00	Parking lot (chapter 21)		Ö		0.00	
8.00	Remuneration applicable to provider-based	A-8-2			0.00	8.00
0.00	physician adjustment	A-0-2		<u>'</u>		0.00
9. 00	Home office cost (chapter 21)		0		0.00	9. 00
10.00		4		1	0.00	
	Sale of scrap, waste, etc. (chapter 23)			1		
11. 00	Nonallowable costs related to certain		0	1	0.00	11. 00
40.00	Capital expenditures (chapter 24)	4.0.4	000 707			40.00
12. 00	Adjustment resulting from transactions with	A-8-1	-389, 787			12. 00
	related organizations (chapter 10)	4	_			
13. 00	Laundry and linen service		0	1		13. 00
14. 00	Revenue - Employee meals		0	)	0.00	
15. 00	Cost of meals - Guests		0	)	0.00	
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					
17. 00	Sale of drugs to other than patients		0	1		17. 00
18.00	Sale of medical records and abstracts		0		0.00	18. 00
19.00	Vendi ng machi nes		0		0.00	19. 00
20.00	Income from imposition of interest, finance		0	)	0.00	20. 00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		l o		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
20.00	Bopt cor att on Barrarings and Trixtares			FI XTURES	1.00	20.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2 00	24. 00
24.00	Sopressia troff movable equipment		١	EQUI PMENT	2.00	27.00
25. 00	DONATI ONS	Α	_15_010	ADMINISTRATIVE & GENERAL	4.00	25. 00
	MEALS & ENTERTAL NMENT	A			4.00	
	•	A		ADMINISTRATIVE & GENERAL	4.00	
100.00	Total (sum of lines 1 through 99) (Transfer		-423, 717			100. 00
	to Worksheet A, col. 6, line 100)		l	1	1	l
(1) 1)0	scrintion - all chanter references in this co	iumn nertain to	) CMS Pub 15-1	i e e e e e e e e e e e e e e e e e e e		

<sup>(1)</sup> 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 SISTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME MERRY HEART SUCCASUNNA

Provi der No.: 315057 OFFICE COSTS

				'	o 12/31/2021   Date/lime Pr   5/26/2022 11	
	·	Li ne No.	Cost (	Center	Expense Items	
		1. 00	2.		3.00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICATION OF THE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00			CAP REL COSTS FLXTURES	- BLDGS &	RENT	1.00
2. 00		1. 00	CAP REL COSTS FIXTURES	- BLDGS &	DEPRECI ATI ON	2. 00
3. 00		1. 00	CAP REL COSTS FIXTURES	- BLDGS &	INTEREST	3. 00
4. 00		1. 00	CAP REL COSTS FIXTURES	- BLDGS &	FEES	4. 00
5. 00 6. 00 7. 00		4. 00 4. 00 1. 00	ADMINISTRATIVE ADMINISTRATIVE CAP REL COSTS	& GENERAL	CONTRACT SVS DUES & SUBSCRIPTIONS RENT	5. 00 6. 00 7. 00
6	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	0. 00 0. 00	FI XTURES			8. 00 9. 00 10. 00
	12.	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	0 295, 824 253, 697 4, 000 141, 032 267 110, 393 0 0 805, 213	780, 000 0 0 0 0 0 0 415, 000 0 0 1, 195, 000	C		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

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

Provider No.: 315057

Worksheet A-8-1 From 01/01/2021 Parts I-II Date/Time Prepared: 5/26/2022 11:46 am 12/31/2021

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

	3				· ·
1.00		Α	B. BONIFACIO, ET. A	L. 100.00	1. 00
2. 00		A	B. BONIFACIO, ET. A	L. 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
spe	eci fy:				

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

		l Related Organi	zation(s) and/	or Home Office	4		
		3.					
					4		
					4		
					4		
					4		
		Name	Percentage of	Type of Business			
				31			
			Ownershi p		4		
		4.00	5. 00	6, 00	1		
		4.00	3.00	0.00			
DART	I LUTEBBEL ATLANGUEB TO BELATER OBSANIE	ATLANICAL AND CAR HOME AFEL AF			41		

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

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

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

ror parposos or orariming rormbarosmone andor erer	9 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.

COST CENTER   SERVICE COSTS   Provide No. 313057   For 100   SO 1/2/31/2001   SO 1/2/31/2	Heal th	Financial Systems	MERRY HEART S	SUCCASUNNA		In Lie	eu of Form CMS-2	2540-10
CAPITAL RELATED COSTS  AND CAPITAL RELATED COSTS  TIXTURES  AT COCKET  TIXTURES  1.00  0.00	COST A	ILLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315057	From 01/01/2021	Part I	pared:
Control   Cont				CAPI TAL REI	ATED COSTS		372072022 11.	40 aiii
CENERAL SERVICE COST CENTERS		Cost Center Description	for Cost Allocation (from Wkst A				Subtotal	
1.00   0.0100   CAP REL COSTS - BLIDGS A FIXTURES   1.137, 569     1.137, 569     0.00				1. 00	2.00	3.00	3A	
2.00   00200   CAP REL COSTS - MOYABLE EQUI PMENT   0   1, 245, 975   0   0   1, 245, 975   0   0   1, 245, 975   0   0   1, 245, 975   0   0   1, 245, 975   0   0   1, 245, 975   0   0   1, 245, 975   0   0   1, 245, 975   0   0   1, 245, 975   0   0   1, 245, 975   0   0   0   0   0   0   0   0   0								
0.00300   BMPLOYEE BENEFITS		1 1	1	1, 137, 569				
0.000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.			-1	0				1
0.000   0.0000   LAIJNDRY & LINEN SERVICE   103,790   26,548   0   20,485   150,823   6.00   0.0000   0.0000   0.0000   0.0000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.0000   0.0000   0.0000   0.0000   0.000   0		1 1	1	189, 459				1
0.000   0.0000   0.001   0.001   0.001   0.001   0.001   0.001   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000								
B.O.D   ORDOO   DIETARY   696, 048   85, 667   0   80. 573   862, 288   8. 00   0   126, 944   773, 477   9. 00   10. 00   1000   CENTRAL SERVICES & SUPPLY   0   0   0   0   0   0   0   10. 00   10. 00   10. 00   10. 00   10. 00   0   0   10. 0			1					
0.000 0.0000 NURSING ADMINISTRATION 596,528 0 0 126,944 723,372 9,00 1.00 0 0 0 0 0 0 0 0 0 1.00 1.00 1.0			1					
11. 00   01100   PHARMACY   0   0   0   0   0   0   11. 00     12. 00   01200   MEDICAL SERVICE   207, 146   3,732   0   0   0,496   44.819   12.00     13. 00   01300   SOCIAL SERVICE   207, 146   3,732   0   0   0   0   0   0   14.00     15. 00   01500   NURSING AND ALLED HEALTH EDUCATION   0   0   0   0   0   0   0   0     15. 00   01500   PATIENT ACTIVITIES   354,258   84,832   0   68,703   507,793   15.00			1	0				
12 00   01200   MEDICAL RECORDS & LIBRARY   39, 923   0   0   8.496   48.419   12.00			1	0		0 0	•	
13.00   01300   SOCIAL SERVICE   207, 146   3,732   0   44,081   254,959   13.00     15.00   01500   PATIENT ACTIVITIES   354,258   84,832   0   68,703   507,793   15.00     NIPATE TENT ROUTH IN SERVICE COST CENTERS			1	0		0 0	-	
14. 00   01-400   NURSING AND ALLIED HEALTH EDUCATION   0   0   0   0   0   0   0   14. 00			1	3, 732				
INPATE ENT ROUTINE SERVICE COST CENTERS   3, 565, 173   679, 273   0   609, 909   4, 854, 355   30. 00   310. 00   310. 00   310. 00   310. 00   310. 00   310. 00   320. 00   320. 00   320. 00   320. 00   600. 00   0   0   0   0   0   32. 00   330. 00   330. 00   100. 00   100. 00   0   0   0   0   0   0   0   32. 00   330. 00   330. 00   100. 00   100. 00   0   0   0   0   0   0   0   0	14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		-	0	
00   03000   SALLED NURSING FACILITY	15. 00		354, 258	84, 832		0 68, 703	507, 793	15. 00
31 00   03100   NURSING FACILITY	30 00		3 565 173	679 273		0 609 909	4 854 355	30.00
33.00   03300   0716PL LONG TERN CARE   0   0   0   0   0   0   33.00		1	1		i	·		
ANCILLARY SERVICE COST CENTERS			1				-	
40.00   04000   RADIOLOGY	33. 00		0	0		0 0	0	33.00
141 00   04100   LABORATORY   52, 407   0   0   0   52, 407   41, 00   020   04200   NTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0	40. 00		19, 961	0		0 0	19, 961	40.00
43.00   04300   04300   0440								1
44.00   04400   PHYSICAL THERAPY   456, 143   21, 750   0   68, 140   546, 033   44.00   45.00   04500   OCCUPATIONAL THERAPY   311, 669   0   0   37, 971   349, 640   45.00   45.00   04500   OCCUPATIONAL THERAPY   12,030   0   0   0   0   12,030   46.00   47.00   04700   CLECTROCARDIOLOGY   0   0   0   0   0   0   0   47.00   04700   CLECTROCARDIOLOGY   0   0   0   0   0   0   0   48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   48.00   49.00   04900   ROUGS CHARGED TO PATIENTS   415,940   0   0   0   0   0   415,940   49.00   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   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   0   50.00   05000   CLINIC   0   0   0   0   0   50.00   05000   05100   05100   0   0   50.00   05100   05100   05100   0   50.00   05100   05100   0   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   0   50.00   05100   05100   0   0   50.00   05100   05100   0   0   50.00   05100   05100   0   0   50.00   05100   05100   0   0   50.00   0510		l l	-1			0 0		
45.00   04500   OCCUPATIONAL THERAPY   311,669   0   0   37,971   349,604   45.00   46.00   04600   SPECH PATHOLOGY   12,030   0   0   0   12,030   46.00   46.00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   47.00   48.00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   48.00   49.00   04900   DRUGS CHARGED TO PATIENTS   415,940   0   0   0   0   0   415,940   50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   50.00   51.00   05100   SUPPORT SURFACES   25,036   0   0   0   0   0   50.00   51.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51.00   05100   SUPPORT SURFACES   25,036   0   0   0   0   0   0   0   51.00   05100   SUPPORT SURFACES   25,036   0   0   0   0   0   0   0   51.00   05100   SUPPORT SURFACES   25,036   0   0   0   0   0   0   0   0   61.00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   0   0   61.00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   0   61.00   06200   FOHC   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   71.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   71.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   71.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   71.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   81.00   08000   MALPRACTICE PREMI UMS & PAID LOSSES   81.00   81.00   08100   INTEREST EXPENSE   82   82.00   82.00   08200   UTILIZATION REVIEW - SNF   82.00   83.00   83.00   08300   HOSPICE   SUBTOTALS (sum of 1 ines 1-84)   12,020,073   1,133,304   0   1,245,975   12,015,808   80.00   NONTREI MBURSABLE COST CENTERS   0   0   0   0   0   0   91.00   09100   BARBER AND BEAUTY SHOP   7,391   4,265   0   0   0   0   0   0   91.00   09100   BARBER AND BEAUTY SHOP   7,391   4,265   0   0   0   0   0   0   91.00   09100   BARBER AND BEAUTY SHOP			-1			0 68 140	_	1
46.00   04600   SPEECH PATHOLOGY   12,030   0   0   0   12,030   46.00   47.00   04700   LECTROCARDIOLOGY   0   0   0   0   0   47.00   48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   49.00   04900   DRUGS CHARGED TO PATIENTS   415,940   0   0   0   0   415,940   49.00   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   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   51.00   05000   SUPPORT SURFACES   25,036   0   0   0   0   0   51.00   05100   SUPPORT SURFACES   25,036   0   0   0   0   0   60.00   06000   CLINIC COST CENTERS		1 1	1					1
48. 00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   48. 00   49. 00   04900   DRUGS CHARGED TO PATIENTS   415,940   0   0   0   0   415,940   49. 00   05000   DRUGS CHARGED TO PATIENTS   415,940   0   0   0   0   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   51. 00   DISPORT SURFACES   25,036   0   0   0   0   0   51. 00   DISPORT SURFACES   0   0   0   0   0   60. 00   O6000   CLI NI C   0   0   0   0   0   0   61. 00   06000   CLI NI C   0   0   0   0   0   0   62. 00   O6000   CLI NI C   0   0   0   0   0   0   62. 00   O6000   CLI NI C   0   0   0   0   0   62. 00   O7000   HOME HEALTH AGENCY COST   0   0   0   0   0   71. 00   O7000   HOME HEALTH AGENCY COST   193   0   0   0   0   0   71. 00   O7100   AMBULANCE   193   0   0   0   0   0   0   71. 00   O7100   AMBULANCE   193   0   0   0   0   0   71. 00   O7300   CMHC   SPECI AL PURPOSE COST CENTERS   81. 00   81. 00   O8000   MALPRACTI CE PERMI UNS & PAID LOSSES   81. 00   81. 00   O8100   INTEREST EXPENSE   82. 00   0   0   0   0   82. 00   SUBTOTALS (sum of lines 1-84)   12,020,073   1,133,304   0   1,245,975   12,015,808   89. 00   89. 00   SUBTOTALS (sum of lines 1-84)   12,020,073   1,133,304   0   1,245,975   12,015,808   89. 00   91. 00   O9000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   91. 00   O9000   BARBER AND BEAUTY SHOP   7,391   4,265   0   0   0   0   0   91. 00   O9000   O9000   O9000   O9000   O9000   O0000   O0000   O0000   O0000   O0000   91. 00   O9000   O9000   O9000   O0000   O0000   O0000   O00000   O00000   91. 00   O9000   O9000   O9000   O00000   O00000   O0000000000		04600 SPEECH PATHOLOGY	1	0		0 0		1
49. 00 04900 DRUGS CHARGED TO PATIENTS		1 1	- 1	0		0 0		
50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   50.00				0				1
OUTPATIENT SERVICE COST CENTERS   O			1	0		0 0		1
60. 00	51.00		25, 036	0		0 0	25, 036	51.00
61. 00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   62. 00   62. 00   O6200   FOHC   OTHER REI MBURSABLE COST CENTERS    70. 00   07000   HOME   HEALTH   AGENCY COST   0   0   0   0   0   0   71. 00   07100   AMBULANCE   193   0   0   0   0   193   71. 00   73. 00   07300   CMHC   O   0   0   0   0   0   0    80. 00   08000   MALPRACTI   CE PREMI   UMS & PAI D   LOSSES   80. 00   08200   UTI   LI ZATI   ON REVIEW - SNF   82. 00   08200   UTI   LI ZATI   ON REVIEW - SNF   83. 00   08300   HOSPI   CE   O   0   0   0   0   0   83. 00   08200   UTI   LI ZATI   ON REVIEW - SNF   80. 00   SUBTOTALS (sum of li nes 1-84)   12, 020, 073   1, 133, 304   0   1, 245, 975   12, 015, 808   89. 00   NONREI   MBURSABLE   COST   CENTERS    90. 00   09100   BARBER   AND   BEAUTY   SHOP   7, 391   4, 265   0   0   0   0   0   91. 00   09200   OPHYSI   CI ANS   PRI VATE   OFFI   CES   0   0   0   0   0   92. 00   09300   NONPAI   D WORKERS   0   0   0   0   0   0   93. 00   09400   PATI   ENTS   LAUNDRY   0   0   0   0   0   99. 00   Negative   Cost   Centers   0   0   0   0   0   99. 00   Negative   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Negative   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0   0   0   0   99. 00   Operation   Cost   Centers   0	40.00			0			1 0	40.00
62. 00   06200   FOHC   OTHER REI MBURSABLE COST CENTERS								
70.00		06200 FQHC						
71. 00	70.00						1	70.00
73. 00								
80. 00					1			
81.00   08100   INTEREST EXPENSE     81.00   82.00   08200   UTILIZATION REVIEW - SNF   0   0   0   0   0   0   83.00   89.00   SUBTOTALS (sum of lines 1-84)   12,020,073   1,133,304   0   1,245,975   12,015,808   89.00   NONREI MBURSABLE COST CENTERS								
82. 00		1 1						
83. 00   08300   HOSPI CE   0   0   0   0   0   0   0   83. 00   89. 00   SUBTOTALS (sum of lines 1-84)   12,020,073   1,133,304   0   1,245,975   12,015,808   89. 00    NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   91. 00   09100   BARBER AND BEAUTY SHOP   7,391   4,265   0   0   0   11,656   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   0   0   0   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   0   0   93. 00   94. 00   09400   PATI ENTS LAUNDRY   0   0   0   0   0   94. 00   98. 00   Cross Foot Adjustments   0   0   0   0   0   99. 00   99. 00   Negati ve Cost Centers   0   0   0   0   0   99. 00								
NONREI MBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O		l l	0	0				
90. 00	89. 00		12, 020, 073	1, 133, 304		0 1, 245, 975	12, 015, 808	89. 00
91. 00	90. 00		O	0		0 0	0	90.00
93. 00   09300   NONPAID   WORKERS   0 0 0 0 0 0 93. 00   94. 00   09400   PATIENTS LAUNDRY   0 0 0 0 0 0 94. 00   98. 00   Cross Foot Adjustments   0 0 0 0 0 0 98. 00   99. 00   Negative Cost Centers   0 0 0 0 0 0 99. 00			7, 391	4, 265		0 0		1
94.00     09400     PATIENTS LAUNDRY     0     0     0     0     94.00       98.00     Cross Foot Adjustments     0     0     0     0     0     98.00       99.00     Negative Cost Centers     0     0     0     0     0     99.00			0	0		0 0	•	
98.00         Cross Foot Adjustments         0         0         0         0         98.00           99.00         Negative Cost Centers         0         0         0         0         0         99.00		1	0	0		0		
99.00   Negative Cost Centers   0   0   0   0   99.00		1		0		o n	-	
100. 00   TOTAL   12, 027, 464  1, 137, 569  0  1, 245, 975  12, 027, 464  100. 00	99. 00	Negative Cost Centers	0	0		-	0	99. 00
	100.00	TOTAL	12, 027, 464	1, 137, 569		0 1, 245, 975	12, 027, 464	100. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Da

				T	o 12/31/2021	Date/Time Pre 5/26/2022 11:	pared: 46 am
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	TO GIII
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 375, 399					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	129, 907	657, 765	5			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	37, 118	18, 994	206, 935			6. 00
7.00	00700 HOUSEKEEPI NG	71, 173	9, 510	0	369, 885		7. 00
8.00	00800 DI ETARY	212, 212	61, 291	0	36, 027	1, 171, 818	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	178, 049	0	0	0	0	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11. 00	01100 PHARMACY	0	0	0	0	0	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	11, 916	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	62, 746	2, 670	0	1, 569		13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	124 0/0	(0.404	0	0	0	14.00
15. 00	O1500 PATIENT ACTIVITIES	124, 969	60, 694	. 0	35, 676	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	1, 194, 670	485, 994	206, 935	285, 672	1, 171, 818	30.00
31. 00	03100 NURSING FACILITY	1, 194, 670	400, 994	200, 933	200, 072	1, 171, 616	31.00
32. 00	03200   CF/11D	0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		0	0	_	0	33. 00
33. 00	ANCI LLARY SERVI CE COST CENTERS			,			33.00
40. 00	04000 RADI OLOGY	4, 912	0	0	0	0	40. 00
41. 00	04100 LABORATORY	12, 898	0	o o	_	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	12, 370	0		0	Ő	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	o o	o O	ő	43. 00
44. 00	04400 PHYSI CAL THERAPY	134, 380	15. 561	0	9, 147	Ō	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	86, 047	0	0	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	2, 961	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	102, 364	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	6, 161	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	1					
60.00	06000 CLINIC	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	U	0	61.00
62. 00	O6200   FQHC   OTHER REI MBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00	07100 AMBULANCE	47	0		_	0	71.00
73. 00	07300 CMHC	0	0		_		73.00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u>,                                     </u>	J		70.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100   NTEREST EXPENSE						81. 00
	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	2, 372, 530	654, 714	206, 935	368, 091	1, 171, 818	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	2, 869	3, 051	0	1, 794	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	0	93. 00
94. 00	09400 PATIENTS LAUNDRY		0	0	0	0	94. 00
98. 00	Cross Foot Adjustments		0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99.00
100.00	TOTAL	2, 375, 399	657, 765	206, 935	369, 885	1, 171, 818	1100.00

| Period: | Worksheet B | From 01/01/2021 | Part I | Date/Time Prepared: | 5/26/2022 | 11: 46 am |

						5/26/2022 11:	46 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9. 00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						5. 00 6. 00 7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	901, 521					8. 00 9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY	0	0	0			10.00
11. 00 12. 00	01100   PHARMACY   01200   MEDI CAL RECORDS & LI BRARY	0	0	0	(0.225		11.00
13. 00		0	0	0	60, 335	321, 944	12. 00 13. 00
14. 00	+ I		0	0	0	321, 744	14. 00
15. 00	1 1	0	0	o o	0	0	15. 00
30.00	03000 SKILLED NURSING FACILITY	901, 521	0	0	60, 335	321, 944	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00		0	0	0	0	_	32. 00
33. 00		0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	I I	0	0	0	0		40.00
41.00		0	0	0	0	0	41.00
42. 00		0	0	0	0	0	42.00
43.00	,	0	0	0	0	0	43.00
44. 00 45. 00		0	0	0	0	0	44. 00 45. 00
46. 00		0	0	0	0	0	46. 00
	1		0	0	0	0	
47. 00 48. 00		0	0	0	0	0	47. 00 48. 00
		0	0	0	0	0	
49.00	1	0	0	0	0		49.00
50. 00 51. 00	+ I	0	0	0	0	0	50. 00 51. 00
51.00	05100 SUPPORT SURFACES  OUTPATIENT SERVICE COST CENTERS	l U	U	l ol	0	0	51.00
60. 00		O	0	0	0	0	60. 00
61. 00	+ I	0	0	0	0	0	61. 00
62. 00	1 1	١	U	U	0	0	62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00		0	0	O	0	0	70. 00
71. 00	1 1		0		0	1	71. 00
73. 00	1 1		0	0	0	Ö	73. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	١			73.00
80. 00							80. 00
81. 00							81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	1	0	0	0	0	0	83. 00
89. 00	+ I	901, 521	0	Ö	60, 335		
07.00	NONREI MBURSABLE COST CENTERS	701,021	J	١	00,000	021,711	07.00
90. 00		O	0	0	0	0	90. 00
91. 00		l o	0	0	0	Ö	91. 00
92. 00	I I	l o	0	-	0	Ö	92. 00
93. 00			0		0	Ö	93. 00
94. 00	I I		n	l o	0	Ö	94. 00
98. 00		o	0		· ·		98. 00
99. 00		o	0	0	0	0	99. 00
100.00		901, 521	0	Ö	60, 335		
		,	٦	, 9	22, 300	,	

| Peri od: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Da Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315057

						To 12/31/2021	Date/Time Pre 5/26/2022 11:	
				OTHER GENERAL			072072022 11.	TO dill
				SERVI CE				
	Cost	t Center Description	NURSI NG AND	PATI ENT	Subtotal	Post Stepdown	Total	
			ALLI ED HEALTH	ACTI VI TI ES		Adjustments		
			EDUCATI ON	45.00	47.00	17.00	10.00	
	CENEDAL CI	EDVI OF COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1.00		ERVICE COST CENTERS  REL COSTS - BLDGS & FIXTURES			1		I	1.00
2.00		REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	1 1	LOYEE BENEFITS						3. 00
4.00		NISTRATIVE & GENERAL						4. 00
5.00	00500 PLAN	NT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUN	NDRY & LINEN SERVICE						6. 00
7.00	00700 HOUS							7. 00
8.00	00800 DI E1	1						8. 00
9.00		SING ADMINISTRATION						9. 00
10.00		TRAL SERVI CES & SUPPLY						10.00
11.00	01100 PHAF							11.00
12. 00 13. 00		CAL RECORDS & LIBRARY AL SERVICE						12. 00 13. 00
14. 00		SING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	1 1	ENT ACTIVITIES	0	729, 132				15. 00
10.00		ROUTINE SERVICE COST CENTERS		7277102				10.00
30.00	03000 SKI L	LED NURSING FACILITY	0	729, 132	10, 212, 37	6 0	10, 212, 376	30. 00
31.00		SING FACILITY	0	0		0	0	31. 00
32. 00	03200 I CF		0	0	•	0	0	
33. 00		ER LONG TERM CARE	0	0		0 0	0	33. 00
40. 00	04000 RADI	SERVI CE COST CENTERS	0	0	24, 87	3 0	24 072	40. 00
41. 00	04100 LAB		0	0			24, 873 65, 305	
42. 00	1 1	RAVENOUS THERAPY	0	0		0 0	05, 303	
43. 00		GEN (INHALATION) THERAPY	0	0		o o	Ö	
44.00	1 1	SI CAL THERAPY	0	0	705, 12	1 0	705, 121	
45.00	04500 OCCL	JPATI ONAL THERAPY	0	0	435, 68	7 0	435, 687	45. 00
46. 00	1 1	ECH PATHOLOGY	0	0	14, 99	1 0	14, 991	46. 00
47. 00		CTROCARDI OLOGY	0	0		0	0	1
48. 00		CAL SUPPLIES CHARGED TO PATIENTS	0	0	F10 20	0	0	48. 00
49. 00 50. 00	1 1	GS CHARGED TO PATIENTS TAL CARE - TITLE XIX ONLY	0	0		0 0	518, 304	49. 00 50. 00
51.00	1 1	PORT SURFACES	0	0	•	-	31, 197	1
01.00		T SERVICE COST CENTERS	<u> </u>	J	01,17	,, ,	01,177	01.00
60.00	06000 CLI N		0	0		0 0	0	60.00
61.00	06100 RURA	AL HEALTH CLINIC	0	0		0 0	0	61. 00
62. 00	06200 FQHO							62. 00
70.00		MBURSABLE COST CENTERS		^	ı		1	70.00
70.00	1 1	E HEALTH AGENCY COST	0	0		0	0	
71. 00 73. 00	07100 AMBU 07300 CMH0		0	0		0 0		1
73.00		URPOSE COST CENTERS	U	0		0 0	0	73.00
80. 00		PRACTICE PREMIUMS & PAID LOSSES						80. 00
		EREST EXPENSE						81.00
82.00		_IZATION REVIEW - SNF						82. 00
83. 00	08300 HOSE		0	0		0		
89. 00		TOTALS (sum of lines 1-84)	0	729, 132	12, 008, 09	4 0	12, 008, 094	89. 00
00.00		RSABLE COST CENTERS	0	0			1 0	00.00
90. 00 91. 00		T, FLOWER, COFFEE SHOPS & CANTEEN BER AND BEAUTY SHOP	0	0	19, 37	0	0 19, 370	
92. 00		SICIANS PRIVATE OFFICES	0	0	19, 37	0 0	17, 370	1
93. 00		PAID WORKERS	Ö	Ö		o o	Ö	1
94. 00		ENTS LAUNDRY	0	0		0 0	0	1
98. 00	1 1	ss Foot Adjustments	0	0		0	0	
99.00		ative Cost Centers	0	0	10	0	0	
100.00	)   TOT <i>A</i>	AL	0	729, 132	12, 027, 46	4 0	12, 027, 464	1100.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315057

						То	12/31/2021	Date/Time Pre 5/26/2022 11:	
				CAPI TAL REI	ATED COSTS			372072022 11.	TO alli
	,	Cost Contor Doscription	Directly	BLDGS &	MOVABLE		Subtatal	EMPLOYEE	
	,	Cost Center Description	Directly Assigned New	FI XTURES	EQUI PMENT		Subtotal	BENEFITS	
			Capi tal						
			Related Costs	4 00	0.00		0.4	2.00	
	CENEDA	L SERVICE COST CENTERS	0	1. 00	2. 00		2A	3. 00	
1.00		CAP REL COSTS - BLDGS & FLXTURES							1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT							2. 00
3.00		EMPLOYEE BENEFITS	0	0		0	0	0	3.00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	0	189, 459 28, 751		0	189, 459 28, 751	0	4. 00 5. 00
6. 00		LAUNDRY & LINEN SERVICE	0	26, 731		0	26, 548	0	6.00
7. 00		HOUSEKEEPI NG	o	13, 292		0	13, 292	0	7. 00
8.00	00800	DI ETARY	0	85, 667		0	85, 667	0	8. 00
9. 00		NURSING ADMINISTRATION	0	0		0	0	0	9. 00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	0		0	0	0	10. 00 11. 00
12. 00	1 1	MEDICAL RECORDS & LIBRARY		0		0	0	0	12.00
13. 00	1 1	SOCIAL SERVICE	o	3, 732		0	3, 732	0	13. 00
14.00		NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14. 00
15. 00		PATIENT ACTIVITIES	0	84, 832		0	84, 832	0	15. 00
30. 00		ENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY		679, 273		0	679, 273	0	30. 00
31. 00		NURSING FACILITY		0/9, 2/3		0	0/9, 2/3	0	31.00
32. 00		ICF/IID	o	0		0	Ö	0	32. 00
33. 00		OTHER LONG TERM CARE	0	0		0	0	0	33. 00
		ARY SERVICE COST CENTERS	1				al		
40. 00 41. 00		RADI OLOGY LABORATORY	0	0		0	0	0	40. 00 41. 00
42.00		INTRAVENOUS THERAPY	0	0		0	0	0	42.00
43. 00		OXYGEN (INHALATION) THERAPY	0	0		0	ō	0	43. 00
44. 00		PHYSI CAL THERAPY	0	21, 750		0	21, 750	0	44. 00
45. 00		OCCUPATIONAL THERAPY	0	0		0	0	0	45. 00
46. 00 47. 00	1 1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0		0	U O	0	46. 00 47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	ő	0	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0		0	О	0	49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50. 00
51. 00		SUPPORT SURFACES I ENT SERVICE COST CENTERS	0	0		0	0	0	51. 00
60. 00			O	0		0	o	0	60. 00
61. 00		RURAL HEALTH CLINIC	0	0		0	ō	0	61. 00
62. 00									62. 00
70.00		REI MBURSABLE COST CENTERS	O	0			ام	0	70.00
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE	0	0		0	0	0	
73. 00	1 1		o	0		0	o	0	
		L PURPOSE COST CENTERS							
	1 1	MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF							81. 00 82. 00
83. 00		HOSPI CE	0	0		0	o	0	
89. 00		SUBTOTALS (sum of lines 1-84)	0	1, 133, 304		0	1, 133, 304	0	
		MBURSABLE COST CENTERS	T				_1		
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0	0 4, 265		0	0 4, 265	0	90. 00 91. 00
91.00		PHYSICIANS PRIVATE OFFICES		4, ∠05 ∩		0	4, 205 N	0	91.00
93. 00		NONPALD WORKERS		0		O	o	0	93. 00
94. 00	09400 I	PATIENTS LAUNDRY	0	0		0	О	0	94. 00
98.00		Cross Foot Adjustments		_			0	-	98. 00
99. 00 100. 00		Negative Cost Centers TOTAL	o	0 1, 137, 569		0	0 1, 137, 569	0	99. 00 100. 00
100.00	ا ا	IVIAL	ı V	1, 137, 309	l	J	1, 137, 309	U	1.00.00

Period: Worksheet B From 01/01/2021 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315057

				Ť.	o 12/31/2021	Date/Time Pre 5/26/2022 11:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	40 dili
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	189, 459					1. 00 2. 00 3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	10, 361	39, 112				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	2, 961	1, 129	30, 638			6. 00
7.00	00700 HOUSEKEEPI NG	5, 677	565	0	19, 534		7. 00
8.00	00800 DI ETARY	16, 926	3, 644	0	1, 903	108, 140	8. 00
9.00	00900 NURSING ADMINISTRATION	14, 201	0	0	o	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	O	0	0	o	0	10.00
11.00	01100 PHARMACY	O	0	0	o	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	950	0	0	o	0	12. 00
13.00	01300 SOCIAL SERVICE	5, 005	159	0	83	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 PATIENT ACTIVITIES	9, 967	3, 609	0	1, 884	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	95, 285	28, 900	30, 638	15, 086	108, 140	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200   CF/IID	0	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	392	0	0	0	0	40. 00
41.00	04100 LABORATORY	1, 029	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	10, 718	925	0	483	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	6, 863	0	0	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	236	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	8, 164	0	0	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	491	0	0	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS			1 -	_1		
60.00	06000 CLINIC	0	0	-		0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00	06200 FOHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70 00
70. 00 71. 00	07100 AMBULANCE	4	0		0	0	70. 00 71. 00
73.00	07300 CMHC	0	0		0	0	73.00
73.00	SPECIAL PURPOSE COST CENTERS	J O	U	<u> </u>	U	U	73.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
	08100   INTEREST EXPENSE			•			81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	189, 230	38, 931	30, 638	19, 439		89. 00
07.00	NONREI MBURSABLE COST CENTERS	107,200	55, 751	1 00,000	17, 107	100, 110	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	o	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	229	181		95	0	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	Ö	, o	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	ő	o	0	93. 00
94. 00	09400 PATIENTS LAUNDRY		n	ő	ol Ol	0	94. 00
98. 00	Cross Foot Adjustments	1	· ·	1 0	ol	0	98. 00
99. 00	Negative Cost Centers	l	0	Ō	o	0	99. 00
100.00	TOTAL	189, 459	39, 112	30, 638	19, 534	108, 140	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

						5/26/2022 11:	46 am_
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9. 00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 3.00 4.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						5. 00 6. 00 7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	14, 201					8. 00 9. 00
10.00		0	0				10.00
11. 00	I I	0	0	0			11.00
12. 00		0	0	0	950		12.00
13. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	8, 979	13.00
14. 00		0	0	0	0	0	14. 00
15. 00		0	0	0	0	0	15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 44 004			050		
30.00	1	14, 201	0	0	950		30.00
31.00		0	0	0	0	0	31. 00
32. 00		0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	J U	0	U U	0	0	33. 00
40. 00		O	0	O	0	0	40. 00
41. 00			0	0	0		41. 00
42. 00			0		0	Ö	42. 00
43. 00			0	0	0	Ö	43. 00
44. 00			0	0	0	Ö	44. 00
45. 00			0	0	0	Ö	45. 00
46. 00			0	o o	0	Ö	46. 00
47. 00			0	0	0	0	47. 00
48. 00			0	0	0	Ö	48. 00
49. 00			0	o o	0	Ö	49. 00
50. 00			0	o o	0	0	50. 00
51. 00			0	0	0	Ö	51. 00
01.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>			01.00
60. 00		0	0	0	0	0	60.00
61. 00		o	0	o	0	0	61. 00
62. 00	1		_			_	62. 00
	OTHER REIMBURSABLE COST CENTERS			L		I.	
70. 00		0	0	0	0	0	70.00
71.00	07100 AMBULANCE	o	0	0	0	0	71.00
73.00		o	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 H0SPI CE	0	0	0	0	0	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	14, 201	0	0	950	8, 979	89. 00
	NONREI MBURSABLE COST CENTERS	,					
90. 00		0	0	0	0		90.00
91. 00		0	0	0	0	0	91.00
92. 00		0	0	0	0		92.00
93. 00		0	0	0	0	0	93. 00
94. 00		0	0	0	0	0	94. 00
98. 00		0	0	0			98. 00
99.00		0	0	0	0	0	99.00
100.0	0   TOTAL	14, 201	0	0	950	8, 979	100. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315057

						To 12/31/2021	Date/Time Pre 5/26/2022 11:	
				OTHER GENERAL			372072022 11.	40 dili
				SERVI CE				
	Cost Center Description	N	URSING AND	PATI ENT	Subtotal	Post Step-Down	Total	
			LIED HEALTH	ACTI VI TI ES		Adjustments		
			EDUCATI ON	45.00	47.00	17.00	10.00	
	CENEDAL SERVICE COST CENTERS		14. 00	15. 00	16. 00	17. 00	18. 00	
1.00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FLXT	IDES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIT							2.00
3.00	00300 EMPLOYEE BENEFITS							3. 00
4.00	00400 ADMINISTRATIVE & GENERAL							4. 00
5.00	00500 PLANT OPERATION, MAINT. & REF	PAIRS						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								11.00
12. 00 13. 00	1							12. 00 13. 00
14. 00	1	ICATI ON	0					14. 00
15. 00	1	JOATTON	0	100, 292				15. 00
10.00	INPATIENT ROUTINE SERVICE COST CEN	TERS	<u> </u>	100/ 272				
30.00	03000 SKILLED NURSING FACILITY		0	100, 292	1, 081, 74	4 0	1, 081, 744	30. 00
31.00	1		0	0		0	0	31. 00
32. 00	1		0	0		0	0	
33. 00			0	0		0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY		0	0	39	2 0	392	40. 00
41. 00	1 1		0	0	1, 02	_	1, 029	1
42. 00	1 1		ő	0		o o	0	42. 00
43. 00			o	0		0	0	43. 00
44.00	04400 PHYSI CAL THERAPY		o	0	33, 87	6 0	33, 876	44. 00
45.00	1		0	0	6, 86	3 0	6, 863	45. 00
46. 00	1		0	0	23		236	1
47. 00	1 1	NATI ENTO	0	0		0	0	•
48. 00 49. 00	1 1	PATTENTS	0	0		0	0 8, 164	48. 00 49. 00
50.00	1 1		0	0	8, 16	0	0, 104	50.00
51.00			0	0		-	491	ł
	OUTPATIENT SERVICE COST CENTERS		-1	-,		- 1		
60.00	06000 CLI NI C		0	0		0	0	60. 00
61. 00			0	0		0	0	61. 00
62. 00								62. 00
70.00	OTHER REIMBURSABLE COST CENTERS		ما	0				70.00
70. 00 71. 00	1		0	0		0 4 0	0	70. 00 71. 00
73.00	1 1		0	0		0	4 0	•
73.00	SPECIAL PURPOSE COST CENTERS		<u> </u>	<u> </u>	'	51 0	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID I	OSSES						80. 00
	08100 INTEREST EXPENSE							81. 00
82. 00								82. 00
83. 00			0	0		0	0	
89. 00		)	0	100, 292	1, 132, 79	9 0	1, 132, 799	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS &	CANTEEN	ما	٥		0 0	0	90. 00
91. 00	1	CANTLLN	0	0	4, 77	9	4, 770	1
92. 00	1 1		Ö	0	1, , ,	0	0	ı
93. 00	1 1		o	o		o o	0	1
94.00			o	O		0	0	
98. 00			O	0		0	0	
99.00			0	0	1 407 54	0	0	
100.00	0   TOTAL		O	100, 292	1, 137, 56	9 0	1, 137, 569	1100.00

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

					o 12/31/2021	Date/Time Pre 5/26/2022 11:	pared:
		CAPITAL REI	ATED COSTS			5/26/2022   11: -	40 alli
	Cost Center Description	BLDGS &	MOVABLE	 EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FIXTURES	EQUI PMENT	BENEFI TS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM COST)	
		1.00	2.00	3.00	4A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS    OO100   CAP REL COSTS - BLDGS & FIXTURES	64, 018	Γ	T		Ι	1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	04,010	o				2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	5, 855, 048		0 (50 0/5	3.00
4. 00 5. 00	OO4OO   ADMINISTRATIVE & GENERAL   OO5OO   PLANT OPERATION, MAINT. & REPAIRS	10, 662 1, 618		602, 838 94, 937			4. 00 5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 494	0	96, 262	2 0	150, 823	6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	748 4, 821	0	151, 239 378, 626		289, 202 862, 288	7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	4, 821		596, 528		723, 472	9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY	0	O	C		0	10.00
11. 00 12. 00	O1100   PHARMACY   O1200   MEDI CAL RECORDS & LI BRARY	0	0	)		0 48, 419	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	210	Ö	207, 146			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1	_	1	14. 00
15. 00	01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	4, 774	<u> </u>	322, 848	0	507, 793	15. 00
30.00	03000 SKILLED NURSING FACILITY	38, 227	O			., .,	30. 00
31. 00 32. 00	03100   NURSING FACILITY   03200   CF/IID	0	0	1		1	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	Ö				33. 00
40.00	ANCILLARY SERVICE COST CENTERS			J		10.0/1	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0					40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	O	o c		0	42. 00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	1 224	0	)		0 546, 033	43. 00 44. 00
45.00	04500 OCCUPATIONAL THERAPY	1, 224 0		178, 431		349, 640	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	O	C	0	12, 030	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 PATIENTS	0	Ö		Ö		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1			50.00
51. 00	O5100   SUPPORT SURFACES   OUTPATIENT SERVICE COST CENTERS	0	0	)  C	) 0	25, 036	51. 00
60.00	06000 CLI NI C	0	1	•			60. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	O	C	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	1				70.00
71. 00 73. 00	07100   AMBULANCE	0		•			71. 00 73. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00 81. 00	08000   MALPRACTICE PREMIUMS & PAID LOSSES   08100   INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83.00	08300 HOSPI CE	0	0	1			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)   NONREIMBURSABLE COST CENTERS	63, 778	0	5, 855, 048	-2, 375, 399	9, 640, 409	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		1			90. 00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	240	0				91. 00 92. 00
93. 00	09300 NONPALD WORKERS	0	Ö		_	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	O	C	0	0	94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00	Cost to be allocated (per Wkst. B,	1, 137, 569	o	1, 245, 975	5	2, 375, 399	
103.00	Part I)   Unit cost multiplier (Wkst. B, Part I)	17. 769518	0. 000000	0. 212804		0. 246103	103 00
103.00		17.707510	0.00000	0.212804		189, 459	
105 00	Part II)			0.00000		0.010/00	105 00
105.00	Unit cost multiplier (Wkst. B, Part			0.000000	,	0. 019629	105.00
		•	,	•	"	•	•

Period: Worksheet B-1
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/26/2022 11: 46 am

					'	0 12/31/2021	5/26/2022 11:	
		Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
			OPERATION,	LINEN SERVICE (PATIENT DAYS)	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
			MAINT. & REPAIRS	(PATTENT DATS)			(DI RECT	
			(SQUARE FEET)				NURSI NG)	
			5.00	6.00	7. 00	8. 00	9. 00	
4 00		AL SERVICE COST CENTERS	I	I	ı	I		4 00
1. 00 2. 00	1	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3.00		EMPLOYEE BENEFITS						3. 00
4. 00	1	ADMINISTRATIVE & GENERAL						4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS	51, 738					5. 00
6.00		LAUNDRY & LINEN SERVICE	1, 494					6. 00
7.00	1	HOUSEKEEPI NG	748	1	,			7. 00
8.00	1	DI ETARY	4, 821	0	4, 821		140 410	8. 00
9. 00 10. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	0	0	0	140, 419 0	9. 00 10. 00
11. 00		PHARMACY	0	0	0	0	0	11. 00
12. 00	1	MEDICAL RECORDS & LIBRARY	0	Ö	Ö	0	0	12. 00
13.00	01300	SOCIAL SERVICE	210	0	210	0	0	13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14. 00
15. 00		PATIENT ACTIVITIES	4,774	0	4, 774	0	0	15. 00
30. 00		I ENT ROUTI NE SERVI CE COST CENTERS	20 227	21 057	20 227	02 171	140,410	20.00
30.00		SKILLED NURSING FACILITY NURSING FACILITY	38, 227	31, 057 0	38, 227 0	93, 171	140, 419 0	30. 00 31. 00
32. 00	1	ICF/IID	0			-	0	32. 00
33. 00		OTHER LONG TERM CARE	Ö	Ö	•	_	0	33. 00
	ANCI L	LARY SERVICE COST CENTERS						
40.00		RADI OLOGY	0	0			0	40. 00
41.00	1	LABORATORY	0	0	0	0	0	41. 00
42. 00 43. 00	1	INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	0	0	0	0	0 0	42. 00 43. 00
44. 00	1	PHYSICAL THERAPY	1, 224	0	1, 224	0	0	44. 00
45. 00		OCCUPATI ONAL THERAPY	0	0	0		Ö	45. 00
46.00		SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700	ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0		-	0	50. 00 51. 00
31.00		TIENT SERVICE COST CENTERS			0	j o	0	31.00
60. 00		CLINIC	0	0	0		0	60. 00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200							62.00
70.00		REI MBURSABLE COST CENTERS					0	70.00
70. 00 71. 00	1	HOME HEALTH AGENCY COST AMBULANCE	0	0			0 0	70. 00 71. 00
73.00	07300		0				0	73.00
70.00		AL PURPOSE COST CENTERS						70.00
		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	1	INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW - SNF						82. 00
83. 00 89. 00	08300	HOSPICE SUBTOTALS (sum of lines 1-84)	0 51, 498	-		93, 171	0 140, 419	
09.00	NONRE	IMBURSABLE COST CENTERS	51,470	31,037	49, 230	73, 171	140, 419	09.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00	09100	BARBER AND BEAUTY SHOP	240	0	240	0	0	91. 00
92. 00	1	PHYSICIANS PRIVATE OFFICES	0	0		0	0	92. 00
93.00	1	NONPALD WORKERS	0	0	1	0	0	93. 00
94. 00 98. 00	09400	PATIENTS LAUNDRY Cross Foot Adjustments	0	0	0	0	0	94. 00 98. 00
98.00		Negative Cost Centers						98. 00 99. 00
102.00		Cost to be allocated (per Wkst. B,	657, 765	206, 935	369, 885	1, 171, 818	901, 521	
, -		Part I)						
103.00	1	Unit cost multiplier (Wkst. B, Part I)	12. 713383	1			6. 420221	
104.00	)	Cost to be allocated (per Wkst. B,	39, 112	30, 638	19, 534	108, 140	14, 201	104. 00
105.00		Part II) Unit cost multiplier (Wkst. B, Part	0. 755963	0. 986509	0. 394658	1. 160662	0. 101133	105 00
100.00	1		0. 755703	0. 700509	0. 374030	1. 100002	0. 101133	100.00
	•	•	•	•			•	•

Heal th	Financial Systems	MERRY HEART S	SUCCASUNNA		In Lie	u of Form CMS-	2540-10
COST A	ILLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/26/2022 11:	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED TI ME)	
	ASSUEDAN ASSUEDAN ASSUESAN	10.00	11. 00	12. 00	13. 00	14. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES  00200 CAP REL COSTS - BUDGS & FIXTURES  00300 EMPLOYEE BENEFITS  00400 ADMINISTRATIVE & GENERAL  00500 PLANT OPERATION, MAINT. & REPAIRS  00600 LAUNDRY & LINEN SERVICE  00700 HOUSEKEEPING  00800 DIETARY  00900 NURSING ADMINISTRATION  01000 CENTRAL SERVICES & SUPPLY  01100 PHARMACY  01200 MEDICAL RECORDS & LIBRARY  01300 SOCIAL SERVICE	0 0	C	31, 057			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	C	1		0	1
15. 00	01500 PATIENT ACTIVITIES	0	C			0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	C			0	
31. 00 32. 00	03100 NURSING FACILITY 03200   CF/IID	0	C		ή	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	C		1	0	1
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1	,ı		00.00
40.00	04000 RADI OLOGY	0	C	) C	0	0	40. 00
41. 00	04100 LABORATORY	0	C	) C	0	0	
42. 00	04200 I NTRAVENOUS THERAPY	0	C		0	0	
43. 00 44. 00	04300   OXYGEN (INHALATION) THERAPY   04400   PHYSI CAL THERAPY	0				0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	C		ol ol	0	1
46.00	04600 SPEECH PATHOLOGY	0	C	) c	o	0	1
47. 00	04700 ELECTROCARDI OLOGY	0	C	) c	0	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	0	
49. 00 50. 00	04900   DRUGS CHARGED TO PATIENTS   05000   DENTAL CARE - TITLE XIX ONLY	0	C			0	
51. 00	05100 SUPPORT SURFACES	0	C			0	1
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0		C		0	
61.00	06100 RURAL HEALTH CLINIC	0	C	C	0	0	
62. 00	O6200   FOHC   OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	C	) C	0	0	70. 00
71. 00	07100 AMBULANCE	0	C	) c	0	0	71. 00
73. 00	07300 CMHC	0	C	) <u> </u>	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	C	•	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	0	C	31, 057	31, 057	0	89. 00
90. 00	NONREI MBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	C	) C	ol	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	C			0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	C		o	0	1
93. 00	09300 NONPALD WORKERS	0	C	) c	0	0	
94.00	09400 PATIENTS LAUNDRY	0	C	0	0	0	/ 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers			-			98. 00 99. 00
102.00		0	C	60, 335	321, 944	0	102. 00
50	Part I)						55
103.00		0. 000000	0. 000000			0. 000000	
104.00	1 1	0	C	950	8, 979	0	104. 00
105.00	Part II)  Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 030589	0. 289114	0. 000000	105 00
. 55. 50		3. 555556	3. 300000	0.00007	0.20/114	3. 300000	
		,			'		

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | To 12/31/2021 | Date/Time Prepared: Provi der No.: 315057

			To 12/31/2021   Date/Time Pre	
		OTHER GENERAL		
	Cost Center Description	SERVI CE PATI ENT		
	cost denter bescription	ACTIVITIES		
		(PATIENT DAYS)		
	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 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL			3.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS			4. 00 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 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE			12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	01500 PATIENT ACTIVITIES	31, 057		15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	21 057		20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	31, 057 0		30. 00 31. 00
32. 00	03200   CF/11D	o		32. 00
33. 00	03300 OTHER LONG TERM CARE	0		33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0		40. 00
41. 00	04100 LABORATORY	o		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	O		42. 00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0		43. 00 44. 00
45.00	04500 OCCUPATI ONAL THERAPY	o		45. 00
46. 00	04600 SPEECH PATHOLOGY	О		46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	ol Ol		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	О		50. 00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0		51. 00
60. 00	06000 CLINIC	0		60.00
61.00	06100 RURAL HEALTH CLINIC	0		61. 00
62. 00	06200 FOHC OTHER REIMBURSABLE COST CENTERS			62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0		70. 00
71. 00	07100 AMBULANCE	O		71. 00
73. 00	07300 CMHC	0		73. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
81. 00	08100 INTEREST EXPENSE			81. 00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE			82. 00 83. 00
89.00	SUBTOTALS (sum of lines 1-84)	0 31, 057		89. 00
	NONREI MBURSABLE COST CENTERS	- ,		
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFICES	0		91. 00 92. 00
93. 00	09300 NONPALD WORKERS	0		93. 00
94. 00	09400 PATIENTS LAUNDRY	0		94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers			98. 00 99. 00
102.00		729, 132		102. 00
100.00	Part I)	22 477240		102.00
103. 00 104. 00		23. 477219 100, 292		103. 00 104. 00
	Part II)			
105.00		3. 229288		105. 00
	)	I		1

Health Financial Systems	MERRY HEART SUCC	CASUNNA	In Lie	u of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR	ANCILLARY AND OUTPATIENT COST CENTERS	Provi der No.: 315057	From 01/01/2021	Worksheet C Date/Time Prepared: 5/26/2022 11:46 am
Cost Center Descr	ri pti on		m Total Charges	

		1	0 12/31/2021	Date/IIMe Prep   5/26/2022 11:4	
	Cost Center Description	Total (from	Total Charges		to alli
	p	Wkst. B, Pt I,	3	di vi ded by	
		col. 18)		col. 2	
		1. 00	2. 00	3. 00	
	CILLARY SERVICE COST CENTERS				
40. 00   04	000 RADI OLOGY	24, 873	12, 793	1. 944266	40.00
41. 00   04	100 LABORATORY	65, 305	31, 268	2. 088557	41.00
42.00 04	200 I NTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00 04	300 OXYGEN (INHALATION) THERAPY	0	2, 440	0.000000	43.00
44.00 04	400 PHYSI CAL THERAPY	705, 121	877, 305	0. 803735	44.00
45. 00 04	500 OCCUPATI ONAL THERAPY	435, 687	842, 300	0. 517259	45.00
46. 00 04	600 SPEECH PATHOLOGY	14, 991	73, 957	0. 202699	46.00
47.00 04	700 ELECTROCARDI OLOGY	0	0	0.000000	47.00
48. 00 04	800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 720	0.000000	48.00
49. 00 04	900 DRUGS CHARGED TO PATIENTS	518, 304	415, 940	1. 246103	49.00
50.00 05	000 DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00 05	100 SUPPORT SURFACES	31, 197	0	0.000000	51.00
OU	TPATIENT SERVICE COST CENTERS	 			
60.00 06	000 CLI NI C	0	0	0.000000	60.00
61.00 06	100 RURAL HEALTH CLINIC				61.00
62.00 06	200 FQHC				62.00
71. 00   07	100 AMBULANCE	240	0	0. 000000	71.00
100.00	Total	1, 795, 718	2, 258, 723	l	100. 00

Health Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COS	STS	Provi der		Peri od:	Worksheet D	
				From 01/01/2021	Part I	
				Го 12/31/2021	Date/Time Pre 5/26/2022 11:	pared: 46 am
-		Title	XVIII (1)	Skilled Nursing		10 uiii
			1 /	Facility		
		Heal th Care Pi	rogram Charges	Health Care	Program Cost	
Cook Cooker Doored at long	D-4:£ 04	D+ A	D+ D	D 1 ( 1	D+ D (1 1	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges (Fr. Wkst. C			x col. 2)	x col. 3)	
	Column 3)					
	1, 00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND		2.00	3.00	4.00	3.00	
ANCI LLARY SERVICE COST CENTERS	OUT ATTENT OUT					1
40. 00 04000 RADI OLOGY	1. 944266	12, 793	(	24, 873	0	40.00
41. 00   04100   LABORATORY	2. 088557	31, 268		65, 305	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 000000	0		0	0	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	2, 440		0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0. 803735	754, 158		606, 143	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 517259	768, 052		397, 282	0	45. 00
46.00 04600 SPEECH PATHOLOGY	0. 202699	64, 823	(	13, 140	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0	(	0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATII	ENTS 0. 000000	2, 720	(	0	0	48. 00
49.00 O4900 DRUGS CHARGED TO PATIENTS	1. 246103	295, 334	(	368, 017	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0	(	0	0	51. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00  06000 CLI NI C	0. 000000	0		0	0	00.00
61.00  06100 RURAL HEALTH CLINIC						61.00
62. 00   06200   FQHC						62. 00
71. 00 07100 AMBULANCE (2)	0. 000000			O		71. 00
100.00   Total (Sum of lines 40 - 71)		1, 931, 588	(	1, 474, 760	0	100. 00
(1) For title V and XIX use columns 1, 2, and	l 4 only.					

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

Health Financial Systems MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10							2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315057	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/26/2022 11:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		·			1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of cos	st to charges	(From Workshee	t C, column 3	, line 49)	1. 246103	1.00
2.00	Program vaccine charges (From your reco				•	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title 2	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)		1				
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied	
		Part I, Col. 18	(From Wkst. B, Part I, Col.	Costs to Tota		Health Costs for Pass	
		18	14)	Costs - Part		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	24, 873	l e	0.00000	.,		
41. 00	04100 LABORATORY	65, 305	0	0. 00000		ł	
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0.00000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	705 404	0	0.00000		0	
44. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	705, 121	0	0.00000			44. 00 45. 00
45. 00 46. 00	04500 SPEECH PATHOLOGY	435, 687 14, 991		0.00000		<b>l</b>	46.00
47. 00	04700 ELECTROCARDI OLOGY	14, 991		0.00000		0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0.00000		0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	518, 304		0.00000			
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.0,001		0.00000		0	
51. 00	05100 SUPPORT SURFACES	31, 197		0.00000		0	
100.00	Total (Sum of lines 40 - 52)	1, 795, 478	o		1, 474, 760	0	100. 00

		RRY HEART SUCCA	* * * * * * * * * * * * * * * * * * * *		u of Form CMS-2	<u> 2540-1</u>
COMPUT	ATION OF INPATIENT ROUTINE COSTS		Provi der No.: 315057	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 5/26/2022 11:	pared:
			Title XVIII	Skilled Nursing Facility	PPS	
					1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				1.00	
	I NPATI ENT DAYS					1
. 00	Inpatient days including private room days				31, 057	1.0
. 00	Private room days				0	
. 00	Inpatient days including private room days applic		ogram		8, 721	3.0
. 00	Medically necessary private room days applicable	to the Program			0	
. 00	Total general inpatient routine service cost				10, 212, 376	5. C
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges				13, 260, 279	6.0
00	General inpatient routine service charges	io (line 5 di)	(ided by line 6)		0. 770148	
00	Enter private room charges from your records	io (Line 5 di	rided by Title 0)		0. 770148	8.
00						
00	2)	iii charges rrne	o arvided by private	Toom days, Title	0.00	/.
0. 00	00 Enter semi-private room charges from your records					10.
1.00	Average semi-private room per diem charge (Semi-	private room cl	narges line 10, divide	ed by	0. 00	11. (
	semi-private room days)					
2. 00	Average per diem private room charge differential	•				12. (
3. 00	Average per diem private room cost differential (				0.00	
4. 00	Private room cost differential adjustment (Line 2			-: !: 14)	0	14.
5. 00	General inpatient routine service cost net of pri PROGRAM INPATIENT ROUTINE SERVICE COSTS	vate room cost	differential (Line 5	minus iine 14)	10, 212, 376	15.
6. 00	Adjusted general inpatient service cost per diem	(Line 15 divid	ded by line 1)		328. 83	16. (
7. 00	Program routine service cost (Line 3 times line	•	204 23 11110 17		2, 867, 726	
3. 00	Medically necessary private room cost applicable		ne 4 times line 13)		0	1
9. 00	Total program general inpatient routine service c	ost (Line 17	olus line 18)		2, 867, 726	19.
0. 00	Capital related cost allocated to inpatient routi		ts (From Wkst. B, Par	t II column 18,	1, 081, 744	20. (
	line 30 for SNF; line 31 for NF, or line 32 for I					
1. 00	Per diem capital related costs (Line 20 divided				34. 83	
2. 00	Program capital related cost (Line 3 times line				303, 752	
3. 00	Inpatient routine service cost (Line 19 minus li	,	don nocendo)		2, 563, 974	
. 00	Aggregate charges to beneficiaries for excess cos Total program routine service costs for compariso			nus Lino 24)	0 2, 563, 974	1
. 00	Enter the per diem limitation (1)	ii to the cost i	ımıtatıon (Line 23 III	nus IIIle 24)	2, 303, 974	26.
. 00	Inpatient routine service cost limitation (Line 3	times the ner	diem limitation line	26) (1)		27.
3. 00	1 .					28.
	(Transfer to Worksheet E, Part II, line 4) (See i			·= =· /		_0.
) li	nes 26 and 27 are not applicable for title XVIII,	•	d for title V and or t	title XIX	•	

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	31, 057	1.00
2.00	Program inpatient days (see instructions)	8, 721	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. 280806	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 SUCCA	ASUNNA	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLE	MENT FOR TITLE XVIII	Provi der No.: 315057	From 01/01/2021	Worksheet E Part I Date/Time Prepared: 5/26/2022 11:46 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing Facility	PPS	10 4111
			racifity		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)			5, 563, 342	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	,		5, 563, 342	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			686, 721	5. 00
6.00	Allowable bad debts (From your records)			157, 059	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)	ŕ		102, 088	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			4, 978, 709	11. 00
12. 00	Interim payments (See instructions)			4, 975, 910	12. 00
13. 00	Tentati ve adjustment			0	13. 00
14. 00	OTHER adjustment (See instructions)			0	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			0	14. 75
14. 99	Sequestration amount (see instructions)			0	14. 99
15. 00					15. 00
16.00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2,	section 115.2)	2, 799 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 instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26.00	Interim payments (See instructions)			0	26.00
27.00	Tentati ve adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			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	e with CMS Pub.15-2,	section 115.2	0	30. 00

Provi der No.: 315057 Peri od: Worksheet E-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 11:46 am Title XVIII Skilled Nursing PPS

Inpatient Part A   Part B			11 (1)	e AVIII	Facility	PPS	
1.00			Inpatien	t Part A		t B	
1.00							
Total interim payments paid to provider   4,975,910   0   1.00   0   2.00   0   0   0   0   0   0   0   0   0							
InterIm payments' payable on Individual bills, either submitted or to be submitted for the cost reporting period. If none, enter zero	1 00	Takal interior assumants as in the provides	1.00		3. 00		1 00
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero				4, 9/5, 910			
Services rendered in the cost reporting period. If none, enter zero   1.50   2.50	2.00			U		0	2.00
enter zero   anount based on subsequent revision of the Interia mate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00	1					3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider   ADJUSTMENTS TO PROVIDER   0		for the cost reporting period. Also show date of each					
ADJUSTMENTS TO PROVIDER		payment. If none, write "NONE" or enter a zero. (1)					
3.02   3.03   3.04   0   0   0   3.02   3.04   3.05   3.							
3.03   0		ADJUSTMENTS TO PROVIDER				1	
3. 04   0   0   0   3. 04   0   0   3. 04   0   0   3. 05   0   0   3. 05   0   0   3. 05   0   0   3. 05   0   0   3. 05   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   3. 55   0   0   0   0   3. 55   0   0   0   0   0   0   0   0   0						_	
3.05   Provider to Program						1	
Provider to Program				-			
3. 50   ADJUSTMENTS TO PROGRAM   0   0   3. 50   3. 51   3. 52   3. 53   0   0   0   3. 51   3. 52   3. 53   0   0   0   3. 52   3. 53   3. 54   0   0   0   0   3. 53   3. 54   3. 99   4. 975, 910   0   0   3. 59   3. 99   4. 975, 910   0   9   9   9   9   9   9   9   9	3.05	Dravi dan ta Dragnam		U		0	3.05
3.51   3.52   3.53   3.53   3.53   3.53   3.53   3.54   0   0   0   3.552   3.53   3.54   0   0   0   3.553   3.54   0   0   0   3.553   3.54   0   0   0   3.553   3.54   0   0   0   3.553   3.54   0   0   0   3.553   3.59   0   0   0   0   3.553   3.59   0   0   0   0   3.553   0   0   0   0   3.553   0   0   0   0   3.553   0   0   0   0   3.553   0   0   0   0   3.553   0   0   0   0   0   3.553   0   0   0   0   0   0   0   0   0	2 50			0		1	2 50
3.52   3.53   3.54   3.95   3.54   3.95   3.54   3.97   3.59		ADJUSTIMENTS TO TROOKAM		-		1	
3.53   3.54   3.58   3.59				_			1
3.54   3.99   Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   3.54				0		1	
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   3.99    -3.98   10tal interim payments (sum of lines 1, 2, and 3.99)   4,975,910   0   4.00    -3.98   10tal interim payments (sum of lines 1, 2, and 3.99)   4,975,910   0   4.00    -3.98   10tal interim payments (sum of lines 1, 2, and 3.99)   4,975,910   0   4.00    -3.98   10tal interim payments (sum of lines 1, 2, and 3.99)   4,975,910   0   4.00    -3.98   10tal interim payments (sum of lines 1, 2, and 3.99)   4,975,910   0   4.00    -3.98   10tal interim payments (sum of lines 1, 2, and 3.99)   4,975,910   0   5.00    -3.98   10tal interim payments (sum of lines 1, 2, and 3.99)   4,975,910   0   5.00    -3.98   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   5.01    -3.01   12tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   5.50    -3.02   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 5.50   0   0   5.50    -3.03   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 5.50   0   0   5.50    -3.02   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 5.50   0   0   5.50    -3.03   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 5.50   0   0   5.50    -3.04   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 5.50   0   0   5.50    -3.05   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   5.50    -3.05   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   0   5.50    -3.05   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   0   0   5.50    -3.01   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   0   0   0   5.50    -3.01   10tal interim payments (sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   0   0   0   0   0   0   0				0		1	
A.00   Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)   TO BE COMPLETED BY CONTRACTOR		Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		0		0	3. 99
Circansfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)   TO BE COMPLETED BY CONTRACTOR		- 3. 98)					
26 for Part B)   TO BE COMPLETED BY CONTRACTOR	4.00			4, 975, 910		0	4. 00
TO BE COMPLETED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	F 00					I	F 00
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						5.00
Program to Provider							
TENTATIVE TO PROVIDER							
Solution   Contractor   Solution   Solutio	5. 01			0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM   0   0   5.50	5.03			0		0	5. 03
5.51   5.52							
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		TENTATIVE TO PROGRAM		-			
5.99   Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0   5.99   - 5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   PROGRAM TO PROVIDER   2,799   0   6.01   6.02   PROVIDER TO PROGRAM   0   0   0   6.02   7.00   Total Medicare program liability (see instructions)   4,978,709   0   7.00   Contractor Name   Contractor Number   1.00   2.00   8.00   Name of Contractor   8.00							
- 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  - 5.98) 6.00  2,799 0 6.01 0 9.00 0 6.02 7.00 Contractor Name Contractor Name Contractor Number 1.00 2.00  8.00 Name of Contractor				0			
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name Contractor Name Contractor Number  1.00 2.00  8.00 Name of Contractor  8.00 Name of Contractor	5. 99			0		0	5. 99
the cost report. (1) PROGRAM TO PROVIDER PROVIDER TO PROGRAM To tal Medicare program liability (see instructions)  2,799 0 6.01 4,978,709 0 7.00  Contractor Name Contractor Name Number 1.00 2.00  8.00 Name of Contractor 8.00	6 00						6.00
6.01 PROGRAM TO PROVIDER 0	0.00						0.00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name Contractor Number 1.00 2.00  8.00 Name of Contractor 8.00 Name of Contractor	6 01			2 799		0	6 01
7.00         Total Medicare program liability (see instructions)         4,978,709         0         7.00           Contractor Name         Contractor Number           1.00         2.00           8.00         Name of Contractor         8.00				0		-	1
Contractor Name         Contractor Number           1.00         2.00           8.00 Name of Contractor         8.00		·		4, 978, 709		0	•
1.00         2.00           8.00         Name of Contractor         8.00					or Name	Contractor	
8.00 Name of Contractor 8.00							
ļ ļ		I		1.	00	2. 00	
		!				l	8.00

<sup>(1)</sup> 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.

lealth Financial Systems MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10
BALANCE SHEET (If you are nonproprietary and do not maintain Provider No.: 315057 Period: Worksheet G

Health Financial Systems

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

Provi der No.: 315057 | Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/26/2022 11: 46 am

ı y)					5/26/2022 11:	46 ar
		General Fund	Speci fi c Er Purpose Fund	ndowment Fund	Plant Fund	
	T.	1.00	2.00	3. 00	4. 00	
	Assets CURRENT ASSETS					
00	Cash on hand and in banks	1, 690, 810	O	0	0	1.
00	Temporary investments	1,070,010		0	Ö	
00	Notes receivable	o o	Ö	0	Ö	
00	Accounts receivable	930, 806	0	0	0	4.
00	Other recei vabl es	0	0	0	0	5.
00	Less: allowances for uncollectible notes and accounts	0	0	0	0	6.
00	recei vabl e			0		,
00 00	Inventory Prepaid expenses	30, 100	0	0	0	
00	Other current assets	30, 100		0	0	
. 00	Due from other funds	2, 645, 000		0	Ö	
. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	5, 296, 716		0	O	
	FIXED ASSETS					
. 00	Land	0	0	0	0	
. 00	Land improvements	0	0	0	0	1
. 00	Less: Accumulated depreciation	0	0	0	0	
. 00	Buildings Less Accumulated depreciation	0	0	0	0	
. 00	Leasehold improvements			0	0	
. 00	Less: Accumulated Amortization			0	Ö	1
. 00	Fi xed equipment	0	0	0	Ö	
. 00	Less: Accumulated depreciation	0	O	0	O	
. 00	Automobiles and trucks	0	0	0	O	21.
. 00	Less: Accumulated depreciation	0	0	0	0	22
. 00	Major movable equipment	3, 259, 109	0	0	0	
. 00	Less: Accumulated depreciation	-1, 550, 967	0	0	0	
. 00	Minor equipment - Depreciable	0	0	0	0	
. 00	Mi nor equi pment nondepreci abl e	0	0	0	0	
00	Other fixed assets	1 700 143	0	0	0	
. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	1, 708, 142	<u> </u>	U		28
. 00	Investments	0	0	0	O	29
. 00	Deposits on Leases	o o	l o	0	Ö	
. 00	Due from owners/officers	Ō	Ö	0	O	
. 00	Other assets	0	0	0	0	32
. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	0	0	0	0	
. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	7, 004, 858	0	0	0	34
	Liabilities and Fund Balances CURRENT LIABILITIES					+
. 00	Accounts payable	225, 504	O	0	C	35
. 00	Salaries, wages, and fees payable	550, 618		0	Ö	
. 00	Payroll taxes payable	19, 650	O	0	O	
00	Notes & Loans payable (Short term)	0	0	0	0	38
. 00	Deferred income	0	0	0	O	39
. 00	Accel erated payments	0				40
. 00	Due to other funds	0	0	0	0	
. 00	Other current liabilities	705 770	0	0	0	
. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	795, 772	0	0	0	43
00	LONG TERM LIABILITIES  Mortgage payable	0	O	0	O	44
. 00	Notes payable			0	0	
00	Unsecured Loans	0		0	Ö	
00	Loans from owners:	o o	l o	0	Ö	
00	Other long term liabilities	0	O	0	O	
00	OTHER (SPECIFY)	0	0	0	0	49
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	0	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	795, 772	0	0	0	51
00	CAPITAL ACCOUNTS  General fund balance	6, 209, 086				52
00	Specific purpose fund	0, 209, 000	o			53
00	Donor created - endowment fund balance - restricted		١	n		54
00	Donor created - endowment fund balance - unrestricted			Ö		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				O	
00	Plant fund balance - reserve for plant improvement,				0	58
_	repl acement, and expansi on					
$\sim$	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	6, 209, 086		0	0	
00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	7, 004, 858			0	) 6C

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES MERRY HEART SUCCASUNNA In Lieu of Form CMS-2540-10

Provi der No.: 315057

| Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

					To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		General	Fund	Special P	urpose Fund	Endowment Fund	TO GIII
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Fund balances at beginning of period	1.00	6, 755, 345		4.00		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		1, 034, 978			1	2. 00
3. 00	Total (sum of line 1 and line 2)		7, 790, 323				3. 00
4. 00	Additions (credit adjustments)		.,,				4. 00
5.00		O			o	0	5. 00
6.00		O			o	0	6. 00
7.00		O			o	0	7. 00
8.00		0			o	0	8. 00
9.00		0			o	0	9. 00
10.00	Total additions (sum of line 5 - 9)		0		(		10.00
11.00	Subtotal (line 3 plus line 10)		7, 790, 323		(		11.00
12.00	Deductions (debit adjustments)						12.00
13.00	DI VI DENDS	1, 581, 235			0	0	13.00
14. 00	ROUNDI NG	2			0	0	14.00
15. 00		0			0	0	15. 00
16. 00		0		(	0	0	16. 00
17. 00		0		(	0	0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		1, 581, 237				18. 00
19. 00	Fund balance at end of period per balance		6, 209, 086			)	19. 00
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund			
		Endownerre rand	TTant	T drid			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		(	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			0		3. 00
4.00	Additions (credit adjustments)						4. 00
5.00			0				5. 00
6.00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9.00	T. I. I. I. I. ( C. I. E. O)		0				9. 00
10.00	Total additions (sum of line 5 - 9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	O O		(	U		11.00
12.00	Deductions (debit adjustments)		0				12. 00 13. 00
13. 00 14. 00	DI VI DENDS ROUNDI NG		0				14. 00
15. 00	ROUNDING		0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 13 - 17)	0	O I		o		18. 00
19. 00	Fund balance at end of period per balance				0		19. 00
	sheet (Line 11 - line 18)			]	-		00
		'	'	'			•

Health Financial Systems	MERRY HEART SUCCASUNNA		In Lie	eu of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi de	er No.: 315057	Peri od: From 01/01/2021 To 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/26/2022 11:	pared:
Cost Center Description		Inpatient	Outpati ent	Total	40 alli
·		1.00	2. 00	3. 00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00   SKILLED NURSING FACILITY		13, 260, 2	79	13, 260, 279	1.00

			To 12/31/2021	Date/Time Pre 5/26/2022 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Care Services				
1.00	SKILLED NURSING FACILITY	13, 260, 27	9	13, 260, 279	1. 00
2.00	NURSING FACILITY		0	0	2. 00
3.00	ICF/IID		0	0	3. 00
4.00	OTHER LONG TERM CARE		0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	13, 260, 27	9	13, 260, 279	5. 00
	All Other Care Services				
6.00	ANCI LLARY SERVI CES	2, 258, 72	0 0	2, 258, 720	6. 00
7.00	CLINIC		0	0	7. 00
8.00	HOME HEALTH AGENCY COST		0	0	8. 00
9.00	AMBULANCE		0	0	9. 00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10. 10	FQHC		0	0	10. 10
11.00	CMHC		0	0	11. 00
12.00	HOSPI CE		0 0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD	185, 31	2 0	185, 312	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to 15, 704, 31	1 0	15, 704, 311	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, 451, 181	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	
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					14. 00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			12, 451, 181	15. 00

Health Financial Systems	MERRY HEART SUCC	MERRY HEART SUCCASUNNA		In Lieu of Form CMS-2540-10		
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSE	S	Provi der No.: 315057	From 01/01/2021	Worksheet G-3		
			To 12/31/2021	Date/Time Pre 5/26/2022 11:		
				1. 00		
1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)				15, 704, 311	1. 00	
2 00 line contraction allowed and discounts an action of					0 00	

	From 01/01/20 To 12/31/20	021 Date/Time Pre	Date/Time Prepared: 5/26/2022 11:46 am	
		1. 00		
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	15, 704, 311	1. 00	
2.00	Less: contractual allowances and discounts on patients accounts	2, 227, 614	2. 00	
3.00	Net patient revenues (Line 1 minus line 2)	13, 476, 697	3. 00	
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	12, 451, 181	4. 00	
5.00	Net income from service to patients (Line 3 minus 4)	1, 025, 516	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 discounts	0	10.00	
11. 00	· ·	0		
12. 00		0		
13. 00		0		
	Revenue from meals sold to employees and guests	0		
	Revenue from rental of living quarters	0		
	Revenue from sale of medical and surgical supplies to other than patients	0		
	Revenue from sale of drugs to other than patients	0		
	Revenue from sale of medical records and abstracts	0		
	Tuition (fees, sale of textbooks, uniforms, etc.)	0		
	Revenue from gifts, flower, coffee shops, canteen	0		
21. 00		0		
22. 00		0		
23. 00	The state of the s	0	23. 00	
24. 00		9, 462		
24. 50		0		
25. 00	Total other income (Sum of lines 6 - 24)	9, 462		
26. 00	Total (Line 5 plus line 25)	1, 034, 978		
27. 00	Other expenses (specify)	0	27. 00	
28. 00		0	28. 00	
29. 00		0	29. 00	
	Total other expenses (Sum of lines 27 - 29)	0	30. 00	
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	1, 034, 978	31.00	