	I Systems MERF required by law (42 USC 1395g; 42 CFR 413.) since the beginning of the cost reporting p		re to report can resul	t in all interim	u of Form CMS-2540-10 FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315057	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I, II & III
PART I - COST F	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost rep	port		Date: 5/26/20	23 Time: 2:48 pm
use only	2. [] Manually prepared cost report				
5	3. [0] If this is an amended report ent	ter the numbe	r of times the provide	r resubmitted thi	s cost report
	3.01 [] No Medicare Utilization. Enter '				
Contractor	4. [1]Cost Report Status	6. Contractor			
use only	(1) As Submitted		t Cost Report for this	Provider CCN	
	(2) Settled without audit		Cost Report for this		
	(3) Settled with audit		COST Report TOF THIS	PLOVIDEL CON	
	(4) Reopened	9. NPR Date:			
	(5) Amended	10.[0] f	ine 4, column 1 is "4"	: Enter number of	times reopened
	(3) Allended	11.Contracto	r Vendor Code	4	
	5. Date Received:	12.[F] Medi	care Utilization. Ente	er "F" for full, '	'L" for low, or "N"
		for	no utilization.		

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MERRY HEART SUCCASUNNA (315057) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1	Wil	jun Sunga	ř	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	3 Signatory Title CFO				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	-33, 718	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	-33, 718	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.

Heal th	Financial Systems	MERRY	HEART SUCCA	SUNNA			l r	n Lie	u of For	m CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH	I CARE	Provi der	No.: 31505		eriod:		Workshe	et S-2	
COMPLE	X INDENTIFICATION DATA						rom 01/01/ o 12/31/		Part I Date/Ti	me Pre	pared [.]
								2022	5/26/20		
	1.00		2.00		3.00)					
1.00	Skilled Nursing Facility and Skilled Nursing Street: 200 ROUTE 10	PO Box:	Complex Ad	dress:							1.00
	City: SUCCASUNNA	State: N.	J	Zip Code	· 07876						2.00
	County: MORRIS	CBSA Code		Urban/Ru							3.00
3.01	5	CBSA Code									3.01
			Compon	ent Name	Provi		Date	Payme	ent Syst		
					CCN		Certified		0, or N	í	-
			1	. 00	2.00		3.00	V 4.00	XVIII 5.00	XI X 6. 00	
	SNF and SNF-Based Component Identification:		1	. 00	2.00		3.00	4.00	5 5.00	0.00	
4.00	SNF		MERRY HEART	SUCCASU	NA 3150	57 C	01/01/1967	N	Р	N	4.00
	Nursing Facility										5.00
6.00	ICF/IID										6.00
	SNF-Based HHA										7.00
8.00	SNF-Based RHC										8.00
	SNF-Based FQHC SNF-Based CMHC										9.00 10.00
	SNF-Based OLTC										11.00
	SNF-Based HOSPICE										12.00
13.00	SNF-Based CORF										13.00
							From:		To		-
14.00	Cost Deporting Deried (mm (dd (unu))						1.00		2.0		14.00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (See Instructions)						01/01/20	JZZ 4	12/31/	2022	14.00 15.00
15.00								-	Y/	N	13.00
									1. (1
	Type of Freestanding Skilled Nursing Facilit										
16.00	Is this a distinct part skilled nursing facil	lity that	meets the	requi reme	nts set fo	rth i	in 42 CFR		N		16.00
17 00	section 483.5? Is this a composite distinct part skilled nu	rcing fool	ility that y	moote the	roqui romo	nte (cot forth i	n	N		17.00
17.00	42 CFR section 483.5?	I SI NY TAO	iiity that i	lieets the	i equi i elle	ints :	set forth i	11			17.00
18.00	Are there any costs included in Worksheet A	that resul	lted from t	ransacti o	ns with re	lated	d		Y		18.00
	organizations as defined in CMS Pub. 15-1, cl	hapter 10'	? If yes, (complete	Worksheet	A-8-	1.				
	Miscellaneous Cost Reporting Information										
	If this is a low Medicare utilization cost re								N		19.00
19.01	If line 19 is yes, does this cost report mee utilization cost report, indicate with a "Y",				FOF TITING	aio	ow medicare	9	N		19.01
	Depreciation - Enter the amount of depreciat				the method	lind	icated on	Lines	20 - 22)	1
	Straight Line									139, 824	20.00
	Declining Balance									C	21.00
	Sum of the Year's Digits									C	22.00
	Sum of line 20 through 22	6.11							4	139, 824	1
	If depreciation is funded, enter the balance Were there any disposal of capital assets du									C	
	Was accelerated depreciation claimed on any a					ron	ortina neri	od2	I N		25.00 26.00
20.00	(Y/N)	assets 111	the curren	t of any		rep	or tring peri	ou:			20.00
27.00	Did you cease to participate in the Medicare	program a	at end of t	he period	to which	thi s	cost repor	~t	N		27.00
	applies? (Y/N)										
28.00	Was there a substantial decrease in health in	nsurance	proportion (of allowa	ble cost f	rom	prior cost		N		28.00
	reports? (Y/N)							Part	APart B	Other	
								1.00		3.00	
	If this facility contains a public or non-pu							e app	licatior		
	of the lower of the costs or charges enter "	Y" for ea	ch componen	t and typ	e of servi	ce t	hat qualif	ies f	or the		
20.00	exemption. Skilled Nursing Facility							NI	N		20.00
	Skilled Nursing Facility Nursing Facility							N	N	N	29.00 30.00
	ICF/IID										31.00
	SNF-Based HHA							N	N		32.00
	SNF-Based RHC										33.00
34.00	SNF-Based FQHC										34.00
	SNF-Based CMHC								N		35.00
36.00	SNF-Based OLTC						N/ /N				36.00
							Y/N 1.00		2.0	0	-
37,00	Is the skilled nursing facility located in a	state th	at certifie	s the pro	vider as a	SNF			2.0		37.00
	regardless of the level of care given for Ti				u u						
	Are you legally-required to carry malpractice						N				38.00
39.00	Is the malpractice a "claims-made" or "occur "alaims made" anter 1 lf the policy is "seen			e policy	is						39.00
	"claims-made" enter 1. If the policy is "occu	urrence",	enter 2.		Premiur	ns	Paid Los	SPS 1	Self Ins	urance	
					1.00		2.00		3.0		
41.00	List malpractice premiums and paid losses:				0		0		0		41.00

Heal th	Financial Systems	MERRY HEART SUCC	ASUNNA		In Lie	u of Form CM	S-2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.:	315057	Peri od:	Worksheet S	-2
COMPLE	X INDENTIFICATION DATA				From 01/01/2022 To 12/31/2022	Part I Date/Time P	roparod
					10 12/31/2022	5/26/2023 2	
						Y/N	
						1.00	
	Are malpractice premiums and paid losse					N	42.00
	center? Enter Y or N. If yes, check box	and submit supporting s	schedule listin	g cost c	enters and		
	amounts.						
	Are there any home office costs as defi					N	43.00
	If line 43 is yes, enter the home offic	ce chain number and enter	the name and a	ddress o	f the home		44.00
-	office on lines 45, 46 and 47.						
	1.00	2.00			3.00		
	If this facility is part of a chain org	ganization, enter the nam	e and address o	of the ho	ome office on the	lines	
	bel ow.						
45.00	Name:	Contractor's Name:	0	Contract	or's Number:		45.00
46.00	Street:	PO Box:					46.00
47.00	Ci ty:	State:		Zip Code	:		47.00

	EX REIMBURSEMENT QUESTIONNALRE	TY HEALTH CARE P	Provi der	No.: 315057	Period: From 01/01/2022 To 12/31/2022	Date/Time Pr	epared
					Y/N	5/26/2023 2: Date	48 pm
					1.00	2.00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column 1	, "Y" fo	r Yes or "N"			_
00	Provider Organization and Operation Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)	ly prior to the begin the date of the chang	ning of e in col	the cost umn 2. (see	N		1.
				Y/N	Date	V/I	
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date			1.00 N	2.00	3.00	2.
00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home offices d to the provider or l, or members of the	, drug its board	Y			3.
				Y/N	Туре	Date	
				1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prep Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If Are the cost report total expenses and total	" for Audited, "C" fo te copy or enter date no, see instructions revenues different f	r rom	Y	C		4.
	those on the filed financial statements? If reconciliation.	column 1 is "Y", subm 	it		Y/N	Legal Oper.	
					1.00	2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch- legal operator of the program? (Y/N)	ool? (Y/N) Column 2:	Is the	provider the	N	N	6.
00	Were costs claimed for Allied Health Program	s? (V/N) see instruct			N		7.
00	Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s	ng the cost reporting		for Nursing	N N		8.
00	School and/or Allied Health Program? (Y/N) s	ng the cost reporting		for Nursing		Y/N 1.00	
00	Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad deb	ng the cost reporting ee instructions. d debts? (Y/N) see in	period	ons.	N		8
)0 00 00	Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv	period structic hange du ed?lf"	ons. uring this cos Y", see instr	N st reporting ructions.	1.00 Y N N	9. 10. 11.
)0 00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv	period structic hange du ed?lf"	ons. uring this cos Y", see instru	N st reporting ructions.	1.00 Y N N	9. 10. 11.
)0 00 00	Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv cost reporting perio	period structic hange du ed?lf"	ns. nring this cos Y", see instru ", see instru Pa	N st reporting ructions. uctions. art A	1.00 Y N N Part B	8 9 10 11
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv	period structic hange du ed?lf"	ons. uring this cos Y", see instru	N st reporting ructions.	1.00 Y N N	8 9 10 11
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv cost reporting perio Description	period structic hange du ed?lf"	ons. Iring this cos Y", see instru ", see instru Pa Y/N	N st reporting ructions. art A Date	1.00 Y N N Part B Y/N	8 9 10 11
0 00 00	School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv cost reporting perio Description	period structic hange du ed?lf"	ons. Iring this cos Y", see instru ", see instru Pa Y/N	N st reporting ructions. art A Date	1.00 Y N N Part B Y/N	8. 9. 10. 11. 12.
0 00 00 00	School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ballfline 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv cost reporting perio Description 0	period structic hange du ed?lf"	ns. Iring this cos Y", see instru ", see instru Pa Y/N 1.00	N st reporting ructions. art A Date 2.00	1.00 Y N N Part B Y/N 3.00	8. 9. 10. 11. 12. 13.
00 00 00 00 00 00 00 00 00 00 00 00 00	School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y"	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv cost reporting perio Description 0	period structic hange du ed?lf"	ns. Iring this cos Y", see instru ", see instru Pa Y/N 1.00 Y	N st reporting ructions. art A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	
	School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R Report	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv cost reporting perio Description 0	period structic hange du ed?lf"	ns. Iring this cos Y", see instru ", see instru Pa Y/N 1.00 Y	N st reporting ructions. art A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	8. 9,10. 11. 12. 13. 14.
00 00 00 00 00 00 00 00 00	School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad debperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv cost reporting perio Description 0	period structic hange du ed?lf"	ns. Iring this cos Y", see instru Y'', see instru Pa Y/N 1.00 Y N N	N st reporting ructions. art A Date 2.00	1.00 Y N Part B Y/N 3.00 Y N	8 9 10 11 12 13 13 14 15

Heal th	Financial Systems N	MERRY HEART S	SUCCASUNNA		In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY I	HEALTH CARE	Provi der		Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	pared:
						5/26/2023 2:4	
			1.	00	2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/po		SLAVKA		PARTI LOVA		19.00
	held by the cost report preparer in columns 1, 2	2, and 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost repo	ort 🖡	HEALTH CARE RE	SOURCES			20.00
	preparer.						
21.00	Enter the telephone number and email address of	the cost d	609-987-1440		SLAVKA. PARTI LOV	/A@HCRNJ. NET	21.00
	report preparer in columns 1 and 2, respectively	у.					

Heal th	Financial Systems	MERRY HEART	SUCCASUNNA	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provider No.: 31505	7 Period: From 01/01/2022 To 12/31/2022		pared:
		Part B				
		<u>Date</u> 4.00				
	PS&R Data	4.00				
13.00	Was the cost report prepared using the PS&R	05/16/2023				13.00
10.00	only? If either col. 1 or 3 is "Y", enter	00/10/2020				10.00
	the paid through date of the PS&R used to					
	prepare this cost report in cols. 2 and					
	4. (see Instructions.)					
14.00	Was the cost report prepared using the PS&R					14.00
	for total and the provider's records for					
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used to prepare this cost report in columns 2 and					
	4.					
15.00	If line 13 or 14 is "Y", were adjustments					15.00
10.00	made to PS&R data for additional claims that					10.00
	have been billed but are not included on the					
	PS&R used to file this cost report? If "Y",					
	see Instructions.					
16.00	If line 13 or 14 is "Y", then were					16.00
	adjustments made to PS&R data for					
	corrections of other PS&R Report					
17 00	information? If yes, see instructions.					17.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?					17.00
	Describe the other adjustments:					
18.00	Was the cost report prepared only using the					18.00
101.00	provider's records? If "Y" see Instructions.					10100
			3.00			
	Cost Report Preparer Contact Information	1				
19.00	Enter the first name, last name and the title		PREPARER			19.00
	held by the cost report preparer in columns ?	I, 2, and 3,				
20.00	respectively. Enter the employer/company name of the cost i	aport				20.00
20.00	preparer.	eport				20.00
21.00	Enter the telephone number and email address	of the cost				21.00
21.00	report preparer in columns 1 and 2, respectiv					
	, , , , , , , , , , , , , , , , , , ,	5 1		1		1

	Financial Systems ED NURSING FACILITY AND SKILLED NURSING EX STATISTICAL DATA	MERRY HEART S		F	veriod: rom 01/01/2022 o 12/31/2022	Date/Time Prep 5/26/2023 2:48	pared:
				l np	atient Days/Vis	sits	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
. 00	SKILLED NURSING FACILITY	113	41, 245	C		10, 267	1.00
. 00 . 00	NURSING FACILITY	0	0	C		0	2.00 3.00
00	HOME HEALTH AGENCY COST	0	0	C	0	0	4.00
00	Other Long Term Care	0	0				5.00
00	SNF-Based CMHC			_			6.00
00	HOSPICE	0	0 41 245		-	0	7.00
00	Total (Sum of lines 1-7)	113 Inpatient D	41, 245 ays/Vi si ts		Di scharges	10, 267	8.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
00	SKILLED NURSING FACILITY	6.00	7.00	8.00 C	9.00	10.00	1.00
00	NURSING FACILITY	13, 073	52, 212	C	-	0	2.00
00	ICF/IID	0	0			0	3.00
00	HOME HEALTH AGENCY COST	0	0				4.00
00	Other Long Term Care	0	0				5.00
00	SNF-Based CMHC HOSPI CE	0	0	c	0	0	6.00 7.00
00	Total (Sum of lines 1-7)	15, 673	32, 212	C	278	24	8.0
		Discha		Aver	rage Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
00	SKILLED NURSING FACILITY	261	563	0.00		427.79	1.00
. 00	NURSING FACILITY	0	0	0.00		0.00	2.00
. 00 . 00	ICF/IID HOME HEALTH AGENCY COST	0	0			0.00	3.00 4.00
. 00	Other Long Term Care	o	0				5.00
. 00	SNF-Based CMHC						6.00
. 00	HOSPI CE	0	0	0.00			
. 00	Total (Sum of lines 1-7)	261	563	0.00		427.79	8.00
		Average Length of Stay		Admi s	sions		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
0.0		16.00	17.00	18.00	19.00	20.00	1.00
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	57. 21 0. 00	0	312	/	237 0	1.00 2.00
. 00		0.00	0		0	0	3.00
.00	HOME HEALTH AGENCY COST				_	-	4.00
00	Other Long Term Care	0.00				0	5.0
00	SNF-Based CMHC						6.0
. 00 . 00	HOSPICE Total (Sum of lines 1-7)	0. 00 57. 21	0			0 237	7.00 8.00
. 00		Admi ssi ons	Full Time		. /	237	0.00
	Component	Total	Employees on	Nonpai d	-		
	Component	Total	Employees on Payroll	Workers			
		21.00	22.00	23.00	-		
. 00	SKILLED NURSING FACILITY	556	118.60				1.00
. 00	NURSING FACILITY	0	0.00				2.00
. 00	ICF/IID HOME HEALTH AGENCY COST	0	0.00 0.00				3.00 4.00
00	Other Long Term Care	0	0.00				5.00
. 00 . 00 . 00	SNF-Based CMHC		0.00				6.00
. 00	8	0 556		0.00 0.00			

	Financial Systems	MERRY HEART				u of Form CMS-2	
SNF WA	GE INDEX INFORMATION				Period: From 01/01/2022 To 12/31/2022		pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART I I – DI RECT SALARI ES						
	SALARI ES	1		1			
1.00	Total salaries (See Instructions)	6, 071, 136	C	6, 071, 13			
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		5.0
5.00	Revised wages (line 1 minus line 5)	6, 071, 136	0	6, 071, 13			6.0
7.00	Other Long Term Care	0	0		0 0.00		
8.00	HOME HEALTH AGENCY COST	0	0		0 0.00		
9.00	CMHC HOSPI CE	0	0		0 0.00		
10.00	Other excluded areas	0			0 0.00 0 0.00		
12.00		0			0 0.00		
	Subtotal Excluded salary (Sum of lines 7 through 11)	0					
13.00	Total Adjusted Salaries (line 6 minus line 12)	6, 071, 136	C	6, 071, 13	249, 262. 00	24.36	13.0
	OTHER WAGES & RELATED COSTS			-			
14.00	Contract Labor: Patient Related & Mgmt	489, 962	0	489, 96			
15.00	Contract Labor: Physician services-Part A	0	0		0 0.00		
16.00	Home office salaries & wage related costs	0	0		0 0.00	0.00	16.0
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1, 137, 186	C	.,			17.0
18.00	Wage-related costs other (See Part IV)	0	C		0		18.0
19.00	Wage related costs (excluded units)	0	C		0		19.0
20.00	Physician Part A - WRC	0	0		0		20.0
21.00	Physician Part B - WRC	0	0		0		21.0
22.00	Total Adjusted Wage Related cost (see instructions)	1, 137, 186		1, 137, 18	6		22.0

Heal th	Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2022 To 12/31/2022		parad
					10 12/31/2022	5/26/2023 2:4	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES				-		
1.00	Employee Benefits	0	0		0.00		
2.00	Administrative & General	586, 846	0	586, 84	6 26, 286. 00	22. 33	2.00
3.00	Plant Operation, Maintenance & Repairs	197, 748	0	197, 74	B 9, 974. 00	19.83	3.00
4.00	Laundry & Linen Service	77, 317	0	77, 31	7 5, 877. 00	13.16	4.00
5.00	Housekeepi ng	219, 519	0	219, 51	9 13, 308. 00	16.50	5.00
6.00	Dietary	457, 594	0	457, 59	4 24, 180. 00	18. 92	6.00
7.00	Nursing Administration	626, 313	0	626, 31	3 15, 625. 00	40.08	7.00
8.00	Central Services and Supply	0	0) (0.00	0.00	8.00
9.00	Pharmacy	0	0) (0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	33, 040	0	33, 04	0 1, 912. 00	17.28	10.00
11.00	Soci al Servi ce	230, 481	0	230, 48	1 7, 451. 00	30. 93	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	329, 053	0	329, 05	3 10, 992. 00	29.94	13.00
14.00	Total (sum lines 1 thru 13)	2, 757, 911	0	2, 757, 91	1 115, 605. 00	23.86	14.00
				•			-

	Financial Systems	MERRY HEART SU		In Lie	u of Form CMS-2	2540-1
SNF WA	AGE RELATED COSTS		Provider No.: 315057	Peri od:	Worksheet S-3	
				From 01/01/2022 To 12/31/2022		narod
				10 12/31/2022	5/26/2023 2:4	
					Amount	
					Reported 1.00	
	PART IV - WAGE RELATED COSTS				1.00	
	Part A - Core List					1
	RETIREMENT COST					1
1.00	401K Employer Contributions				90, 425	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Con	ribution			0, 425	2.00
3.00	Qualified and Non-Qualified Pension Plan				0	
4.00	Prior Year Pension Service Cost	0031			0	4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to Extern	al Organization)			0	7.00
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension	PLan			0	6.00
7.00	Employee Managed Care Program Administra				0	7.00
	HEALTH AND INSURANCE COST					
3. 00	Health Insurance (Purchased or Self Funde	ed)			325, 413	8.0
9.00	Prescription Drug Plan				0	
10.00	Dental, Hearing and Vision Plan				8, 856	10.0
11.00	Life Insurance (If employee is owner or I	eneficiary)			0	
12.00	Accident Insurance (If employee is owner	or beneficiary)			0	12.0
13.00	Disability Insurance (If employee is owned				0	13.0
14.00	Long-Term Care Insurance (If employee is	owner or beneficiary)		0	14.0
15.00	Workers' Compensation Insurance	5			254, 457	15.0
16.00	Retirement Health Care Cost (Only curren	year, not the extra	ordinary accrual require	ed by FASB 106.	0	16.0
	Non cumulative portion)	-		-		
	TAXES					
17.00	FICA-Employers Portion Only				450, 773	17.0
18.00					0	
19.00	Unemployment Insurance				0	
20. 00	State or Federal Unemployment Taxes				7, 262	20.0
	OTHER					
21.00	Executive Deferred Compensation				0	
	Day Care Cost and Allowances				0	
23.00	Tuition Reimbursement				0	23.0
24.00	Total Wage Related cost (Sum of lines 1	23)			1, 137, 186	24.00
					Amount	
					Reported 1.00	
	Part B - Other than Core Related Cost				1.00	
25 00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00
.5.00	UTIEN WAGE RELATED COSTS (SPECIFT)				0	25.00

Heal th	Financial Systems	MERRY HEART S	SUCCASUNNA		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES				Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adj usted Sal ari es (col 1 + col . 2)	. Related to	Average Hourly Wage (col. 3 ÷	
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	765, 137	143, 318				1.00
2.00	Licensed Practical Nurses (LPNs)	613, 115	114, 843				2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1, 464, 043	274, 230	1, 738, 27	3 81, 944. 00	21.21	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2, 842, 295	532, 391				4.00
5.00	Physical Therapists	206, 502	38, 680				5.00
6.00	Physical Therapy Assistants	66, 577	12, 471	79, 04			6.00
7.00	Physical Therapy Aides	0	0		0 0.00	0.00	7.00
8.00	Occupational Therapists	90, 302	16, 914				8.00
9.00	Occupational Therapy Assistants	79, 220	14, 839	94, 05			9.00
10.00	Occupational Therapy Aides	0	0		0 0.00		
11.00	Speech Therapists	0	0		0 0.00		
12.00	Respiratory Therapists	0	0		0 0.00		12.00
13.00	Other Medical Staff	0	0		0 0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations			1		1	
14.00	Registered Nurses (RNs)	287, 821		287, 82			
15.00	Licensed Practical Nurses (LPNs)	0			0 0.00		
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	18, 707		18, 70	686.00	27.27	16.00
17.00	Total Nursing (sum of lines 14 through 16)	306, 528		306, 52			
18.00	Physical Therapists	75, 808		75, 80	8 1, 363.00	55.62	18.00
19.00	Physical Therapy Assistants	25, 417		25, 41	7 702.00	36.21	19.00
20.00	Physical Therapy Aides	0			0 0.00	0.00	20.00
21.00	Occupational Therapists	52, 052		52, 05	2 931.00	55.91	21.00
22.00	Occupational Therapy Assistants	1, 110		1, 11			22.00
23.00	Occupational Therapy Aides	0			0 0.00		
24.00	Speech Therapists	29, 047		29, 04			
25.00	Respiratory Therapists	0			0 0.00		25.00
26.00	Other Medical Staff	0		l	0 0.00	0.00	26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	MERRY HEART SUCCASUNNA Provi der No.: 315057	Peri od:	u of Form CMS Worksheet S-	
		From 01/01/2022 To 12/31/2022	Date/Time Pr 5/26/2023 2:	
		Group	Days	
1.00		1.00 RUX	2.00	1.00
2.00		RUL		2.00
3.00 4.00		RVX RVL		3.00
5.00		RHX		4.00
6.00		RHL		6.00
7.00		RMX		7.00
8.00 9.00		RML RLX		8.00 9.00
10.00		RUC		10.00
11.00		RUB		11.00
12. 00 13. 00		RUA RVC		12.00 13.00
14.00		RVB		14.00
15.00		RVA		15.00
16. 00 17. 00		RHC RHB		16.00 17.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21. 00 22. 00		RMA RLB		21.00 22.00
23.00		RLA		23.00
24.00		ES3		24.00
25. 00 26. 00		ES2 ES1		25.00 26.00
27.00		HE2		27.00
28.00		HE1		28.00
29. 00 30. 00		HD2 HD1		29.00 30.00
31.00		HC2		31.00
32.00		HC1		32.00
33.00		HB2		33.00
34. 00 35. 00		HB1 LE2		34.00 35.00
36.00		LE1		36.00
37.00		LD2		37.00
38. 00 39. 00		LD1 LC2		38.00 39.00
40.00		LC1		40.00
41.00		LB2		41.00
42. 00 43. 00		LB1 CE2		42.00 43.00
44.00		CE1		43.00
45.00		CD2		45.00
46.00		CD1		46.00
47.00 48.00		CC2 CC1		47.00 48.00
49.00		CB2		49.00
50.00		CB1		50.00
51.00 52.00		CA2 CA1		51.00 52.00
53.00		SE3		53.00
54.00		SE2		54.00
55. 00 56. 00		SE1 SSC		55.00 56.00
57.00		SSC		56.00
58.00		SSA		58.00
59.00		I B2		59.00
60. 00 61. 00		I B1 I A2		60.00 61.00
62. 00		I A1		62.00
63. 00		BB2		63.00
64.00 65.00		BB1 BA2		64.00 65.00
66.00		BA2 BA1		66.00
67.00		PE2		67.00
68.00		PE1		68.00
69. 00 70. 00		PD2 PD1		69.00 70.00
71.00		PC2		71.00
72.00		PC1		72.00
73. 00 74. 00		PB2		73.00
74.00		PB1 PA2		74.00 75.00

Health Financial Systems	MERRY HEART SUCC	ASUNNA		In Lie	u of Form CMS	S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315057	Period: From 01/01/2022	Worksheet S	-7
				To 12/31/2022		
				Group	Days	
				1.00	2.00	
76.00				PA1		76.00
99.00				AAA		99.00
100. 00 TOTAL						100.00
			Expenses	Percentage	Y/N	
			1.00	2.00	3.00	
A notice published in the Federal Register Vo payments beginning 10/01/2003. Congress expect expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fo with direct patient care and related expenses (See instructions)	cted this increase n column 1 the amou r each category to pr yes or "N" for n	to be used nt of the total SNF o if the s	for direct expense for revenue from pending refl	batient care and each category. Er Worksheet G-2, F ects increases as	related iterin PartI, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, Lir	ne 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

	Financial Systems	MERRY HEART SU				u of Form CMS-:	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315057	Period: From 01/01/2022	Worksheet A	
					To 12/31/2022	Date/Time Pre 5/26/2023 2:4	
	Cost Center Description	Sal ari es	Other		1 Reclassi fi cati	Reclassified Trial Balance	
				+ col. 2)	ons I ncrease/Decre		
					ase (Fr Wkst	col . 4)	
					A-6)		
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 343, 977	1, 343, 97	7 0	1, 343, 977	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0	0	1
3.00	00300 EMPLOYEE BENEFITS	0	1, 274, 396	1, 274, 39	6 0	1, 274, 396	3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	586, 846	1, 520, 582	2, 107, 42		2, 107, 428	•
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	197, 748	386, 204			583, 952	•
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	77, 317 219, 519	19, 755 92, 566			97, 072 312, 085	•
8.00	00800 DI ETARY	457, 594	365, 064			822, 658	1
9.00	00900 NURSI NG ADMI NI STRATI ON	626, 313	000,001			626, 313	•
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	, -	0 0	0	
11.00	01100 PHARMACY	0	0		0 0	0	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	33, 040	0	33, 04			12.00
13.00	01300 SOCIAL SERVICE	230, 481	0	230, 48		230, 481	•
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES	0 329, 053	22,009	362, 15	0 0	0	
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	329,033	33, 098	302, 10	011 0	362, 151	15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	2, 842, 295	672, 675	3, 514, 97	0 0	3, 514, 970	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	1
32.00	03200 CF/I D	0	0		0 0	0	32.00
33.00	O3300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	6, 820	6, 82	0 0	6, 820	40.00
40.00	04100 LABORATORY	0	46, 591			46, 591	•
42.00	04200 I NTRAVENOUS THERAPY	0	40, 371	40, 37	0 0	0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	1
44.00	04400 PHYSI CAL THERAPY	470, 930	101, 225	572, 15	5 0	572, 155	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	53, 162			53, 162	•
46.00	04600 SPEECH PATHOLOGY	0	29, 047	29, 04		29, 047	
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	322, 463	322, 46	3 0	322, 463	•
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	,	0 0	0	
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						1 / 2 . 2 .
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0		60.00 61.00
62.00	06200 FQHC	0	0		0	0	62.00
	OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , ,				-	
	07000 HOME HEALTH AGENCY COST	0	0		0 0		70.00
	07100 AMBULANCE	0	380				71.00
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80.00
81.00	08100 I NTEREST EXPENSE		0		0 0	0	
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	1
83.00	08300 HOSPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	6, 071, 136	6, 268, 005	12, 339, 14	1 0	12, 339, 141	89.00
00.00	NONREI MBURSABLE COST CENTERS				0		
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0 7, 188	7, 18			90.00 91.00
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	0	, 100	, 10	0 0		92.00
93.00	09300 NONPAID WORKERS	0	0		0 0	0	•
	09400 PATIENTS LAUNDRY	0	0		0 0		94.00
100.00	TOTAL	6, 071, 136	6, 275, 193	12, 346, 32	.9 0	12, 346, 329	100.00

	Financial Systems SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	MERRY HEART S		No.: 315057	Peri od:	u of Form CMS-2 Worksheet A	20101
LOLA.	STITCATION AND ADJUSTMENT OF TREAL BALANCE O	I LAFENSES	FIOVICE	NO 315057	From 01/01/2022 To 12/31/2022	Date/Time Prep	
	Cost Conton Description	A -1:	Nat European			5/26/2023 2:48	8 pm
	Cost Center Description	Adjustments to					
		Expenses (Fr F Wkst A-8)	(col. 5 +-				
		WKSL A-0)	col. 6)				
		6.00	7.00	-			
	GENERAL SERVICE COST CENTERS	0.00	7.00	I	· · · · ·		
00	00100 CAP REL COSTS - BLDGS & FIXTURES	-260, 129	1, 083, 848				1.0
00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	200, 127	1,000,010	1			2.0
00	00300 EMPLOYEE BENEFITS	0	1, 274, 396	1			3.0
00	00400 ADMI NI STRATI VE & GENERAL	32, 664	2, 140, 092	1			4.0
00	00500 PLANT OPERATION, MAINT. & REPAIRS	02,001	583, 952	1			5.0
00	00600 LAUNDRY & LINEN SERVICE	0	97, 072				6.0
00	00700 HOUSEKEEPI NG	0	312, 085	1			7.0
00	00800 DI ETARY	0	822, 658	1			8.0
00	00900 NURSI NG ADMI NI STRATI ON	0	626, 313	1			9.0
0.00	01000 CENTRAL SERVICES & SUPPLY	0	020, 313	1			10.0
1.00	01100 PHARMACY	0	0	1			11.0
2.00	01200 MEDI CAL RECORDS & LI BRARY	0	33, 040	1			12.0
3.00		0	230, 481				13.0
1. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	230, 401				14.0
5.00		0	362, 151	1			15.0
5. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0	302, 131				15.0
00	03000 SKILLED NURSING FACILITY	0	2 E14 070				30. 0
		0	3, 514, 970	1			
1.00		-	0	1			31.0
2.00		0	0				32.0
3. 00	03300 OTHER LONG TERM CARE	0	0				33.0
	ANCI LLARY SERVICE COST CENTERS		(000				
). 00	04000 RADI OLOGY	0	6, 820				40.0
1.00	04100 LABORATORY	0	46, 591				41.0
2.00		0	0				42.0
3.00	04300 OXYGEN (INHALATION) THERAPY	0	0				43.0
	04400 PHYSI CAL THERAPY	0	572, 155	1			44.0
5.00	04500 OCCUPATIONAL THERAPY	0	53, 162				45. C
5.00		0	29, 047				46.0
7.00	04700 ELECTROCARDI OLOGY	0	0				47. C
3.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				48.0
9.00	04900 DRUGS CHARGED TO PATIENTS	0	322, 463	1			49.0
). 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0				50. C
1.00	05100 SUPPORT SURFACES	0	0				51.0
	OUTPATIENT SERVICE COST CENTERS	1 -1		1			
). 00	06000 CLINIC	0	0	1			60.0
1.00	06100 RURAL HEALTH CLINIC	0	C				61.0
2.00							62.0
	OTHER REIMBURSABLE COST CENTERS	1 1		1			l
0. 00	07000 HOME HEALTH AGENCY COST	0	C				70.0
	07100 AMBULANCE	0	380	1			71.0
3.00	07300 CMHC	0	0				73.0
	SPECIAL PURPOSE COST CENTERS	1 .					
0. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0				80.0
I. 00	08100 I NTEREST EXPENSE	0	0				81.0
2.00	08200 UTILIZATION REVIEW - SNF	0	0				82.0
3.00	08300 HOSPI CE	0	0				83.0
9.00	SUBTOTALS (sum of lines 1-84)	-227, 465	12, 111, 676	,			89.0
	NONREI MBURSABLE COST CENTERS						
0. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C				90.0
I. 00	09100 BARBER AND BEAUTY SHOP	0	7, 188				91. C
	09200 PHYSI CLANS PRI VATE OFFI CES	0	C	1			92. C
	09300 NONPALD WORKERS	0	0				93.0
	09400 PATIENTS LAUNDRY	0	0				94.0
	TOTAL	-227, 465	12, 118, 864	1			100.0

Health Financial Systems	MERRY HEART SUCCASUNNA			In Lieu of Form CMS-2540-10		
RECLASSI FI CATI ONS			Period:	Worksheet A-6)	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 2:4	epared: 8 pm
	Increases					
	Cost Cente	r i	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
TOTALS						
	Total Reclassificat of columns 4 and 5 equal sum of column 9)	must		0	0	100. 00

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

Health Financial Systems MERRY HEART SUCCASUNNA				In Lie	In Lieu of Form CMS-2540-10		
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2022	Worksheet A-	6	
					Date/Time Pr 5/26/2023 2:		
	Decreases						
	Cost Cente	r	Line #	Sal ary	Non Salary		
	6.00		7.00	8.00	9.00		
TOTALS			_				
100.00				0	(0 100. 00	

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

RECONCI	LIATION OF CAPITAL COSTS CENTERS						
			Provi der	No.: 315057	Period: From 01/01/2022 To 12/31/2022	Date/Time Prep	oared:
				Acqui si ti on	s	5/26/2023 2:48	s pm
	Description	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
	Land	0	0		0 0	0	1.00
	Land Improvements	0	0		0 0	0	2.00
	Buildings and Fixtures	0	0		0 0	0	3.00
	Building Improvements	0	0		0 0	0	4.00
	Fixed Equipment	0	0		0 0	0	5.00
	Movable Equipment	3, 259, 108	179, 269		0 179, 269		6.00
	Subtotal (sum of lines 1-6)	3, 259, 108	179, 269		0 179, 269	0	7.00
	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	3, 259, 108	179, 269		0 179, 269	0	9.00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
	Land	0	0				1.00
	Land Improvements	0	0				2.00
	Buildings and Fixtures	0	0				3.00
	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
	Movable Equipment	3, 438, 377	0				6.00
	Subtotal (sum of lines 1-6)	3, 438, 377	0				7.00
	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	3, 438, 377	0				9.00

	Financial Systems	MERRY HEART SU		No 1 215057		u of Form CMS-2	
ADJ US I	MENTS TO EXPENSES		Provi der	No.: 315057	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8 Date/Time Pre 5/26/2023 2:43	pared
			I	Expense C	lassification on		
					ch the Amount is		
						-	
	Description (1)	(2) Basis For Adjustment	Amount	Cos	t Center	Line No.	
		1.00	2.00		3. 00	4.00	
. 00	Investment income on restricted funds		0			0.00	1. (
00	(chapter 2)		0			0.00	2
2.00	Trade, quantity, and time discounts (chapter 8)		0			0.00	2.0
3.00	Refunds and rebates of expenses (chapter 8)		0			0.00	3. (
4.00	Rental of provider space by suppliers		0			0.00	
	(chapter 8)						
5.00	Telephone services (pay stations excluded)		0			0.00	5.
. 00	(chapter 21) Television and radio service (chapter 21)		0			0.00	6.
. 00	Parking lot (chapter 21)		0			0.00	
. 00	Remuneration applicable to provider-based	A-8-2	0			0.00	8.
	physician adjustment						
. 00	Home office cost (chapter 21)		0			0.00	
0.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
1.00	Nonallowable costs related to certain		0			0.00	11.
2.00	Capital expenditures (chapter 24) Adjustment resulting from transactions with	A-8-1	-187, 781				12.
2.00	related organizations (chapter 10)	A 0 1	107,701				12.
3.00	Laundry and linen service		0			0.00	13.
4.00	Revenue - Employee meals		0			0.00	14.
5.00	Cost of meals - Guests		0			0.00	
6.00	Sale of medical supplies to other than		0			0.00	16.
7.00	patients Sale of drugs to other than patients		0			0.00	17.0
8.00	Sale of medical records and abstracts		0			0.00	
9.00	Vending machines		0			0.00	
0. 00	Income from imposition of interest, finance		0			0.00	20.
	or penalty charges (chapter 21)						
21.00	Interest expense on Medicare overpayments		0			0.00	21.
	and borrowings to repay Medicare						
22.00	overpayments Utilization reviewphysicians' compensation		0		REVIEW - SNF	82.00	22
2.00	(chapter 21)		0		INEVIEW - SINI	02.00	22.
3.00	Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23.
				FI XTURES			
4.00	Depreciationmovable equipment			CAP REL COST	S - MOVABLE	2.00	24.
	PONATIONS			EQUI PMENT			0-
		A			VE & GENERAL	4.00	
	MEALS & ENTERTAINMENT Total (sum of lines 1 through 99) (Transfer	A	-12, 894 -227, 465		VE & GENERAL	4.00	25. 100.
	to Worksheet A, col. 6, line 100)		-227, 405				100.

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

STATEM OFFI CE	ENT OF COCTO OF CEDVILOEC FROM DELATER ORCANILZ		SUCCASUNNA			u of Form CMS	-2540-10
	ENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOME	Provi der	No.: 315057	Period: From 01/01/2022 To 12/31/2022	Worksheet A- Parts I-II Date/Time Pr 5/26/2023 2:	epared:
		Line No.	Cost	Center	Expense	e Items	
		1.00		00	3.		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:					OR	_
1.00			CAP REL COSTS FIXTURES		RENT		1.00
2.00			CAP REL COSTS FIXTURES		DEPRECIATI ON		2.00
3.00			CAP REL COSTS FIXTURES		INTEREST		3.00
4.00			CAP REL COSTS FIXTURES		FEES		4.00
5.00		4.00	ADMI NI STRATI VE	& GENERAL	CONTRACTED SVS		5.00
6.00			ADMI NI STRATI VE		DUES & SUBSCRII	PTIONS	6.00
7.00			CAP REL COSTS FIXTURES	- BLDGS &	RENT		7.00
8.00		0.00					8.00
9.00		0.00					9.00
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.						10.00
		Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minu	IS		
		Cost	Wkst. A, col.	col. 5)			
			5				
		4.00	5.00	6.00			
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:					OR	
1.00		0	780, 000				1.00
2.00		295, 824	C				2.00
3.00		171, 535	C) 171, 5			3.00
4.00		1,400	C	1,40			4.00
5.00		72,078		, -, -, -, -, -, -, -, -, -, -, -, -, -,			5.00
6.00		270	0		70		6.00
7.00		111, 112		1			7.00
8.00		0	C		0		8.00
9.00	TOTALS (our of lines 1.0) Transfer	0	C 840.000		0		9.00
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	652, 219	840, 000) -187,78	51		10.00

Health Financial Systems	MERRY HEART SUCCASUNNA			In Lieu of Form CMS-2540-		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provider No.: 315057	From 01/01/2022	Worksheet A-8-1 Parts I-II Date/Time Prepar 5/26/2023 2:48 p		
	Symbol (1)	Name	Percentage of Ownership			
	1.00	2.00	3.00			

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

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

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

1.00	A	B. BONIFACIO, ET. AL.	100.00	1.00
2.00	A	B. BONIFACIO, ET. AL.	100.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

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

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

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

related organization.

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

	Rel ated Organi	zation(s) and/	or Home Office			
	Name	Percentage of	Type of Business			
		Ownershi p				
	4.00	5.00	6.00	1		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(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.

i i par para a construction and			
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 ALLOCATION - GENERAL SERVICE COSTS Cost Center Description Net Expenses for Cost Allocation (from Wkst A col. 7) 0 GENERAL SERVICE COST CENTERS 1.00 GUIDO CAP REL COSTS - BLDGS & FLXTURES 1,083,848	CAPI TAL REL BLDGS & FI XTURES	MOVABLE	Peri od: From 01/01/2022 To 12/31/2022 EMPLOYEE	Worksheet B Part I Date/Time Pre 5/26/2023 2:44	
GENERAL SERVICE COST CENTERS	BLDGS &	MOVABLE			
GENERAL SERVICE COST CENTERS					
GENERAL SERVICE COST CENTERS		EQUI PMENT	BENEFI TS	Subtotal	
	1.00	2.00	3.00	3A	
1.00 00100 CAP_REL_COSIS - BLDGS & FLXTURES 1.083_848					
	1, 083, 848		0		1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT 0 3.00 00300 EMPLOYEE BENEFITS 1, 274, 396	0		0 0 1, 274, 396		2.00
4. 00 00400 ADMINI STRATI VE & GENERAL 2, 140, 092	180, 512		0 1, 274, 390		
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS 583, 952	27, 393		0 41, 509	652, 854	
6.00 00600 LAUNDRY & LI NEN SERVI CE 97, 072	25, 294		0 16, 230	138, 596	
7. 00 00700 HOUSEKEEPI NG 312, 085	12, 664		0 46, 079	370, 828	7.00
8. 00 00800 DI ETARY 822, 658	81, 621		0 96, 054	1, 000, 333	8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON 626, 313	0		0 131, 470	757, 783	
10. 00 01000 CENTRAL SERVICES & SUPPLY 0	0		0 0	0	
11.00 01100 PHARMACY 0	0		0 0	0	
12. 00 01200 MEDI CAL RECORDS & LI BRARY 33, 040 13. 00 01300 SOCI AL SERVI CE 230, 481	3, 555		0 6, 935 0 48, 380	39, 975 282, 416	
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0	3, 555		0 48, 380	202, 410	1
15. 00 01500 PATIENT ACTIVITIES 362, 151	80, 826		0 69,072	512, 049	
INPATIENT ROUTINE SERVICE COST CENTERS					1
30. 00 03000 SKILLED NURSING FACILITY 3, 514, 970	647, 197		0 596, 629	4, 758, 796	30.00
31.00 03100 NURSING FACILITY 0	0		0 0	0	
32. 00 03200 I CF/I I D 0	0		0 0	0	
33. 00 O3300 OTHER LONG TERM CARE	0		0 0	0	33.00
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI 0LOGY 6, 820	0		0 0	6, 820	40.00
40. 00 04100 ABD 02001 0000 400 ABD 02001 0000 400 0000 400 0000 4000 4000	0		0 0	6, 820 46, 591	
42. 00 04200 I NTRAVENOUS THERAPY 0	0		0 0	40, 371	
43.00 04300 0XYGEN (INHALATION) THERAPY 0	0		0 0	0	
44. 00 04400 PHYSI CAL THERAPY 572, 155	20, 723		0 98, 853	691, 731	44.00
45. 00 04500 OCCUPATI ONAL THERAPY 53, 162	0		0 0	53, 162	
46. 00 04600 SPEECH PATHOLOGY 29, 047	0		0 0	29, 047	
47. 00 04700 ELECTROCARDI OLOGY 0	0		0 0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0	0		0 0	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS 322, 463 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0	0		0 0	322, 463 0	1
51. 00 05100 SUPPORT SURFACES 0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS			0 0	0	1 51.00
60. 00 06000 CLINIC 0	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC 0	0		0 0	0	
62.00 06200 FQHC					62.00
OTHER REI MBURSABLE COST CENTERS					1 70 00
70.00 07000 HOME HEALTH AGENCY COST 0 71.00 07100 AMBULANCE 380	0		0 0 0 0	0 380	
71. 00 07100 AMBULANCE 380 73. 00 07300 CMHC 0	0		0 0	380	
SPECIAL PURPOSE COST CENTERS	V		0 0	0	/ 3. 00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES					80.00
81.00 08100 INTEREST EXPENSE				1	81.00
82.00 08200 UTILIZATION REVIEW - SNF					82.00
83. 00 08300 HOSPI CE 0	О		0 0	0	
89.00 SUBTOTALS (sum of Lines 1-84) 12, 111, 676	1, 079, 785		0 1, 274, 396	12, 107, 613	89.00
NONREI MBURSABLE COST CENTERS			0		00.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 91.00 09100 BARBER AND BEAUTY SHOP 7, 188	0		0 0	0	
91. 00 09100 BARBER AND BEAUTY SHOP 7, 188 92. 00 09200 PHYSI CLANS PRI VATE OFFICES 0	4, 063		0 0	11, 251 0	
93. 00 09300 NONPAI D WORKERS 0	0		0 0	0	
94. 00 09400 PATIENTS LAUNDRY 0	0		0 0	0	
98.00 Cross Foot Adjustments 0	o		0 0	0	
	0		0 0	0	
99.00 Negative Cost Centers 0 100.00 TOTAL 12, 118, 864	1, 083, 848		0 1, 274, 396	-	

CDST ALIGATION ENNIOR SINOLE Provider No.: 313057	Heal th	Financial Systems	MERRY HEART S	SUCCASUNNA		In Lie	u of Form CMS-	2540-10
Cost Center Description MUMINISTRATUS & GENERAL WORTH & MUNINI					F	Period: From 01/01/2022	Worksheet B Part I Date/Time Pre	pared:
BINERAL SLEWICE COST CENTERS 1 00 00100 CAP REL COSTS = MOVABLE EQUI FMENT 2.00 2.00 00200 CAP REL COSTS = MOVABLE EQUI FMENT 2.443, 789 4.00 00400 LAWINE SINTATIVE & CREMENL 2.443, 789 5.00 00500 CHAP REL COSTS = MOVABLE EQUI FMENT 2.443, 789 5.00 00500 CHAP REL COSTS = MOVABLE EQUI FMENT 2.443, 789 5.00 00700 FMUSENEEPHINE SERVICE 93, 666 5.00 00700 CHAP REL COSTS = AUPRAY 222, 670 7.00 00700 FMUSENEEPHINE SERVICE 93, 666 7.00 00900 DIFTARY 222, 670 7.00 00900 DIFTARY 20, 000 7.00 00 0 0 7.00 00000 DIFTARY 10, 007 0 0 7.00 00000 DIFTARY 0, 007 0 0 11, 00 11.00 01300 SOCIAL SERVICE 3.310 0 2.021 13.00 11.00 01300 DISTARY 10, 022, 026 604, 206 107, 217 3.67, 871 1.375, 566 30.00		Cost Center Description		OPERATION, MAINT. &				
1.00 ODTOOL CAPE RELL COSTS - BLIDES A FIXTURES 1.00 2.00 ODTOOL CAPE RELL COSTS - BLIDES A FIXTURES 2.443,789 3.00 ODTOOL CAPE RELL COSTS - BLIDES A FIXTURES 2.443,789 5.00 ODTOOL CAPE RELL COSTS - BLIDES A FIXTURES 1.00 5.00 ODTOOL CAPE RELL COSTS - BLIDES A FIXTURES 2.443,789 5.00 ODTOOL CAPE RELL COSTS - SUPPLY 0 4.00 5.00 ODTOOL CAPE RELL COSTS - SUPPLY 0 0 0 0 6.00 ODTOOL CHARL DESCREPTINE 5.00 0 </td <td></td> <td></td> <td>4.00</td> <td>5.00</td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td></td>			4.00	5.00	6.00	7.00	8.00	
2.00 00200 (CAP REL COSTS - MOVABLE FOULPMENT 2.043,789 3.00 00300 (PULVPC ENTITIS) 2.443,789 4.00 00400 ADM MISTRATIVE & GENERAL 2.443,789 6.00 00400 (ADM PURT OPERATION, MAINT & REPAIRS 2.443,789 6.00 00400 (ADM PURT) ENTITION, MAINT & REPAIRS 2.443,789 6.00 00400 (ADM PURT) ENTITION, MAINT & REPAIRS 1.61,301 6.00 00400 (ADM PURT) ENTITION, MAINT & REPAIRS 1.61,301 6.00 00400 (ADM PURT) ENTITION, MAINT & REPAIRS 1.64,002 6.00 00400 (ADM PURT) ENTITION, MAINT & REPAIRS 1.64,002 7.00 0 0 0 7.00 0 0 0 0 7.00 0 0 0 0 0 7.00 0 0 0 0 0 0 7.00 0 0 0 0 0 0 0 7.01 01000 (MURSIN ADD ALLED INFALTH FUDURATION 71,334 3.310 0 2.00 33.00 01300 OTATE ENT M	1 00	GENERAL SERVICE COST CENTERS	1		-	1		1 1 00
5.00 00c00 PLANT OPERATION, MAINT, & REPAIRS 164, 902 817, 756 5.00	2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00 3.00
6.00 00600 LAUNDRY & LINEN SERVICE 35,007 23,614 197,217 6.00 7.00 00700 UNESING ARAIM STRATION 93,666 11,823 0 476,374 7.00 8.00 00800 UIETNK ARAIM STRATION 191,305 0 0 0000 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>								•
7.00 0070C HOUSEKEEPI NG 93, 666 11, 823 0 476, 317 7.00 7.00 9.00 0090C0 INURSI NG ADMINISTRATION 1911, 405 0						7		
B. 00 000000 DIETARY 252, 670 76, 199 0 46, 394 1, 375, 596 8, 00 0.00 00000 CENTRAL SERVICES & SUPPLY 0<								
9 00 00000 NURSI KG ADMIN ISTRATION 191, 405 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							1, 375, 596	
11. 00 01100 PHARMACY 0 0 0 0 0 11. 00 12. 00 01300 MEDICAL RECORDS & LIBRARY 10, 097 0 0 0 11. 00 13. 00 01300 SOCIAL SERVICE 71, 334 3. 319 0 2, 021 0 13. 00 14. 00 01500 PATIENT ACITIVITIES 129, 336 75, 456 0 45, 942 0 15. 00 INMART ENT ROUTINE SERVICE COST CENTERS						0 0		•
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From UNRENING February Part 1 Form		Financial Systems	MERRY HEART S		No . 215057	In Period:	Lieu of Form CMS- Worksheet B	2540-10
Cost Center Description NUISING AM CENTRAL SUPPLY PHARMACY SUPPLY MEDICAL PECODES SOCIAL SERVICE PECODES SOCIAL SERVICE PECODES 1:00 GENERAL SERVICE COST CENTERS 9:00 10:00 11:00 12:00 13:00 1:00 GENERAL SERVICE COST CENTERS 9:00 10:00 11:00 12:00 12:00 13:00 1:00 GOSTO FLANT OPERATION, MAINT & REPAIRS 0:00	CUSTF	ILLUCATION - GENERAL SERVICE CUSIS		Provi der	10.: 315057	From 01/01/2	022 Part I 022 Date/Time Pre	
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33.00 OTHER LONG TERM CARE 204,530 O <th< td=""><td></td><td></td><td>1</td><td></td><td></td><td></td><td></td><td></td></th<>			1					
ANCILLARY SERVICE COST CENTERS 40.00 04000 RADIOLOGY 0<			Ű					
40.00 0 0 0 0 0 0 0 0 44 41.00 04100 LABORATORY 0 0 0 0 0 44 42.00 04200 INTRAVENOUS THERAPY 0 0 0 0 44 43.00 04400 PHYSICAL THERAPY 0 0 0 0 44 44.00 04400 PHYSICAL THERAPY 0 0 0 0 44 40.00 04500 OCCUPATIONAL THERAPY 0 0 0 0 0 44 40.00 04600 SPECH PATHOLOGY 0 0 0 0 0 44 40.00 04600 SPECH PATHOLOGY 0 0 0 0 0 44 40.00 04600 DECKARGED TO PATIENTS 0 0 0 0 0 0 45 0.00 05000 DENTAL CARE - TITLE XI X ONLY 0 0 0 0 0 0 0 0 0 0 0 0	00.00		201,000					00.00
42.00 04200 INTRAVENOUS THERAPY 0 0 0 0 0 42 43.00 04300 DYRGEN (I NHALATI ON) THERAPY 0 0 0 0 0 44 44.00 04400 PHYSICAL THERAPY 0 0 0 0 44 45.00 04500 OCCUPATI ONAL THERAPY 0 0 0 0 44 46.00 04600 SPECIAL THERAPY 0 0 0 0 44 46.00 04600 SPECIAL THERAPY 0 0 0 0 44 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 47 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 47 49.00 49400 DRUSC CHARGED TO PATI ENTS 0 <t< td=""><td>40.00</td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0 0</td><td>40.00</td></t<>	40.00		0	0		0	0 0	40.00
43.00 04300 OYYGEN (INHALATION) THERAPY 0 0 0 0 44.00 44.00 044000 PHYSICAL THERAPY 0 0 0 0 0 44.00 45.00 04500 0CUPATIONAL THERAPY 0 <t< td=""><td>41.00</td><td>04100 LABORATORY</td><td>0</td><td>0</td><td></td><td>0</td><td>0 0</td><td>41.00</td></t<>	41.00	04100 LABORATORY	0	0		0	0 0	41.00
44.00 04400 PHYSI CAL THERAPY 0<	42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0 C	42.00
45.00 OccUPATIONAL THERAPY 0 0 0 0 0 0 44 46.00 O4600 SPEECH PATHOLOGY 0 0 0 0 0 46 47.00 O4700 ELECTROCARDIOLOGY 0 0 0 0 0 46 48.00 O4800 MEDI CAL. SUPPLIES CHARGED TO PATIENTS 0 0 0 0 47 49.00 O4900 DRUGS CHARGED TO PATIENTS 0 0 0 0 46 50.00 O5000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 0 0 57 00 DS000 DUPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 60 61 62 62 62 62 62 62 62 62 62 62 62 62 62 62 64 62 62 62 62 62 62 62 62 62 62 62 62 6			0	0		0	0 0	43.00
46.00 04600 SPEECH PATHOLOGY 0 0 0 0 0 44 47.00 04700 ELECTROCARDIOLOGY 0			0	0		0		
47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>			0	0		0		
48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 44 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 45 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 0			0	0		0	° .	1 101 00
49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 45 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 56 51.00 DSIDOS SUPPORT SURFACES 0 0 0 0 0 56 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 66 0 0 0 0 66 66 66 66 66 0 0 0 0 66 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>-</td><td></td></t<>			0	0		0	-	
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 55 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 57 00 06000 CLI NI C 0 0 0 0 0 66 61.00 06000 CLI NI C 0 0 0 0 66 0 06200 FOHC 0 0 0 0 66 0 07000 HOME HEALTH AGENCY COST 0 0 0 0 71 0 07100 AMBULANCE 0 0 0 0 73 0 07100 AMBULANCE 0 0 0 0 73 0 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81 0 0 0 0 73 0 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81 81 81 81 81 81 81 81 81 81 81 81 82 83			0	0		0		1 101 00
51.00 OS100 SUPPORT SURFACES O O O O S1.00 00.00 CLINIT SERVICE COST CENTERS 0			0	0		0		
OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLINIC 0<			0	-				
60.00 06000 CLINIC 0	51.00		0	0				51.00
62.00 06200 FQHC 62 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 70 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 70 71.00 07100 AMBULANCE 0 0 0 0 0 70 73.00 07300 CMHC 0 0 0 0 0 71 70.00 07300 CMHC 0 0 0 0 0 70 73.00 07300 CMHC 0 0 0 0 71 73.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 0 0 0 71 80.00 08100 INTEREST EXPENSE 81 81 81 81 81 81.00 08200 UTI LI ZATI ON REVIEW - SNF 82 83 83 83 90 90 90 60 60 83 82.00 08300 HOSPI CE 0 0 0 0 0 82 83.00 <t< td=""><td>60.00</td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0 0</td><td>60.00</td></t<>	60.00		0	0		0	0 0	60.00
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 <t< td=""><td>61.00</td><td>06100 RURAL HEALTH CLINIC</td><td>0</td><td>0</td><td></td><td>0</td><td>0 0</td><td>61.00</td></t<>	61.00	06100 RURAL HEALTH CLINIC	0	0		0	0 0	61.00
70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 77 71.00 07100 AMBULANCE 0 0 0 0 0 0 0 0 77 73.00 07300 CMHC 0	62.00	06200 FQHC						62.00
71.00 07100 AMBULANCE 0 0 0 0 71 73.00 07300 CMHC 0 0 0 0 0 0 73 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 80.00 08100 INTEREST EXPENSE 81 82.00 08200 UTI LI ZATI ON REVI EW - SNF 81 83.00 08300 HOSPI CE 0 0 0 83 NOREI MBURSABLE COST CENTERS 8 8 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 9 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 9 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 9			1 1		r	-	1	
73.00 07300 CMHC 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS <								
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 8000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81.00 81.00 08100 INTEREST EXPENSE 81.81 81.00 08200 UTI LI ZATI ON REVI EW - SNF 82.00 08200 UTI LI ZATI ON REVI EW - SNF 82.00 00 0 0 0 83.00 08300 HOSPI CE 0 0 0 0 83.00 00 00 0 0 83.00 0 0 0 0 0 83.00 0 0 0 0 0 0 0 0 0 83.00 0 0 0 0 83.00 0 0 0 0 83.00 0 0 0 0 83.00 0								
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 81.00 08100 INTEREST EXPENSE 81 82.00 08200 UTILIZATION REVIEW - SNF 82 83.00 08300 HOSPICE 0 0 0 83 83.00 08300 HOSPICE 0 0 0 0 83 89.00 SUBTOTALS (sum of lines 1-84) 949, 188 0 0 50, 072 359, 090 84 89.00 OPODO GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90 90.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91 91.00 09200 PHYSICI ANS PRIVATE OFFICES 0 0 0 0 92 92.00 09200 NONRELT OFFICES 0 0 0 0 92 93.00 09300 NONPAID WORKERS 0 0 0 0 93	/3.00		0	0		0	0 0	73.00
81.00 08100 INTEREST EXPENSE 81 82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 82 83.00 08300 HOSPICE 0 0 0 0 83 89.00 SUBTOTALS (sum of lines 1-84) 949, 188 0 0 50, 072 359, 090 85 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 9 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 9 9 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 9 9 93.00 09300 NONPAID WORKERS 0 0 0 0 9	00.00							00.00
82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 82 0 83.00 08300 HOSPICE 0 0 0 0 83.00 83.00 SUBTOTALS (sum of lines 1-84) 949,188 0 0 50.072 359.090 83.00 83.00 0 50.072 359.090 83.00 83.00 0 0 0 0 83.00 83.00 949,188 0 0 0 50.072 359.090 83.00 83.00 90.00 90.00 61.77 1.84.00 949,188 0 0 0 0 0 90.00 90.00 61.77 359.090 83.00 90.00 90.00 91.00 90.00 0 0 0 0 90.00 91.00 90.00 0 0 0 0 90.00 92.00 92.00 92.00 92.00 92.00 93.00 93.00 90.00 0 0 0 0 0 93.00 93.00 93.00								80.00 81.00
83.00 08300 HOSPICE 0 0 0 0 83.00 83.00 SUBTOTALS (sum of lines 1-84) 949,188 0 0 50,072 359,090 85.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 90.00 97.00 90.00 97.00 90.00 97.00 90.00 97.00 90.00 97.00 90.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00								82.00
89.00 SUBTOTALS (sum of lines 1-84) 949,188 0 0 50,072 359,090 89 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 0 0 0 0 900 9100 BARBER AND BEAUTY SHOP 0 0 0 0 9100 9200 PHYSICI ANS PRIVATE OFFICES 0 0 0 0 9200 9300 NONPAID WORKERS 0 0 0 0 9200 9300 0 0 0 9300 0 0 9300 0 0 0 9300 0 0 0 9300 0 0 9300 0 0 0 9300 0 0 0 0 9300 0 0 0 9300 0 0 0 9300 0 0 0 9300 0 0 9300 0 0 0 9300 0 0 9300 0 0 0 0 9300 0 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0 0</td> <td></td>			0	0		0	0 0	
NONREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91 92.00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 92 93.00 09300 NONPAI D WORKERS 0 0 0 0 93			949, 188					
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90 90 91 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91 91 0 0 0 0 91 92 0 9200 PHYSICI ANS PRIVATE OFFICES 0 0 0 0 92 93.00 09300 NONPAID WORKERS 0 0 0 0 93 0 0 0 0 93 0 0 0 0 0 93 0 0 0 0 0 93 0			,					1
92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92 93.00 09300 NONPAID WORKERS 0 0 0 0 93	90.00		0	0		0	0 0	90.00
93.00 09300 NONPAID WORKERS 0 0 0 0 93	91.00	09100 BARBER AND BEAUTY SHOP	0			0	0 0	91.00
			0	0		0	0 0	
94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 94			0	0		0	-	
			0			0	0 0	
		5	0					98.00
			0			-		
100. 00 TOTAL 949, 188 0 0 50, 072 359, 090 100	100.00	ין IUTAL	949, 188	0	I	U 50,	U1∠ 359,090	1100.00

Heal th	Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	u of Form CMS-:	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315057	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/26/2023 2:4	pared:
			OTHER GENERAL SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	PATI ENT	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
4 00	GENERAL SERVICE COST CENTERS	1	1	1			1 1 00
1.00 2.00 3.00 4.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						1.00 2.00 3.00 4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 7.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						6.00 7.00
8.00	00800 DI ETARY						8.00
9.00 10.00 11.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY						9.00 10.00 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	0					14.00
15.00	01500 PATIENT ACTIVITIES	0	762, 783				15.00
30.00	03000 SKILLED NURSING FACILITY	0				10, 422, 295	30.00
31.00 32.00	03100 NURSING FACILITY 03200 ICF/IID	0			0 0	0	31.00 32.00
33.00	03300 OTHER LONG TERM CARE	0		204, 53		204, 530	1
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0	0 E	43 0	9 542	40.00
40.00	04100 LABORATORY	0		8, 54 58, 39		8, 543 58, 359	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	0	897, 5	0 0 78 0	0 897, 578	43.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	66, 59		66, 590	
46.00	04600 SPEECH PATHOLOGY	0	0	36, 38		36, 384	46.00
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	47.00 48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	403, 9	5	403, 913	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	-		0 0	0	1
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVI CE COST CENTERS	0	0	1	0 0	0	51.00
60.00	06000 CLI NI C	0			0 0	0	60.00
	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0	0	61.00 62.00
	OTHER REIMBURSABLE COST CENTERS	L	1	1			
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0			0 0 76 0	0	70.00 71.00
	07300 CMHC	0			0 0	470	1
	SPECIAL PURPOSE COST CENTERS	1	I	1			
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
81.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0			0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	762, 783	12, 098, 60	68 0	12, 098, 668	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	20, 10	96 0	20, 196	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00 94.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY					0	1
98.00	Cross Foot Adjustments	0	0		0 0	0	98.00
99.00	Negative Cost Centers	0	0	10 110 0	0 0	0	99.00
100.00	TOTAL	0	762, 783	12, 118, 80	64 0	12, 118, 864	1100.00

Heal th	Financial Systems	MERRY HEART S	UCCASUNNA			In Lie	u of Form CMS-	2540-10
	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315057	Peric From To		Worksheet B Part II Date/Time Pre 5/26/2023 2:4	pared:
			CAPI TAL REL	ATED COSTS				
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FI XTURES	MOVABLE EQUI PMENT		Subtotal	EMPLOYEE BENEFI TS	
		0	1.00	2.00		2A	3.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES							1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT							2.00
3.00	00300 EMPLOYEE BENEFITS	0	0		0	0	0	3.00
4.00	00400 ADMINISTRATIVE & GENERAL	0	180, 512		0	180, 512	0	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	27, 393		0	27, 393	0	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	25, 294		0	25, 294	0	
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY	0	12, 664		0	12,664	0	7.00 8.00
8.00 9.00	00900 NURSI NG ADMI NI STRATI ON	0	81, 621		0	81, 621	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	0	10.00
11.00	01100 PHARMACY	0	0		0	0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	0	12.00
13.00	01300 SOCIAL SERVICE	0	3, 555		0	3, 555	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
15.00	01500 PATIENT ACTIVITIES	0	80, 826		0	80, 826	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		(47, 107	1	0	(47 107		20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	647, 197 0		0	647, 197 0	0	30.00 31.00
31.00	03200 CF/I D	0	0		0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	0	33.00
	ANCI LLARY SERVICE COST CENTERS		-	I	-			
40.00	04000 RADI OLOGY	0	0		0	0	0	40.00
41.00	04100 LABORATORY	0	0		0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	20, 723		0	20, 723	0	44.00 45.00
45.00	04600 SPEECH PATHOLOGY	0	0		0	0	0	45.00
47.00	04700 ELECTROCARDI OLOGY	0	0		Ö	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
(0.00	OUTPATIENT SERVICE COST CENTERS		0		0			1 (0.00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0	0	0	60.00 61.00
62.00	06200 FQHC	0	0		0	0	0	62.00
02.00	OTHER REIMBURSABLE COST CENTERS							02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
71.00	07100 AMBULANCE	0	0		0	0	0	71.00
73.00	07300 CMHC	0	0		0	0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS	1 1			-			00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE							80.00 81.00
81.00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF							81.00
83.00	08300 HOSPI CE	0	0		0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	1, 079, 785		0	1, 079, 785	0	
	NONREI MBURSABLE COST CENTERS	· · ·						1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	•
91.00	09100 BARBER AND BEAUTY SHOP	0	4, 063		0	4, 063	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	0	•
93.00	09300 NONPALD WORKERS	0	0		0	0	0	
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0		U	0	0	94.00 98.00
98.00 99.00	Negative Cost Centers		0		0	0	0	
100.00		0	1, 083, 848		Ö	1, 083, 848		100.00
		· ·						•

	Financial Systems	MERRY HEART S		N- 215057 D		u of Form CMS-2	2540-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provi der	F	veriod: rom 01/01/2022 o 12/31/2022	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	5/26/2023 2: 4 DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	1			1		1 1 00
1.00 2.00 3.00 4.00 5.00 6.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	180, 512 12, 180 2, 586 (012	39, 573 1, 143	29, 023			1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY	6, 919 18, 663	572 3, 687	0 0		105, 934	7.00
9.00	00900 NURSI NG ADMI NI STRATI ON	14, 138	3,087	-	0	105, 934	1
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
11.00	01100 PHARMACY	0	0	0	0	0	
	01200 MEDICAL RECORDS & LIBRARY	746	0	0	0	0	
	01300 SOCIAL SERVICE	5, 269	161	0	86	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 PATIENT ACTIVITIES	9, 553	3, 652	0	1, 944	0	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
	03000 SKILLED NURSING FACILITY	88, 789	29, 238			105, 934	
	03100 NURSING FACILITY	0	0			0	
	03200 I CF/I I D	0	0			0	
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	127	0	0	0	0	40.00
	04100 LABORATORY	869	0			0	
	04200 I NTRAVENOUS THERAPY	009	0		0	0	
	04300 OXYGEN (INHALATION) THERAPY	0	0	-	0	0	
	04400 PHYSI CAL THERAPY	12, 906	936		498	0	
	04500 OCCUPATIONAL THERAPY	992	0	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	542	0	0	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	04900 DRUGS CHARGED TO PATIENTS	6, 016	0	0	0	0	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	-	0	
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0			0	
	06200 FQHC	0	0		0	0	62.00
	OTHER REIMBURSABLE COST CENTERS	1 1		I	1 1		
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	7	0	0	0	0	71.00
73.00	07300 CMHC	0	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS	-1					
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF	0	0	0		0	82.00
83.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	180, 302	39, 389	29, 023	20, 057	105 024	1
	NONREI MBURSABLE COST CENTERS	100, 302	39, 389	29,023	20,057	105, 934	07.00
89.00		-	0	0	0	0	90.00
					- V		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 210		0	98	0	91.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0 210 0	184 0		98 0	0	
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		184		98 0 0		92.00
90.00 91.00 92.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		184		0	0	92.00 93.00
90. 00 91. 00 92. 00 93. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		184	0	0	0 0	92.00 93.00 94.00
90.00 91.00 92.00 93.00 94.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers		184	0 0 0 0 0		0 0 0	92.00 93.00 94.00 98.00 99.00

	Financial Systems FION OF CAPITAL RELATED COSTS	MERRY HEART S		No.: 315057		iod: m 01/01/2022	u of Form CMS-2 Worksheet B Part II	2010 10
					To	12/31/2022	Date/Time Prep 5/26/2023 2:48	
	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							
	00100 CAP REL COSTS - BLDGS & FIXTURES							1.00
	00200 CAP REL COSTS - MOVABLE EQUIPMENT							2.00
	00300 EMPLOYEE BENEFITS							3.00
	00400 ADMINISTRATIVE & GENERAL							4.00
	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE							5.00 6.00
	00700 HOUSEKEEPING							7.00
	00800 DI ETARY							8.00
	00900 NURSI NG ADMI NI STRATI ON	14, 138						9.00
	01000 CENTRAL SERVICES & SUPPLY	0	0					10.00
	01100 PHARMACY	0	0		0			11.00
	01200 MEDI CAL RECORDS & LI BRARY	0	0		0	746		12.00
	01300 SOCIAL SERVICE	0	0		0	0	9, 071	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
15.00	01500 PATIENT ACTIVITIES	0	0		0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
	03000 SKILLED NURSING FACILITY	11, 092	0		0	746	9, 071	30.00
	03100 NURSING FACILITY	0	0		0	0	0	31.00
	03200 CF/I D	0	0		0	0	0	32.00
	03300 OTHER LONG TERM CARE	3, 046	0		0	0	0	33.00
	ANCI LLARY SERVICE COST CENTERS							
	04000 RADI OLOGY	0	0		0	0	0	40.00
		0	0		0	0	0	41.00 42.00
	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	0	0		0	0	0	42.00
	04400 PHYSI CAL THERAPY	0	0		0	0	0	43.00
	04500 OCCUPATI ONAL THERAPY	0	0		0	0	0	45.00
	04600 SPEECH PATHOLOGY	0	0		0	0	0	46.00
	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·						
	06000 CLI NI C	0	0		0	0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0		0	0	0	61.00
								62.00
	OTHER REIMBURSABLE COST CENTERS							
		0	0		0	0	0	70 00
	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0	0	0	71.00
71.00 73.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC						-	
71.00 73.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0	0	0	71.00 73.00
71.00 73.00 80.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		0	0	0	71.00 73.00 80.00
71.00 73.00 80.00 81.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE	0	0		0	0	0	71.00 73.00 80.00 81.00
71.00 73.00 80.00 81.00 82.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF	0	0 0		0	0	0	71.00 73.00 80.00 81.00 82.00
71.00 73.00 80.00 81.00 82.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 I NTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE		0		0	0	000	71.00 73.00 80.00 81.00
71.00 73.00 80.00 81.00 82.00 83.00 89.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF	0	000		000	000	0	71.00 73.00 80.00 81.00 82.00 83.00
71. 00 73. 00 80. 00 81. 00 82. 00 83. 00 89. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)		000		000	000	000	71.00 73.00 80.00 81.00 82.00 83.00
71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS	0 0 0 0 14, 138	0 0 0 0		000000000000000000000000000000000000000	0 0 0 746	0 0 9, 071	71.00 73.00 80.00 81.00 82.00 83.00 89.00
71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0 0 0 0 14, 138	0 0 0 0 0		0 0 0 0 0	0 0 0 746	0 0 9, 071	71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00
71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0 0 0 0 14, 138	0 0 0 0 0		0 0 0 0 0	0 0 746 0 0 0	0 0 9,071 0 0 0	71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00
71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0 0 0 0 14, 138	0 0 0 0 0		0 0 0 0 0	0 0 746 0 0 0 0 0	0 0 9,071 0 0 0 0	71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00
71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00 98.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments	0 0 0 0 14, 138				0 0 0 746 0 0 0 0 0 0 0	0 0 9,071 0 0 0 0 0 0 0 0 0 0	71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00 98.00
71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers	0 0 0 0 14, 138	0 0 0 0 0			0 0 0 746 0 0 0 0 0 0 0	0 0 9,071 0 0 0 0 0 0 0 0	71.00 73.00 80.00 81.00 82.00 83.00 89.00 90.00 91.00 92.00 93.00 94.00 98.00

Heal th	Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	u of Form CMS-:	2540-10
	TION OF CAPITAL RELATED COSTS			No.: 315057	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/26/2023 2:4	pared:
			OTHER GENERAL SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	PATI ENT ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS		[1			1 00
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00 3.00
3.00 4.00	00400 ADMINISTRATIVE & GENERAL						4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 PATIENT ACTIVITIES	0	95, 975				15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	0	95, 975	1, 032, 63	31 0	1, 032, 631	30.00
	03100 NURSI NG FACILI TY	0			0 0	1, 032, 031	31.00
32.00	03200 I CF/I I D	0	0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0			16 0	3, 046	
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0		12	27 0	127	40.00
41.00	04100 LABORATORY	0				869	
42.00	04200 INTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0	1	0 0 53 0	0 35, 063	
44.00	04400 PHISICAL THERAPT	0		90		35, 083 992	
46.00	04600 SPEECH PATHOLOGY	0			12 0	542	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	6, 0	16 0	6, 016	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0)	0 0	0	51.00
(0.00		0	0	1		0	1 (0.00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0			0 0	0	60.00 61.00
62.00	06200 FQHC	0			0	0	62.00
	OTHER REIMBURSABLE COST CENTERS	1	I	•			
	07000 HOME HEALTH AGENCY COST	0	0)	0 0	0	70.00
	07100 AMBULANCE	0			7 0		1 1 1 0 0
73.00	07300 CMHC	0	0)	0 0	0	73.00
~~~~~	SPECIAL PURPOSE COST CENTERS						
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.00 82.00
83.00	08300 HOSPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0		1, 079, 29		1, 079, 293	
	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	0	0	4, 5	55 0	4, 555	•
92.00	09200 PHYSI CLANS PRI VATE OFFICES	0	0		0 0	0	92.00
93.00	09300 NONPAID WORKERS	0	0		0 0	0	•
94.00 98.00	09400 PATIENTS LAUNDRY	0				0	94.00 98.00
98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0			0 0	0	
100.00	5	0	95, 975	1, 083, 84		1, 083, 848	
	1 1		, ,,,,,,	1 1,000,0	Ч Ч	.,,,	1 : 00

	Financial Systems	MERRY HEART		N- 045055		eu of Form CMS-2	2540-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2022	Worksheet B-1	
				T	o 12/31/2022	Date/Time Prep 5/26/2023 2:43	
		CAPI TAL REI	ATED COSTS			0/20/2023 2.4	
			100/100/5				
	Cost Center Description	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	& GENERAL	
		(SQUARE FEET)		(GROSS		(ACCUM COST)	
		. ,		SALARI ES)		. ,	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4A	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	64, 018					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	01,010	C				2.00
3.00	00300 EMPLOYEE BENEFITS	0	0	6, 071, 136			3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	10, 662					4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	1, 618 1, 494		197, 748 77, 317		652, 854 138, 596	5.00 6.00
7.00	00700 HOUSEKEEPING	748		219, 519		370, 828	7.00
8.00	00800 DI ETARY	4, 821	0	457, 594		1, 000, 333	8.00
9.00	00900 NURSING ADMINISTRATION	0	C	626, 313		757, 783	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	C	0	0	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY			33, 040		0 39, 975	11.00 12.00
13.00	01300 SOCIAL SERVICE	210	-	230, 481		282, 416	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0				0	14.00
15.00	01500 PATIENT ACTIVITIES	4, 774	0	329, 053	0	512, 049	15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	38, 227	C	2, 842, 295	0	4, 758, 796	30.00
30.00	03100 NURSING FACILITY	0				4, 738, 790	30.00
	03200   CF/I   D	0	-		-	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	C	0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS					( 000	10.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0				6, 820 46, 591	40.00
41.00	04200 I NTRAVENOUS THERAPY	0			Ű.	40, 391	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	C	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	1, 224		470, 930		691, 731	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0	C C	0	53, 162	
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY				0	29, 047 0	46.00 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	C	0	322, 463	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		-	0	50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVICE COST CENTERS	0	0	C	0	0	51.00
60.00	06000 CLINIC	0	c	C	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0					61.00
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS	0	C	c	0	0	70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE					0 380	
	07300 CMHC	0			0	0	73.00
	SPECIAL PURPOSE COST CENTERS	1	1	1	1		
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.00 82.00
82.00 83.00	08300 HOSPI CE	0	C	c	0	0	82.00
89.00	SUBTOTALS (sum of lines 1-84)	63, 778	C	6, 071, 136	-2, 443, 789	9, 663, 824	89.00
	NONREI MBURSABLE COST CENTERS	-	-	-		_	
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0 240				11 251	90.00 91.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFICES	240				11, 251 0	92.00
93.00	09300 NONPAI D WORKERS	0	0	C	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	C	0	0	94.00
98.00	Cross Foot Adjustments						98.00
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 083, 848	l o	1 27/ 304		2, 443, 789	99.00
102.00	Part I)	1,003,040		1, 274, 396		2,443,709	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	16. 930363	0. 000000	0. 209911		0. 252586	
104.00				C		180, 512	104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part			0. 000000		0. 018657	105 00
100.00				0.00000		0.010057	103.00
				•			•

Health Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	u of Form CMS-:	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2022	Worksheet B-1	
				o 12/31/2022	Date/Time Pre	pared:
	DIANT				5/26/2023 2:4	8 pm
Cost Center Description	PLANT OPERATI ON,	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON	
		(PATIENT DAYS)				
	REPAI RS				(DI RECT	
	(SQUARE FEET) 5.00	6.00	7.00	8.00	NURSI NG) 9. 00	
GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	9.00	
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00 00300 EMPLOYEE BENEFITS						3.00
4. 00 00400 ADMI NI STRATI VE & GENERAL 5. 00 00500 PLANT OPERATI ON, MAI NT. & REPAI RS	51, 738					4.00 5.00
6.00 00600 LAUNDRY & LINEN SERVICE	1, 494	32, 212				6.00
7.00 00700 HOUSEKEEPI NG	748	0				7.00
8. 00 00800 DI ETARY	4, 821	0	4, 821	96, 636		8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON 10. 00 01000 CENTRAL SERVI CES & SUPPLY	0	0		0	162, 378 0	9.00 10.00
11. 00 01100 PHARMACY	0	0		0	0	11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	0	C	0	0	12.00
13.00 01300 SOCIAL SERVICE	210	0	210	0	0	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION		0	C	-	0	14.00
15.00 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	4, 774	0	4,774	0	0	15.00
30. 00 03000 SKILLED NURSING FACILITY	38, 227	32, 212	38, 227	96, 636	127, 389	30.00
31. 00 03100 NURSING FACILITY	00,227	02/212			0	31.00
32. 00 03200 I CF/I I D	0	0			0	32.00
33. 00 03300 OTHER LONG TERM CARE	0	0	C	0	34, 989	33.00
40. 00 04000 RADI OLOGY	0	0	l c	0	0	40.00
40. 00 04000 KADI 0L031 41. 00 04100 LABORATORY	0	0		-	0	40.00
42.00 04200 INTRAVENOUS THERAPY	0	0	C		0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	C	-	0	43.00
44. 00 04400 PHYSI CAL THERAPY	1, 224	0	1, 224		0	44.00
45.00 04500 OCCUPATI ONAL THERAPY 46.00 04600 SPEECH PATHOLOGY	0	0	0	0	0	45.00 46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0		0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENT	rs o	0	C	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 51.00 05100 SUPPORT SURFACES	0	0	-		0	50.00 51.00
51. 00 05100 SUPPORT SURFACES OUTPATI ENT SERVICE COST CENTERS	0	0		0	0	51.00
60. 00 06000 CLINIC	0	0	C	)	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	0	C	0	0	61.00
62.00 06200 FQHC						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					71.00
73.00 07300 CMHC	0	0	C	0	0	73.00
SPECIAL PURPOSE COST CENTERS			1	1		
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE						80.00 81.00
82.00 08200 UTILIZATION REVIEW - SNF						81.00
83. 00 08300 HOSPI CE	0	0	c	0	0	
89.00 SUBTOTALS (sum of lines 1-84)	51, 498	32, 212	49, 256	96, 636	162, 378	89.00
NONREI MBURSABLE COST CENTERS	-N					
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTER 91.00 09100 BARBER AND BEAUTY SHOP	EN 0 240	0	240	-	0	90.00 91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	0	0	240	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	C	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	C	0	0	94.00
98.00 Cross Foot Adjustments						98.00 99.00
99.00Negative Cost Centers102.00Cost to be allocated (per Wkst. B,	817, 756	197, 217	476, 317	1, 375, 596	949, 188	
Part I)	0,100	, 217		., ., ., ., .,	,	
103.00 Unit cost multiplier (Wkst. B, Part		6. 122470	1			
104.00 Cost to be allocated (per Wkst. B, Part II)	39, 573	29, 023	20, 155	105, 934	14, 138	104.00
105.00 Unit cost multiplier (Wkst. B, Part	t 0. 764873	0. 901000	0. 407205	1. 096217	0. 087068	105.00

Health Financial Systems	MERRY HEART S	SUCCASUNNA		In Lie	u of Form CMS-:	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2022	Worksheet B-1	
				To 12/31/2022	Date/Time Pre 5/26/2023 2:4	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	NURSI NG AND	
	SERVICES & SUPPLY	(COSTED REQUI S)	RECORDS & LI BRARY	(PATI ENT DAYS)	ALLIED HEALTH EDUCATION	
	(COSTED	KEQUI 3)	(TIME SPENT)		(ASSI GNED	
	REQUI S)		× · · /		TIME)	
	10.00	11.00	12.00	13.00	14.00	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         CAP         REL         COSTS         -         BLDGS & FIXTURES			1			1.00
2.00 00200 CAP REL COSTS - BEDGS & FIXIORES						2.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
						7.00
8. 00 00800 DI ETARY 9. 00 00900 NURSI NG ADMI NI STRATI ON						8.00 9.00
10. 00 01000 CENTRAL SERVICES & SUPPLY	637, 805					10.00
11.00 01100 PHARMACY	0	0				11.00
12.00 01200 MEDI CAL RECORDS & LI BRARY	0	0	32, 212			12.00
13. 00 01300 SOCIAL SERVICE	0	0	) ()	027212	_	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			0	
15. 00 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	) (	0 0	0	15.00
30. 00 03000 SKILLED NURSING FACILITY	315, 342	0	32, 212	2 32, 212	0	30.00
31.00 03100 NURSING FACILITY	0	0			0	31.00
32.00 03200 I CF/I I D	0	0		0 0	0	32.00
33. 00 03300 OTHER LONG TERM CARE	0	0	) (	0 0	0	33.00
40. 00 04000 RADI OLOGY	0	0		0	0	40.00
41. 00  04100  LABORATORY	0	0			0	40.00
42. 00 04200 I NTRAVENOUS THERAPY	0	0		0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	) (	0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0	0	) (	0 0	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0		0	0	45.00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	0	0			0	46.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	322, 463	0		0 0	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0			0	50.00
51.00 05100 SUPPORT SURFACES	0	0	) (	0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS	0			0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0	0			0	61.00
62. 00 06200 FQHC		c c			0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000 HOME HEALTH AGENCY COST	0	0			0	
71.00 07100 AMBULANCE	0	0		0	0	71.00
73. 00 07300 CMHC SPECIAL PURPOSE COST CENTERS	U	0	<u>ı</u> (	<u> </u>	0	73.00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 08100 INTEREST EXPENSE						81.00
82.00 08200 UTILIZATION REVIEW - SNF						82.00
83.00 08300 HOSPI CE	0	0		0	0	
89.00 SUBTOTALS (sum of Lines 1-84) NONREIMBURSABLE COST CENTERS	637, 805	0	32, 212	2 32, 212	0	89.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	) (	0 0	0	
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	) (	0 0	0	92.00
93. 00 09300 NONPAID WORKERS	0	0	) ()	0 0	0	93.00
94.00 09400 PATIENTS LAUNDRY 98.00 Cross Foot Adjustments	0	0	n (	ן ע	0	94.00 98.00
99.00 Negative Cost Centers						98.00 99.00
102.00 Cost to be allocated (per Wkst. B,	0	0	50, 072	359, 090	0	102.00
Part I)						
103.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000			0.000000	
104.00 Cost to be allocated (per Wkst. B, Part II)	0	0	746	9, 071	0	104.00
105.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 023159	0. 281603	0.000000	105.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MERRY HEART S	Provider No.: 315057	Peri od:	u of Form CMS-2540 Worksheet B-1
				From 01/01/2022 To 12/31/2022	Date/Time Prepare
	Cost Center Description	OTHER GENERAL SERVI CE PATI ENT ACTI VI TI ES (PATI ENT DAYS) 15.00		<u> </u>	<u>5/26/2023 2:48 p</u> r
	GENERAL SERVICE COST CENTERS				
12.00 13.00 14.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	32, 212			1 2 3 4 5 6 7 7 8 9 9 10 11 12 13 14 15
30.00	03000 SKI LLED NURSI NG FACI LI TY	32, 212			30
31.00 32.00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	000000000000000000000000000000000000000			31 32 33
40.00	04000 RADI OLOGY	0			40
41.00 42.00 43.00 44.00 45.00 45.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDIOLOGY 04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 0UTPATIENT SERVICE COST CENTERS				41 41 42 43 44 45 46 47 48 49 50 51
	06000 CLINIC	0			60
	06100 RURAL HEALTH CLINIC 06200 FOHC OTHER REIMBURSABLE COST CENTERS	0			61 62
	07000 HOME HEALTH AGENCY COST	0			70
	07100 AMBULANCE 07300 CMHC	0 0			71 73
31.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF				80 81 82
	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 32, 212			83 89
20.00					
91.00 92.00 93.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0 762, 783			90 91 92 93 94 98 99 102
103.00 104.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	23. 680088 95, 975			103 104
105.00	Part II) Unit cost multiplier (Wkst. B, Part II)	2. 979480			105

Health Financial Systems MERRY HEAR	T SUCCASUNNA	In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENT		eriod:	Worksheet C	
	T	rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/26/2023 2:4	
Cost Center Description	Total (from	Total Charges		
	Wkst. B, Pt I,		di vi ded by	
	<u>col. 18)</u>		<u>col. 2</u>	
	1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS	0.540	0.044	0.055404	10.00
40. 00 04000 RADI OLOGY	8, 543		0.955486	
41.00 04100 LABORATORY	58, 359	20, 146	2.896803	
42. 00 04200 I NTRAVENOUS THERAPY	0	0	0.000000	
43. 00 04300 0XYGEN (INHALATION) THERAPY	0	4, 662	0.00000	
44. 00 04400 PHYSI CAL THERAPY	897, 578		1.829227	
45. 00 04500 OCCUPATI ONAL THERAPY	66, 590		0. 141807	
46.00 04600 SPEECH PATHOLOGY	36, 384	72, 682	0.500592	
47. 00 04700 ELECTROCARDI OLOGY	0	0	0.00000	
48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	3, 836	0.00000	
49.00 04900 DRUGS CHARGED TO PATIENTS	403, 913	191, 091	2. 113721	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000	
51.00 05100 SUPPORT SURFACES	0	0	0.00000	51.00
OUTPATIENT SERVICE COST CENTERS	-	-1		
60. 00 06000 CLINIC	0	0	0.00000	
61.00 06100 RURAL HEALTH CLINIC				61.00
62.00 06200 FQHC				62.00
71.00 07100 AMBULANCE	476	-	0.00000	
100. 00   Total	1, 471, 843	1, 261, 626		100. 00

Health Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315057	Period: From 01/01/2022	Worksheet D Part I	
				To 12/31/2022		
		Title	XVIII (1)	Skilled Nursing		
				Facility		
		Health Care Pi	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col 1	
	to Charges		, are b	x col. 2)	x col. 3)	
	(Fr. Wkst. C			í í	í í	
	Column 3)					
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	LENT COST					
ANCI LLARY SERVI CE COST CENTERS		1	1			
40. 00 04000 RADI OLOGY	0. 955486			0 8, 543		10100
41.00 04100 LABORATORY	2.896803			0 58, 359		1 00
42.00 04200 I NTRAVENOUS THERAPY	0. 000000			0 0	0	1 12:00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0 0	0	
44.00 04400 PHYSI CAL THERAPY	1. 829227			0 835, 349		1 11 00
45.00 04500 OCCUPATIONAL THERAPY	0. 141807			0 64, 862		10.00
46.00 04600 SPEECH PATHOLOGY	0. 500592			0 34, 208		10.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 0	0	1
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	101.00
49.00 04900 DRUGS CHARGED TO PATIENTS	2. 113721			0 403, 913	0	1 1 1 0 0
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0. 000000	0		0 0	0	51.00
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60,00
61. 00 06100 RURAL HEALTH CLINIC	0.00000	0		0 0	0	61.00
62. 00 06200 FQHC						62.00
71. 00 07100 AMBULANCE (2)	0. 000000			0	_	71.00
100.00 Total (Sum of Lines 40 - 71)	0.00000	1, 211, 077		0 1, 405, 234		100.00
(1)  For the V and VIV was solved a - 71		1,211,077	I	1,403,234	0	1.00.00

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

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

Health Financial Systems	MERRY HEART	SUCCASUNNA		In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315057	Period: From 01/01/2022 To 12/31/2022		
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		÷			1.00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of co			t C, column 3	, line 49)	2. 113721	1.00
2.00 Program vacci ne charges (From your reco					0	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	viders, transf	er this amoun	t to Worksheet	0	3.00
E, Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
	(From Wkst. B,	(From Wkst. B,		Cost (From h Wkst. D Part	& Allied Health Costs	
	18 Part 1, COL		Costs to Tota		for Pass	
	10		Costs - Part		Through (Col.	
		,	(Col . 2 / Col		3 x Col. 4)	
			1)			
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
ANCILLARY SERVICE COST CENTERS				- 1		
40. 00 04000 RADI OLOGY	8, 543	0	0.00000			
41.00 04100 LABORATORY	58, 359	0	0.0000			
42.00 04200 I NTRAVENOUS THERAPY	0	0	0.0000		0	
43. 00 04300 0XYGEN (I NHALATI ON) THERAPY 44. 00 04400 PHYSI CAL THERAPY	007 570	0	0.0000		0	
44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 OCCUPATI ONAL THERAPY	897, 578 66, 590	0	0.00000			
46. 00 04600 SPEECH PATHOLOGY	36, 384	0	0.00000			
47. 00 04700 ELECTROCARDI OLOGY	30, 384	0	0.00000		0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000		0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	403, 913	0	0. 00000		-	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000		0	
51.00 05100 SUPPORT SURFACES	0	0	0.00000		0	
100.00 Total (Sum of lines 40 - 52)	1, 471, 367	0		1, 405, 234	0	100. 00

OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315057	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/26/2023 2:4	pared
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	INPATIENT DAYS				1
. 00	Inpatient days including private room days			32, 212	1 1.0
. 00	Private room days			0	
. 00	Inpatient days including private room days applicable to	the Program		6, 272	3.0
. 00	Medically necessary private room days applicable to the P			0	
. 00	Total general inpatient routine service cost	5		10, 422, 295	5.0
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
. 00	General inpatient routine service charges			12, 839, 846	6.0
. 00	General inpatient routine service cost/charge ratio (Line	e 5 divided by line 6)		0. 811715	7.
. 00	Enter private room charges from your records			0	8.
. 00	Average private room per diem charge (Private room charge	s line 8 divided by private	room days, line	0.00	9.
	2)			1	
0.00	Enter semi-private room charges from your records			0	
1.00	Average semi-private room per diem charge (Semi-private semi-private room days)	room charges line 10, divide	d by	0.00	11.
2.00	Average per diem private room charge differential (Line 9	minus line 11)		0.00	12
3.00	Average per diem private room cost differential (Line 7 t			0.00	
4.00	Private room cost differential adjustment (Line 2 times I			0.00	
5.00	General inpatient routine service cost net of private room		minus line 14)	10, 422, 295	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
6.00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		323.55	16.
7.00	Program routine service cost (Line 3 times line 16)	5 ,		2, 029, 306	17.
3. 00	Medically necessary private room cost applicable to progra	am (line 4 times line 13)		0	18.
9.00	Total program general inpatient routine service cost (Li	ne 17 plus line 18)		2, 029, 306	19.
0. 00	Capital related cost allocated to inpatient routine servioline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ce costs (From Wkst. B, Par	t II column 18,	1, 032, 631	20.
1.00	Per diem capital related costs (Line 20 divided by line	1)		32.06	21.
2.00	Program capital related cost (Line 3 times line 21)	-		201, 080	
3.00	Inpatient routine service cost (Line 19 minus line 22)			1, 828, 226	
4.00	Aggregate charges to beneficiaries for excess costs (From	m provider records)		0	
5.00	Total program routine service costs for comparison to the	cost limitation (Line 23 mi	nus line 24)	1, 828, 226	25.
6. 00	Enter the per diem limitation (1)				26.
7.00	Inpatient routine service cost limitation (Line 3 times the	he per diem limitation line	26) (1)		27.
8.00			line 27)		28.
	(Transfer to Worksheet E, Part II, line 4) (See instruction	one)			1

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	32, 212	1.00
2.00	Program inpatient days (see instructions)	6, 272	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. 194710	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Т

	ART SUCCASUNNA		u of Form CMS-2	2540-1
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315057	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Pre 5/26/2023 2:43	
	Title XVIII	Skilled Nursing	PPS	
		Facility		
			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF R			1.00	
00 Inpatient PPS amount (See Instructions)	KEI MBURSEMENT		4, 027, 727	1.0
00 Nursing and Allied Health Education Activities (pass thr	sough navmonts)		4,027,727	
00 Subtotal (Sum of Lines 1 and 2)	ough payments)		4, 027, 727	3.0
			4,027,727	4.0
00 Primary payor amounts 00 Coinsurance			380, 397	4.C
			104, 038	
<ul> <li>Allowable bad debts (From your records)</li> <li>Allowable Bad debts for dual eligible beneficiaries (See</li> </ul>	instructions)		104, 038	7.0
<b>o</b>	e filstructions)		-	
00 Adjusted reimbursable bad debts. (See instructions)			67, 625	
00 Recovery of bad debts - for statistical records only			0	
.00 Utilization review			0	10.0
.00 Subtotal (See instructions)			3, 714, 955	
.00 Interim payments (See instructions)			3, 701, 340	
. 00 Tentati ve adjustment			0	
. 00 OTHER adjustment (See instructions)			0	
. 50 Demonstration payment adjustment amount before sequestra			0	
. 55 Demonstration payment adjustment amount after sequestrat			0	14.5
. 75 Sequestration for non-claims based amounts (see instruct	tions)		852	
. 99 Sequestration amount (see instructions)			46, 481	
0.00 Balance due provider/program (see Instructions)			-33, 718	
. 00 Protested amounts (Nonallowable cost report items in acc			0	16.0
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT	LESSER OF COST OR CHARGES - I	TILE XVIII UNLY		1 47 6
.00 Ancillary services Part B			0	
.00 Vaccine cost (From Wkst D, Part II, line 3)			0	18.0
.00 Total reasonable costs (Sum of lines 17 and 18)			0	
.00 Medicare Part B ancillary charges (See instructions)			0	20.0
.00 Cost of covered services (Lesser of line 19 or line 20)			0	21.0
.00 Primary payor amounts			0	
. 00 Coinsurance and deductibles			0	-
.00 Allowable bad debts (From your records)	instructions)		0	
. 01 Allowable Bad debts for dual eligible beneficiaries (see	e mstructrons)		0	
. 02 Adjusted reimbursable bad debts (see instructions)			0	
.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	)		-	
.00 Interim payments (See instructions)			0	
.00 Tentative adjustment			-	27.0
00 Other Adjustments (See instructions) Specify	ati an		0	
8.50 Demonstration payment adjustment amount before sequestra			-	28.5
8.55 Demonstration payment adjustment amount after sequestrat			0	
3. 99 Sequestration amount (see instructions)			0	
9.00 Balance due provider/program (see instructions)	accordance with CNC Dub 15 2 -	action 115 0	0	
0.00  Protested amounts (Nonallowable cost report items) in ac	cordance wrth CMS Pub. 15-2, S	ection 115.2	0	30. C

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315057	Period: From 01/01/202 To 12/31/202		epared
		Ti tl	e XVIII	Skilled Nursin Facility		10 pm
		Inpatien	t Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		3, 701, 3	0 0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
01	Program to Provider ADJUSTMENTS TO PROVIDER		1	0	0	3.
02	ADJUSTIMENTS TO TROVIDER			0	0	
03				0	0	) 3.
04				0	0	
05				0	0	) 3.
50	Provider to Program ADJUSTMENTS TO PROGRAM		1	0	0	) 3
50 51	ADJUSTMENTS TO PROGRAM			0		
52				0	0	
53				0	0	
54				0	0	) 3
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)			0	0	) 3
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		3, 701, 3	340	0	4
	TO BE COMPLETED BY CONTRACTOR		1		1	1 -
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
01	Program to Provider TENTATIVE TO PROVIDER			0	0	) 5
)2				0	0	
)3				0	0	
	Provider to Program				1	
0	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
12 19	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0		
'	- 5. 98)			5		
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER			0	0	
)2	PROVIDER TO PROGRAM		33, 7		0	
00	Total Medicare program liability (see instructions)		3, 667, 6		0	) 7
			Contr	actor Name	Contractor Number	
	Name of Contractor			1.00	2.00	8

 8.00
 Name of Contractor

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

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der	No.: 315057	Period: From 01/01/2022 To 12/31/2022	Worksheet G Date/Time Pre 5/26/2023 2:4	epare
		General Fund	Specific Purpose Fund	Endowment Fund		
	Accesto	1.00	2.00	3.00	4.00	
	Assets CURRENT ASSETS					1
0	Cash on hand and in banks	1, 321, 708		0 0	0	) 1.
0	Temporary investments	0		0 0	0	2
0	Notes receivable	0		0 0	0	
0 0	Accounts receivable Other receivables	850, 046		0 0	0	
0	Less: allowances for uncollectible notes and accounts				0	
0	recei vabl e	0		0 0	0	Ί
0	Inventory	0		0 0	0	) 7
0	Prepaid expenses	12, 735		0 0	0	
0	Other current assets	0		0 0	0	
00	Due from other funds	2, 785, 000		0 0	0	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10) FIXED ASSETS	4, 969, 489		0 0	0	) 11
00	Land	0		0 0	0	12
00	Land improvements	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	14
00	Bui I di ngs	0		0 0	0	) 15
00	Less Accumulated depreciation	0		0 0	0	
00	Leasehold improvements	0		0 0	0	
00 00	Less: Accumulated Amortization Fixed equipment	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	
00	Automobiles and trucks	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	
00	Major movable equipment	3, 438, 377		0 0	0	23
	Less: Accumulated depreciation	-1, 694, 967		0 0	0	
	Minor equipment - Depreciable	0		0 0	0	
	Minor equipment nondepreciable	0		0 0	0	
	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	1, 743, 410		0 0	0	
00	OTHER ASSETS	1, 743, 410	<u> </u>	0 0	0	1 20
00	Investments	0		0 0	0	29
00	Deposits on Leases	0		0 0	0	30
00	Due from owners/officers	51, 451		0 0	0	
	Other assets	0		0 0	0	
00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	51, 451		0 0	0	
00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	6, 764, 350		0 0	0	) 34
	CURRENT LI ABI LI TI ES					
00	Accounts payable	105, 995		0 0	0	35
00	Salaries, wages, and fees payable	594, 472		0 0	0	
	Payroll taxes payable	23, 513		0 0	0	
	Notes & Loans payable (Short term)	0		0 0	0	
00 00	Deferred income Accelerated payments	0		0 0	0	39
	Due to other funds	0		0 0	0	
	Other current liabilities	0		0 0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	723, 980		0 0	0	
	LONG TERM LIABILITIES					
00	Mortgage payable	0		0 0	0	
	Notes payable	0		0 0	0	
00	Unsecured Loans	0		0 0	0	
00 00	Loans from owners: Other long term liabilities	0		0 0	0	
	OTHER (SPECIFY)	0		0 0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		0 0	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	723, 980		0 0	0	51
	CAPI TAL ACCOUNTS	-				
00	General fund balance	6, 040, 370				52
00	Specific purpose fund			0		53
00 00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55
00	Plant fund balance - invested in plant			0	o	
00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	6, 040, 370		0 0	0	) 59

Heal th	Financial Systems	MERRY HEART S	UCCASUNNA		In Lie	u of Form CMS-2	2540-10
	ENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315057	Peri od: From 01/01/2022 To 12/31/2022	Worksheet G-1 Date/Time Pre 5/26/2023 2:4	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1 00	Fund halanana at haginning of pariod	1.00	2.00	3.00	4.00	5.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	1 0 0 0 0 840, 000 0 0 0 0 0	6, 209, 086 671, 283 6, 880, 369 1 6, 880, 370 840, 000 6, 040, 370			0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund			
1 00	Fund heleness at heginning of period	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ROUNDING	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0 0	0 0 0 0 0		0 0 0 0		10.0010.0011.0012.0013.0014.0015.0016.0017.0018.0019.00

Heal th	Financial Systems MERRY HEART	SUCCASUNNA		In Lie	eu of Form CMS-:	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315057	Period: From 01/01/2022 To 12/31/2022		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		12, 839, 8	46	12, 839, 846	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)		12, 839, 8	46	12, 839, 846	5.00
	All Other Care Services			1 -		
6.00	ANCI LLARY SERVICES		1, 261, 6	27 0	.,,	6.00
7.00				0	0	7.00
8.00	HOME HEALTH AGENCY COST			0	0	8.00
9.00	AMBULANCE			0	0	
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10.10
	СМНС			0	0	11.00
	HOSPICE			0 0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD		236, 1		236, 105	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer colu Worksheet G-3, Line 1)	mn 3 to	14, 337, 5	78 0	14, 337, 578	14.00
	Cost Center Description					
				1.00	2.00	
	PART II - OPERATING EXPENSES		<u>.</u>	1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				12, 346, 329	1.00
2.00	Add (Specify)			0		2.00
3.00				0		3.00
4.00				0		4.00
5.00				0		5.00
6.00				0		6.00
7.00				0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			-	0	8.00
9.00	Deduct (Specify)			0		9.00
10.00				0		10.00
11.00				0		11.00
12.00				0		12.00
13.00				0		13.00
	Total Deductions (Sum of lines 9 - 13)				0	
	Total Operating Expenses (Sum of Lines 1 and 8, minus line	14)			12, 346, 329	
				ļ	, , 02 /	

Heal th	Financial Systems MERRY HEART SUCCASUNNA Ir		In Lie	u of Form CMS-2	540-10	
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		S	Provider No.: 315057	Peri od:	Worksheet G-3	
				From 01/01/2022		
				To 12/31/2022	Date/Time Prep 5/26/2023 2:48	
	· · · · · · · · · · · · · · · · · · ·				372072023 2.40	
					1.00	
1.00	0 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)				14, 337, 578	1.00
2.00	Less: contractual allowances and discounts on patients accounts				1, 330, 057	2.00
3.00	Net patient revenues (Line 1 minus line 2)				13, 007, 521	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, Line 15)				12, 346, 329	4.00
5.00	Net income from service to patients (Line 3 minus 4)				661, 192	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					0	10.00
11.00					0	11.00
12.00	Parking lot receipts				0	12.00
13.00	· · · · · · · · · · · · · · · · · · ·				0	13.00
14.00					0	14.00
15.00					0	15.00
16.00	5 11 1				0	16.00
17.00					0	17.00
18.00					0	18.00
19.00					0	19.00
20.00					0	20.00
21.00	5				0	21.00
22.00	5 1				0	22.00
23.00					0	23.00
24.00					10, 091	24.00
24.50	COVI D-19 PHE Fundi ng				0	24.50
25.00	Total other income (Sum of lines 6 - 24)				10, 091	25.00
26.00	Total (Line 5 plus line 25)				671, 283	26.00
27.00	Other expenses (specify)				0	27.00
28.00					0	28.00
29.00					0	29.00
30.00					0	30.00
31.00	00 Net income (or loss) for the period (Line 26 minus line 30)				671, 283	31.00