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

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expires: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315157 Worksheet S Parts I, II & III Peri od: From 01/01/2022 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/10/2023 9: 29 am PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 5/10/2023 Time: 9:29 am use only ] Manually prepared cost report 2 [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [ 1 ] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[ N ] First Cost Report for this Provider CCN (2) Settled without audit 8.[ N ] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11. Contractor Vendor Code

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

5. Date Received:

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

for no utilization.

## 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 MORRISTOWN POST ACUTE REHAB & NURSIN ( 315157 ) 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		
	1		2	SI GNATURE STATEMENT	
1	Ber	Kurland	Y	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	Ben Kurl and			2
3	Signatory Title	CE0			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		58, 724	0	0	1. 00
2.00 NURSING FACILITY		O		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		O	0		5. 00
6.00 SNF - BASED FQHC I		O	0		6. 00
7.00 SNF - BASED CMHC I		O	0		7. 00
7.10 SNF - BASED CORF I		O	0		7. 10
100. 00 TOTAL	(	58, 724	0	0	100. 00

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

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

Health Financial Systems MORRISTOWN POST ACUTE REHAB & NURSIN In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315157 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/10/2023 9:29 am 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 77 MADISON AVENUE PO Box: 1.00 2.00 City: MORRISTOWN State: NJ Zi p Code: 07960 2.00 3.00 County: MORRIS CBSA Code: 35084 Urban/Rural: U 3.00 CBSA Code: 3. 01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF MORRISTOWN POST ACUTE 315157 11/20/1992 N Р Ν 4.00 REHAB & NURSIN 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12 00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 6LLC 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 925 254 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 925, 254 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00

0

0

41.00

0

41.00 List malpractice premiums and paid losses:

Heal th	Health Financial Systems MORRISTOWN POST ACUTE REHAB & NURSIN In Lieu				u of Form CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING X INDENTIFICATION DATA	FACILITY HEALTH CARE	Provider No.: 31	5157 Peri od: From 01/01/2022 To 12/31/2022		pared:
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid losse	ve and General cost	N	42. 00		
	center? Enter Y or N. If yes, check box	cost centers and				
	amounts.					
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	pter 10?		N	43. 00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and add	ress of the home		44. 00
	office on lines 45, 46 and 47.					
	1.00	2. 00		3. 00		
	If this facility is part of a chain org	ganization, enter the name	e and address of	the home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Cor	ntractor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47.00	Ci ty:	State:	Zi į	p Code:		47.00

	n Financial Systems MORRI ED NURSING FACILITY AND SKILLED NURSING FACILI	STOWN POST ACUTE TY HEALTH CARE		No.: 315157 F	Peri od:	u of Form CMS- Worksheet S-2	
COMPLI	EX REIMBURSEMENT QUESTIONNAIRE				From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
					Y/N	5/10/2023 9: 2 Date	9 am
					1. 00	2. 00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy)	ses enter in colum	ın 1, "Y" fo	r Yes or "N" f	for No. For all	the date	
	Completed by All Skilled Nursing Facilites						1
1. 00	Provider Organization and Operation Has the provider changed ownership immediate	v prior to the be	eainnina of	the cost	N		1.00
	reporting period? If column 1 is "Y", enter instructions)	the date of the ch	nange in col	umn 2. (see			
				Y/N 1.00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in	the Medicare Prog	gram? If	N N	2.00	3.00	2. 00
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and	d in column				
3. 00	Is the provider involved in business transactions.	tions, including m	nanagement	Υ			3. 00
	contracts, with individuals or entities (e.g.					1	
	or medical supply companies) that are related officers, medical staff, management personnel					1	
	of directors through ownership, control, or						
	relationships? (see instructions)			Y/N	Type	Date	
	Te			1. 00	2. 00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepare	ared by a Certifie	ed Public	Y	C		4.00
1. 00	Accountant? (Y/N) Column 2: If yes, enter "A"	' for Audited, "C"	' for	·	Ŭ	1	1.00
	Compiled, or "R" for Reviewed. Submit compleavailable in column 3. (see instructions) If					1	
5. 00	Are the cost report total expenses and total	revenues differer	nt from	N			5. 00
	those on the filed financial statements? If a reconciliation.	column 1 is "Y", s	submit				
	Teconer i atron.				Y/N	Legal Oper.	
	Account Februari and Assisting				1. 00	2. 00	
6. 00	Approved Educational Activities  Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column	2: Is the	provider the	N	N	6.00
7 00	legal operator of the program? (Y/N)	-2 (V/N) i notr	wati ana		N		7 00
7. 00 3. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so	ng the cost report		for Nursing	N N		7. 00 8. 00
	Jacobs and of Affica hearth frogram: (1714) 30	ce matractions.				Y/N	
						4 00	
	Rad Dobts					1. 00	
9. 00	Bad Debts Is the provider seeking reimbursement for bad					1. 00 Y	9. 00
	Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb				reporting		9.00
9. 00 10. 00 11. 00	Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	t collection polic	cy change du	ring this cost		Y	10. 00
10. 00 11. 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	t collection policed/or coinsurance v	cy change du waived? If "	ring this cost	ıcti ons.	Y N	10.00
10. 00 11. 00	Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	t collection policed/or coinsurance v	cy change du waived? If "	ring this cost Y", see instru ", see instruc	actions.	Y N N	10. 00
10. 00 11. 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instruc ", see instruc Pa	ctions.	Y N N Part B Y/N	10.00
10. 00 11. 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	t collection policed/or coinsurance v	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instruc ", see instruc Pa	ctions.	Y N N N Part B	10.00
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10. 00 11. 00 12. 00	Is the provider seeking reimbursement for bar Ifline 9 is "Y", did the provider's bad debreriod? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instruc ", see instruc Pa Y/N 1.00	etions.  The strip of the strip	Y N N N Part B Y/N 3.00	10.00
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10. 00 11. 00 12. 00 13. 00	Is the provider seeking reimbursement for backet in the provider's bad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R was the cost report prepared using the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instruc ", see instruc Pa Y/N 1.00	etions.  The strip of the strip	Y N N N Part B Y/N 3.00	10.00
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10. 00 11. 00 12. 00	Is the provider seeking reimbursement for bact of line 9 is "Y", did the provider's bad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instru ", see instruc Pa Y/N 1.00	etions.  The strip of the strip	Y N N Part B Y/N 3.00	10. 00 11. 00 12. 00 13. 00
10. 00 11. 00 12. 00 13. 00	Is the provider seeking reimbursement for bact of line 9 is "Y", did the provider's bad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instru ", see instruc Pa Y/N 1.00  Y	etions.  The strip of the strip	N N N Part B Y/N 3.00 Y	10. 00 11. 00 12. 00 13. 00
0. 00 1. 00 2. 00 3. 00 4. 00	Is the provider seeking reimbursement for backet in the provider's bad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instru ", see instruc Pa Y/N 1.00	etions.  The strip of the strip	Y N N Part B Y/N 3.00	10. 00 11. 00 12. 00 13. 00
10. 00 11. 00 12. 00 13. 00	Is the provider seeking reimbursement for bact of line 9 is "Y", did the provider's bad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instru ", see instruc Pa Y/N 1.00  Y	etions.  The strip of the strip	N N N Part B Y/N 3.00 Y	10. 00 11. 00 12. 00 13. 00
0. 00 1. 00 2. 00 3. 00 4. 00	Is the provider seeking reimbursement for bact of line 9 is "Y", did the provider's bad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instru ", see instruc Pa Y/N 1.00  Y	etions.  The strip of the strip	N N N Part B Y/N 3.00 Y	10. 00 11. 00 12. 00 13. 00
0. 00 1. 00 2. 00 3. 00 4. 00	Is the provider seeking reimbursement for backet in the provider's bad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instru ", see instruc Pa Y/N 1.00  Y	etions.  The strip of the strip	N N N Part B Y/N 3.00 Y	10. 00 11. 00 12. 00 13. 00
10. 00 11. 00 12. 00	Is the provider seeking reimbursement for bact of line 9 is "Y", did the provider's bad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	t collection polic d/or coinsurance v  cost reporting pe  Descripti	cy change du vaived? If " eriod? If "Y	ring this cost Y", see instru  ", see instruc  Pa  Y/N  1.00  Y	etions.  The strip of the strip	N N N Part B Y/N 3.00	10. 00 11. 00 12. 00 13. 00 14. 00

Ν

17.00

18.00

Ν

corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were

adjustments made to PS&R data for Other?
Describe the other adjustments:

18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions.

Heal th	Financial Systems MORRISTOWN POST A	CUTE R	EHAB & NURSIN	In	In Lieu of Form CMS-2540-10		
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAR	E	Provi der No.: 315157	Period: From 01/01/2	Worksheet S-	2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/		epared: 29 am	
			1. 00		2. 00		
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/position	KLTT	Υ	BLI SSI T		19. 00	
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
20.00	Enter the employer/company name of the cost report	HEAL	TH CARE RESOURCES			20.00	
	preparer.						
21.00	Enter the telephone number and email address of the cost	609-	987-1440	KI TTY. BLI S	SIT@HCRNJ. NET	21. 00	
	report preparer in columns 1 and 2, respectively.						

| Peri od: | Worksheet S-2 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: 
 Heal th
 Financial
 Systems
 MORRISTOWN
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 ACU

 SKILLED
 NURSING
 FACILITY
 AND
 SKILLED
 NURSING
 FACILITY
 HEALTH
 CARE
 Provi der No.: 315157 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 12/31/2022	Date/lime Prepared:   5/10/2023 9:29 am
		Part B		<u>'</u>	
		Date			
		4. 00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R	03/20/2023			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and				
14 00	4. (see Instructions.) Was the cost report prepared using the PS&R				14. 00
14.00	for total and the provider's records for				14.00
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15.00	If line 13 or 14 is "Y", were adjustments				15. 00
	made to PS&R data for additional claims that				
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
1/ 00	see Instructions.				1/ 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for				16. 00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17. 00	If line 13 or 14 is "Y", then were				17. 00
	adjustments made to PS&R data for Other?				
	Describe the other adjustments:				
18.00	Was the cost report prepared only using the				18. 00
	provider's records? If "Y" see Instructions.				
			3. 00		
	Cost Report Preparer Contact Information Enter the first name, last name and the title	/naci ti an	CONSULTANT		19. 00
19.00	held by the cost report preparer in columns 1		CONSULTANT		19.00
	respectively.	i, 2, and 5,			
20. 00	Enter the employer/company name of the cost r	report			20. 00
	preparer.	- It			=5. 55
21.00	Enter the telephone number and email address	of the cost			21. 00
	report preparer in columns 1 and 2, respectiv	vel y.			

 
 Health Financial Systems
 MORRISTOWN POST ACUT

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

Provi der No.: 315157

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

				To	12/31/2022	Date/Time Prep   5/10/2023 9:29	
				I npa	atient Days/Vis		
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00 2.00 3.00 4.00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	287 0 0	104, 755 0 0	0	12, 143	37, 723 0 0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 6. 10 7. 00	Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE	0	0	0	0	0	5. 00 6. 00 6. 10 7. 00
8. 00	Total (Sum of lines 1-7)	287	104, 755	0	12, 143	37, 723	8. 00
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	CVILLED NUDGING FACILLETY	6.00	7.00	8. 00	9. 00	10.00	4 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	13, 595 0	63, 461 0	0	444	146 0	1. 00 2. 00
3. 00	ICF/IID	O	O			o	3. 00
4.00	HOME HEALTH AGENCY COST	0	0				4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC		U I				5. 00 6. 00
6. 10	SNF-Based CORF						6. 10
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	0 13, 595	0 63, 461	0	0 444	0 146	7. 00 8. 00
8.00	Total (Suil of Titles 1-7)	Di scha		Aver	age Length of		8.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	386	976	0.00	27. 35	258. 38	1.00
2. 00 3. 00	NURSING FACILITY	0	0	0. 00		0. 00 0. 00	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST		Ĭ			0.00	4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00 6. 10	SNF-Based CMHC SNF-Based CORF						6. 00 6. 10
7.00	HOSPI CE	O	O	0. 00	0.00	0. 00	7. 00
8. 00	Total (Sum of lines 1-7)	386 Average Length	976	0.00 Admis	27.35	258. 38	8. 00
		of Stay					
	Component	Total 16.00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
1. 00	SKILLED NURSING FACILITY	65. 02	17.00	538	93	350	1. 00
2.00	NURSING FACILITY	0. 00	О		0	0	2. 00
3. 00 4. 00	I CF/IID   HOME HEALTH AGENCY COST	0. 00			O	0	3. 00 4. 00
5. 00	Other Long Term Care	0.00				0	5. 00
6.00	SNF-Based CMHC						6. 00
6. 10 7. 00	SNF-Based CORF HOSPI CE	0. 00	o	0	o	0	6. 10 7. 00
8. 00	Total (Sum of lines 1-7)	65. 02	0	538	93	350	8. 00
		Admissions	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I 22.00	Workers 23.00			
1. 00	SKILLED NURSING FACILITY	981	164. 50	0. 00			1. 00
2.00	NURSING FACILITY	0	0.00	0.00			2.00
3. 00 4. 00	I CF/IID   HOME HEALTH AGENCY COST		0. 00	0. 00			3. 00 4. 00
5.00	Other Long Term Care	0	0. 00	0. 00			5. 00
6. 00 6. 10	SNF-Based CMHC SNF-Based CORF		0. 00 0. 00	0. 00 0. 00			6. 00 6. 10
7. 00	HOSPI CE	0	0.00				7. 00
8. 00	Total (Sum of lines 1-7)	981	164. 50	0.00			8. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/ Health Financial Systems
SNF WAGE INDEX INFORMATION MORRISTOWN POST ACUTE REHAB & NURSIN
Provider No.: 315157

				'	0 12/31/2022	5/10/2023 9: 29	
		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 II - DIRECT SALARIES						
	SALARI ES		_		1		
1.00	Total salaries (See Instructions)	8, 570, 860	0	8, 570, 860			1. 00
2.00	Physician salaries-Part A	0	0	0	0. 00		2. 00
3.00	Physician salaries-Part B	0	0	0	0.00		3. 00
4.00	Home office personnel	0	0	0	0.00		4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	8, 570, 860	0	8, 570, 860			6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST						8.00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	8, 570, 860	0	8, 570, 860	342, 351. 00	25. 04	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	4, 335, 231	0	4, 335, 231			14.00
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		15.00
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0. 00	16.00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	1, 201, 442	0	1, 201, 442			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see	1, 201, 442	0	1, 201, 442			22.00
	instructions)						

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared: | From 01/01/2022 | Part III | Part | Par Health Financial Systems
SNF WAGE INDEX INFORMATION MORRISTOWN POST ACUTE REHAB & NURSIN
Provider No.: 315157

				· ·		5/10/2023 9: 20	9 am
		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	0.00	0.00	1. 00
2.00	Administrative & General	299, 386	0	299, 386	7, 939. 00	37. 71	2. 00
3.00	Plant Operation, Maintenance & Repairs	239, 582	0	239, 582	11, 955. 00	20. 04	3. 00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4.00
5.00	Housekeepi ng	540, 321	0	540, 321	35, 070. 00	15. 41	5. 00
6.00	Di etary	933, 255	0	933, 255	46, 421. 00	20. 10	6. 00
7.00	Nursing Administration	1, 301, 666	0	1, 301, 666	33, 308. 00	39. 08	7. 00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	32, 461	0	32, 461	2, 152. 00	15. 08	10.00
11. 00	Social Service	122, 122	0	122, 122	4, 041. 00	30. 22	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	188, 870	0	188, 870	10, 605. 00	17. 81	13.00
14. 00	Total (sum lines 1 thru 13)	3, 657, 663	[ o	3, 657, 663	151, 491. 00	24. 14	14. 00

From 01/01/2022 Part IV 12/31/2022 Date/Time Prepared: 5/10/2023 9: 29 am Amount Reported 1.00 PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 0 1.00 2 00 Tax Sheltered Annuity (TSA) Employer Contribution 0 2.00 3.00 Qualified and Non-Qualified Pension Plan Cost 0 3.00 Prior Year Pension Service Cost 0 4.00 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 5.00 401K/TSA Plan Administration fees 0 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 Employee Managed Care Program Administration Fees 7.00 0 7.00 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 294, 844 8.00 9.00 Prescription Drug Plan 0 9.00 Dental, Hearing and Vision Plan 10.00 10.00 0 Life Insurance (If employee is owner or beneficiary) 11.00 Ω 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 13.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 14.00 0 Workers' Compensation Insurance 175, 230 15.00 15 00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 Non cumulative portion) 17 00 731, 368 17 00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 0 18.00 Unemployment Insurance 19.00 0 19.00 20.00 State or Federal Unemployment Taxes Ω 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00

0 23 00

24.00

0 25.00

1, 201, 442

Amount Reported 1.00

Tuition Reimbursement

24.00 Total Wage Related cost (Sum of lines 1 - 23)

Part B - Other than Core Related Cost

25.00 OTHER WAGE RELATED COSTS (SPECIFY)

23 00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provi der No.: 315157

Peri od: Worksheet S-3 From 01/01/2022 Part V To 12/31/2022 Date/Time Prepared:

5/10/2023 9:29 am Occupational Category Amount Fri nge Adj usted Pai d Hours Average Hourly Benefits Sal ari es (col Related to Reported Wage (col. 3 col . 4) 1 + col. 2Salary in col 5. 00 3.00 1.00 2.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 457, 136 64, 080 521, 216 9, 814. 00 53. 11 1.00 Licensed Practical Nurses (LPNs) 1, 740, 222 243, 941 1, 984, 163 44, 646. 00 2.00 44.44 2.00 3.00 Certified Nursing Assistant/Nursing 2, 789, 420 391, 015 3, 180, 435 136, 400. 00 23.32 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 4, 986, 778 699, 036 5, 685, 814 190, 860. 00 29.79 4.00 5.00 0.00 Physical Therapists 0 00 5 00 0 Physical Therapy Assistants 0.00 6.00 0 C 0 0.00 6.00 7.00 Physical Therapy Aides 0 0 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 0.00 8.00 0 0 0 0 0.00 8.00 0 0 0.00 9.00 0.00 9.00 10.00 Occupational Therapy Aides 0 0 0.00 0.00 10.00 0 0 11.00 Speech Therapists 0 0.00 0.00 11.00 0 12.00 Respiratory Therapists 0 00 0 00 12 00 Ω 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 7, 920. 00 80. 19 14 00 Registered Nurses (RNs) 635, 133 635, 133 14 00 15.00 Licensed Practical Nurses (LPNs) 1, 542, 591 1, 542, 591 23, 620. 00 65.31 15.00 Certified Nursing Assistant/Nursing 738, 803 738, 803 14, 466. 00 51.07 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 2, 916, 527 2, 916, 527 46, 006. 00 63.39 17.00 18.00 Physical Therapists 327, 665 327, 665 5, 226. 00 62.70 18.00 19.00 Physical Therapy Assistants 209, 049 209, 049 4,001.00 52.25 19.00 Physical Therapy Aides 20.00 46, 528 46, 528 1, 781. 00 26.12 20.00 Occupational Therapists 5, 626. 00 21.00 310, 065 310,065 55. 11 21.00 Occupational Therapy Assistants 22.00 260, 409 260, 409 5, 670. 00 45.93 22.00 Occupational Therapy Aides 0.00 0.00 23.00 23.00 24.00 Speech Therapists 264, 988 264, 988 3, 701. 00 71. 60 24.00 Respiratory Therapists 0.00 25.00 25.00 0 0 0.00 0 26.00 Other Medical Staff 0 0.00 0.00 26.00

Peri od:

From 01/01/2022

12/31/2022 Date/Time Prepared: 5/10/2023 9: 29 am Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE2 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC<sub>2</sub> 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB<sub>2</sub> 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 68.00 PE1 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00 75.00 75.00 PA<sub>2</sub>

Health Financial Systems	MORRISTOWN POST ACUTE REHAB & NUF	RSIN	In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der		Peri od:	Worksheet S-7	'
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/10/2023 9:2	
			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 Registory payments beginning 10/01/2003. Congress of expenses. For lines 101 through 106: Entered tool umn 2 the percentage of total expenses line 1, column 3. Indicate in column 3 "with direct patient care and related expenses (See instructions)	expected this increase to be used er in column 1 the amount of the s for each category to total SNF Y" for yes or "N" for no if the s	d for direct p expense for e revenue from spending refle	atient care and ach category. Er Worksheet G-2, F cts increases as	related Iter in Part I, Issociated	104.00
101. 00  Staffi ng 102. 00  Recrui tment					101. 00 102. 00
103.00 Retention of employees					103. 00
104. 00 Trai ni ng					104. 00
105. 00 OTHER (SPECIFY)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I	, line 1, column 3)				106. 00

Health Fir	nancial Systems MORRI	STOWN POST ACUTE	E REHAB & NUR	SIN	In Lie	eu of Form CMS-2	2540-10
	ICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315157 F	Peri od:	Worksheet A	
				F	rom 01/01/2022		
				Ι	To 12/31/2022		
						5/10/2023 9: 2	9 am
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
					Increase/Decre	(col. 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)	,	
		1.00	2. 00	3.00	4.00	5. 00	
GEN	IERAL SERVICE COST CENTERS						
	100 CAP REL COSTS - BLDGS & FIXTURES		5, 744, 289	5, 744, 289	9 0	5, 744, 289	1.00
	BOO EMPLOYEE BENEFITS	o	1, 224, 283			1, 224, 283	3. 00
	400 ADMINISTRATIVE & GENERAL	299, 386	2, 842, 370			3, 141, 756	4. 00
	500 PLANT OPERATION, MAINT. & REPAIRS	239, 582	554, 822			794, 404	5. 00
		239, 302	334, 622	794, 404	1		
	500 LAUNDRY & LINEN SERVICE	5 40 004	04 745	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	0	6. 00
	700 HOUSEKEEPI NG	540, 321	91, 745			632, 066	7. 00
	BOO DI ETARY	933, 255	589, 396			1, 522, 651	8. 00
	900 NURSING ADMINISTRATION	1, 301, 666	18, 000	1, 319, 666	0	1, 319, 666	9. 00
10.00 010	000 CENTRAL SERVICE & SUPPLY	0	0	(	0	0	10.00
12.00 012	200 MEDICAL RECORDS & LIBRARY	32, 461	0	32, 461	0	32, 461	12.00
	300 SOCIAL SERVICE	122, 122	0	122, 122		122, 122	13. 00
	500 PATIENT ACTIVITIES	188, 870	40, 599			229, 469	15. 00
I ND	PATIENT ROUTINE SERVICE COST CENTERS	100,070	10,077	227, 107	,	227, 107	10.00
	000 SKILLED NURSING FACILITY	4, 913, 197	3, 479, 470	8, 392, 667	7	8, 392, 667	30.00
		4, 913, 197	3, 479, 470	0, 392, 007			ı
	100 NURSING FACILITY	0	0		0	0	31. 00
	200   I CF/I I D	0	0	(	0	0	32. 00
	300 OTHER LONG TERM CARE	0	0	(	0	0	33. 00
ANC	CILLARY SERVICE COST CENTERS						
40.00 040	DOO RADI OLOGY	0	9, 090	9, 090	0	9, 090	40.00
41. 00 041	100 LABORATORY	o	93, 603	93, 603	0	93, 603	41.00
	200 I NTRAVENOUS THERAPY	0	0	(	0	0	42.00
	300 OXYGEN (INHALATION) THERAPY	0	31, 148	31, 148	0	31, 148	43. 00
	400 PHYSI CAL THERAPY		605, 044			605, 044	•
		0					•
	500 OCCUPATI ONAL THERAPY	U	570, 474			570, 474	1
	500 SPEECH PATHOLOGY	0	264, 988	264, 988	3	264, 988	1
	700 ELECTROCARDI OLOGY	0	0	(	0	0	47. 00
	BOO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	48. 00
49.00 049	POO DRUGS CHARGED TO PATIENTS	0	371, 193	371, 193	0	371, 193	49. 00
50.00 050	DOO DENTAL CARE - TITLE XIX ONLY	0	0	(	0	0	50.00
51.00 051	100 SUPPORT SURFACES	o	0		o	0	51.00
	200 OTHER ANCILLARY SERVICE COST CENTERS	o	0	1 (	0	0	52.00
	TPATIENT SERVICE COST CENTERS	9			, , , , ,	Ü	02.00
	BOO OTHER OUTPATIENT SERVICE COST CENTER	O	0		0	0	63. 00
	HER REIMBURSABLE COST CENTERS	U U	U		0	U	03.00
			42.024	42.024		42.024	71 00
	100 AMBULANCE	0	43, 926				71.00
	200 CORF	0	0	(	0	0	72. 00
	BOO CMHC	0	0	(	0	0	73. 00
	400 OTHER REIMBURSABLE COST	0	0	(	0	0	74. 00
SPE	CIAL PURPOSE COST CENTERS						
80.00 080	000 MALPRACTICE PREMIUMS & PAID LOSSES		0	C	0	0	80. 00
81. 00 081	100 INTEREST EXPENSE		0	1 (	0	O	81. 00
	200 UTI LI ZATI ON REVI EW	0	0	1		Ö	
	BOO HOSPI CE		0			0	83. 00
	400 OTHER SPECIAL PURPOSE COST CENTERS	0	0				84. 00
	l e e e e e e e e e e e e e e e e e e e	0 570 0/0	1/ 574 440	25 145 200			
89. 00	SUBTOTALS (sum of lines 1-84)	8, 570, 860	16, 574, 440	25, 145, 300	) U	25, 145, 300	89. 00
	IREI MBURSABLE COST CENTERS		_	ı	.1	_	
	000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(	0	0	90. 00
	100 BARBER AND BEAUTY SHOP	0	4, 465	4, 465	0	4, 465	
92. 00 092	200 PHYSICIANS PRIVATE OFFICES	0	0	(	0	0	92. 00
93. 00   093	NONPALD WORKERS	0	0	(	0	0	93. 00
94. 00 094	100 PATIENTS LAUNDRY	o	0		o	0	94.00
	500 OTHER NONREIMBURSABLE COST CENTERS	ol	0	1	0	0	95. 00
100.00	TOTAL	8, 570, 860	16, 578, 905	25, 149, 765	0	25, 149, 765	
1	1		.,	, , , , , ,	, 9	., ,	

 Heal th Financial
 Systems
 MORRISTOWN POST ACUTE
 REHAB & NURSIN

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.:

Health Financial Systems MORR	STOWN POST ACU	TE REHAB & NUR	SI N	In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315157	Peri od:	Worksheet A	
				From 01/01/2022		
				To 12/31/2022		
Cost Center Description	Adjustments to	Nat Eynansas		L .	5/10/2023 9: 2	9 alli
COST CENTER DESCRIPTION		For Allocation				
	Wkst A-8)	(col. 5 +-				
	wkst k o)	col. 6)				
	6. 00	7.00	1			
GENERAL SERVICE COST CENTERS	0.00	7.00				
1. 00 00100 CAP REL COSTS - BLDGS & FLXTURES	-1, 508, 131	4, 236, 158				1.00
3. 00 00300 EMPLOYEE BENEFITS	1, 300, 131	1, 224, 283				3. 00
4. 00   00400 ADMI NI STRATI VE & GENERAL	-1, 595, 953		1			4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	1, 373, 733	794, 404				5.00
6. 00 00600 LAUNDRY & LINEN SERVICE	0	7,74,404				6.00
7. 00   00700   HOUSEKEEPI NG	0	632, 066				7. 00
8. 00   00800 DI ETARY	0	1, 522, 651	1			8.00
9. 00   00900   NURSI NG   ADMI NI STRATI ON	0	1, 319, 666	1			9. 00
10. 00 01000 CENTRAL SERVICE & SUPPLY	0	1, 317, 000				10.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	32, 461	1			12. 00
13. 00   01300   SOCIAL SERVICE	0	1	1			13. 00
15. 00 01500 PATIENT ACTIVITIES	0					15. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	U	227, 407	1			15.00
30. 00 03000 SKILLED NURSING FACILITY	0	8, 392, 667	,			30.00
31. 00   03100   NURSI NG FACILITY	0	0, 392, 007	1			31.00
32. 00   03200   1CF/11D	0	1	1			32.00
33. 00   03300   OTHER LONG TERM CARE	0		1			33.00
ANCI LLARY SERVI CE COST CENTERS	U		'			33.00
40. 00 04000 RADI OLOGY	0	9, 090	\			40.00
	0		1			1
	0	93, 603	1			41.00
	_	_	1			42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY	0		1			43.00
44. 00 04400 PHYSI CAL THERAPY	0	605, 044	1			44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	570, 474	1			45. 00
46. 00   04600   SPEECH PATHOLOGY	0	264, 988	1			46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0				47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	271 102				48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0	371, 193	1			49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	1			50.00
51. 00 05100 SUPPORT SURFACES	0		1			51.00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	1			52.00
OUTPATIENT SERVICE COST CENTERS			\			/2 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	ή			63.00
71. 00 OTHER REIMBURSABLE COST CENTERS 71. 00 O7100 AMBULANCE		42.024	I			71. 00
72. 00   07200   CORF	0		1			
73. 00   07300   CMHC	0	l e	1			72. 00 73. 00
74. 00 07400 OTHER REIMBURSABLE COST	0		1			74.00
SPECIAL PURPOSE COST CENTERS	U		ή			74.00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	0	N .			80.00
81. 00 08100 I NTEREST EXPENSE	0		•			81.00
82. 00   08200   UTI LI ZATI ON REVI EW	0					82.00
	0					83. 00
83. 00   08300   HOSPI CE 84. 00   08400   OTHER SPECI AL PURPOSE COST CENTERS	0					84. 00
89.00   SUBTOTALS (sum of lines 1-84)	-3, 104, 084	22, 041, 216	<u>'</u>			89. 00
NONREI MBURSABLE COST CENTERS	-3, 104, 064	22,041,210	'			09.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0				90.00
	0		1			
91. 00   09100   BARBER AND BEAUTY SHOP 92. 00   09200   PHYSICIANS PRIVATE OFFICES		4, 465				91. 00 92. 00
93. 00   09300   NONPALD WORKERS						92.00
94. 00   09400   PATI ENTS LAUNDRY						93.00
95. 00   09500 OTHER NONREIMBURSABLE COST CENTERS						95.00
100.00 TOTAL	-3, 104, 084	22, 045, 681	Ί			100.00
100.00    101NE	3, 104, 004	1 22,043,001	I			1.00.00

Health Financial Systems MORF	RISTOWN POST ACUTE RE	EHAB & NUR	SIN	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2022 To 12/31/2022		pared:
		Increases				
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
TOTALS						
100. 00	Total Reclassifications (Sum 0			0	100. 00	
	of columns 4 and 5	of columns 4 and 5 must				
	equal sum of column	ns 8 and				
	7 <i> </i>					

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 MO	RRISTOWN POST ACUTE RI	HAB & NUR	SIN	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315157	Peri od:	Worksheet A-6	•
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	
					5/10/2023 9: 2	29 am
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der No.: 315157

						5/10/2023 9: 20	9 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2, 192, 508	34, 377	0	34, 377	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	72, 675	65, 558	0	65, 558	0	6.00
7.00	Subtotal (sum of lines 1-6)	2, 265, 183	99, 935	0	99, 935	0	7.00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	2, 265, 183	99, 935	0	99, 935	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	3					
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	2, 226, 885	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	138, 233	0				6.00
7.00	Subtotal (sum of lines 1-6)	2, 365, 118	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	2, 365, 118	0				9.00

Provi der No.: 315157

Peri od: Worksheet A-8

From 01/01/2022
To 12/31/2022 Date/Time Prepared:

				10 12/01/2022	5/10/2023 9: 2	9 am
	·			Expense Classification on		
				To/From Which the Amount is	to be Adiusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	bescription (1)	Adjustment	Amount	COST CONTEN	LITIC NO.	
		1.00	2. 00	3.00	4. 00	
1.00	Investment income on restricted funds	B B		ADMI NI STRATI VE & GENERAL	4. 00	1. 00
1.00	(chapter 2)	В	-0, 441	ADMINISTRATIVE & GENERAL	4.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
2.00	8)		U		0.00	2.00
3.00	1 - /		0		0.00	3. 00
	Refunds and rebates of expenses (chapter 8)		0			
4. 00	Rental of provider space by suppliers		0		0. 00	4. 00
F 00	(chapter 8)		0		0.00	г оо
5. 00	Tel ephone services (pay stations excluded)		Ü		0. 00	5. 00
	(chapter 21)		•		0.00	
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7. 00	Parking lot (chapter 21)		0		0. 00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	10.00
11. 00	Nonallowable costs related to certain		0		0. 00	11. 00
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	-1, 500, 969			12.00
	related organizations (chapter 10)					
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals		0		0.00	14.00
15.00	Cost of meals - Guests		0		0.00	15.00
16. 00	Sale of medical supplies to other than		0		0.00	16.00
	patients					
17.00	Sale of drugs to other than patients		0		0.00	17.00
18. 00	Sale of medical records and abstracts	В	-1, 425	ADMINISTRATIVE & GENERAL	4. 00	18.00
19.00	Vendi ng machi nes		0		0.00	19. 00
20.00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW	82. 00	22. 00
22.00	(chapter 21)		· ·		02.00	22.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
20.00	popriori atroni barrariigo ana rrixtaros		· ·	FI XTURES		20.00
24. 00	Depreciationmovable equipment		0	*** Cost Center Deleted ***	2. 00	24. 00
25. 00	Bepresider of movable equipment		0	dost derrer bereted	0.00	
25. 00	RESIDENT MISSING ITEMS	A	_1 100	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	FINES & PENALTIES	A		ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02 25. 03	MARKETING & ADVERTISING	A		ADMINISTRATIVE & GENERAL	4.00	
	1	1		•		
25. 04	BAD DEBT	A		ADMINISTRATIVE & GENERAL	4.00	25. 04
25. 05	MANAGEMENT FEE	A		ADMINISTRATIVE & GENERAL	4.00	25. 05
25. 07	OTHER REVENUE MISC	В		ADMINISTRATIVE & GENERAL	4.00	25. 07
25. 08		В		ADMINISTRATIVE & GENERAL	4. 00	25. 08
100.00	Total (sum of lines 1 through 99) (Transfer		-3, 104, 084			100. 00
	to Worksheet A, col. 6, line 100)					
(1) D-			CMC Duk 1F 1			

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

Health Financial Systems MORRISTOWN POST ACUTE REHAB & NURSIN STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: EHAB & NURSIN In Lieu of Form CMS-2540-10
Provider No.: 315157 Period: Worksheet A-8-1
From 01/01/2022 Parts I-II
To 12/21/2022 Parts I-II

OFFICE COSTS				o 12/31/2022		
	Li ne No.	Cost C	enter	Expense		27 dili
	1.00	2. C	00	3. (	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REC	UIRED AS A RESULT	OF TRANSACTION	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00		CAP REL COSTS -	- BLDGS &	RENT		1.00
2.00	1	ADMI NI STRATI VE	& GENERAL	LESSOR A&G COST	ΓS	2. 00
3. 00	0. 00					3.00
4. 00	0.00					4. 00
5. 00	0.00					5.00
6. 00	0.00					6.00
7. 00	0.00					7.00
8. 00	0.00					8.00
9. 00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer colum 6, line 100 to Worksheet A-8, column 3, li						10. 00
	Amount	Amount	Adjustments			4
	Allowable In		(col. 4 minus			
		Wkst. A, col.	col . 5)			
	0031	5	COI . 3)			
	4.00	5.00	6. 00			
PART I. COSTS INCURRED AND ADJUSTMENTS REC CLAIMED HOME OFFICE COSTS:	UIRED AS A RESULT	OF TRANSACTION	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00	3, 489, 469	4, 997, 600	-1, 508, 131			1. 00
2. 00	7, 162	0	7, 162	2		2. 00
3. 00	0	0	0			3. 00
4. 00	0	0	0			4. 00
5. 00	0	0	0			5. 00
6. 00	0	0	0	)		6. 00
7. 00	0	0	0			7. 00
8. 00	0	0	0	)		8. 00
9. 00	0	0	0	)		9. 00
10.00 TOTALS (sum of lines 1-9). Transfer colum 6, line 100 to Worksheet A-8, column 3, li 12.		4, 997, 600	-1, 500, 969			10. 00

Provi der No.: 315157 Peri od: Worksheet A-8-1 From 01/01/2022 OFFICE COSTS Parts I-II Date/Time Prepared: 12/31/2022

				3/10/2023 9.2	9 alli
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2.00	3. 00		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/C	R 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	1	1	i
1.00	A	B KURLAND	99.00	1.00
2.00	A	N KURLAND	1.00	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:				l

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

	Rel ated Organi	zation(s) and/	or Home Office
	Name	Percentage of Ownership	Type of Business
DART LL LATERDEL ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6.00

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. 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	77 MADISON PROPCO LLC	99. 00 REALTY	1.00
2. 00	77 MADISON PROPCO LLC	1. 00 REALTY	2.00
3. 00		0.00	3.00
4.00		0.00	4.00
5. 00		0.00	5. 00
6. 00		0.00	6.00
7. 00		0.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

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

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

Provider No.: 315157 | Period: Worksheet B From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	12/31/2022	Date/Time Pre 5/10/2023 9:2	pared:
			CAPI TAL			5/10/2023 9: 2	9 alli
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDGS &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	<b>'</b>	for Cost	FIXTURES	BENEFITS		& GENERAL	
		Allocation					
		(from Wkst A					
		col. 7)					
	T	0	1.00	3. 00	3A	4. 00	
1 00	GENERAL SERVICE COST CENTERS	4 227 150	4 22/ 150				1 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	4, 236, 158					1.00
3.00	OO300	1, 224, 283			2 212 000	2 212 000	3. 00
4.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 545, 803			2, 212, 898		4. 00 5. 00
5. 00 6. 00	00600 LAUNDRY & LINEN SERVICE	794, 404	133, 395 78, 582		963, 847 78, 582		6. 00
7. 00	00700 HOUSEKEEPING	632, 066		-	745, 432		7. 00
8. 00	00800 DI ETARY	1, 522, 651	208, 340		1, 871, 411		8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	1, 319, 666			1, 571, 411		9. 00
10. 00	01000 CENTRAL SERVICE & SUPPLY	1, 317, 000	0 30, 270		1, 371, 017		10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	32, 461	19, 517	-	56, 862	1	12. 00
13. 00	01300 SOCIAL SERVICE	122, 122			156, 736		13. 00
15. 00	01500 PATIENT ACTIVITIES	229, 469			257, 887		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
30.00	03000 SKILLED NURSING FACILITY	8, 392, 667	2, 792, 380	739, 254	11, 924, 301	1, 330, 486	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200   CF/IID	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	9, 090		-	9, 090		40. 00
41. 00	04100 LABORATORY	93, 603	0	- 1	93, 603		41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	1	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	31, 148		0	31, 148		43. 00
44.00	04400 PHYSI CAL THERAPY	605, 044			724, 249		
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	570, 474			639, 323		45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	264, 988	9, 784		274, 772 0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	371, 193		· ·	385, 332	_	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0,1,1,0	11,107	Ö	000, 002	0	50.00
51. 00	05100 SUPPORT SURFACES	Ö	Ö	Ö	0	1	51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	Ö	1	0		52. 00
	OUTPATIENT SERVICE COST CENTERS		<u>'</u>			<u> </u>	
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	43, 926	0		43, 926	4, 901	71. 00
72. 00	07200 CORF	0	0	-	0	1	72. 00
73. 00	07300 CMHC	0	0	0	0	_	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
00 00	SPECIAL PURPOSE COST CENTERS	T	I	1		I	00.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 82. 00	O8100   INTEREST EXPENSE   O8200   UTI LI ZATI ON REVIEW						81. 00 82. 00
82.00	08300 HOSPI CE	0	0	0	0	0	82.00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0		0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	22, 041, 216	4, 236, 158	-	22, 041, 216		89. 00
07.00	NONREI MBURSABLE COST CENTERS	22,041,210	4, 230, 130	1, 207, 377	22, 041, 210	2,212,400	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	4, 465			4, 465		
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	o	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments	0	0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	TOTAL	22, 045, 681	4, 236, 158	1, 289, 597	22, 045, 681	2, 212, 898	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					12/31/2022	5/10/2023 9: 2	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	<b>'</b>	OPERATION,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS					
		5. 00	6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 071, 391					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	24, 651	112, 001				6. 00
7.00	00700 HOUSEKEEPI NG	10, 060	0	838, 666			7. 00
8.00	00800 DI ETARY	65, 355	l .	52, 827	2, 198, 401		8. 00
9.00	00900 NURSING ADMINISTRATION	17, 660	l .	14, 275		1, 779, 132	9. 00
10.00	01000 CENTRAL SERVI CE & SUPPLY	0	0	0	0	0	10.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	6, 123	0	4, 949	0	Ō	12.00
13. 00	01300 SOCIAL SERVICE	5, 094	l .	4, 819	0	ō	13. 00
15. 00	01500 PATIENT ACTIVITIES	0	0	0	0	Ō	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>			10.00
30.00	03000 SKILLED NURSING FACILITY	875, 952	112, 001	708, 046	2, 198, 401	1, 779, 132	30.00
31. 00	03100 NURSING FACILITY	0,0,702	0	0	2, 1, 0, 101	0	31.00
32. 00	03200   CF/IID	0	0	Ö	0	ő	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	Ö	0	ő	33.00
00.00	ANCI LLARY SERVI CE COST CENTERS			,			00.00
40. 00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	_	Ö	0		41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	Ö	0	ő	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0		0	0	ő	43.00
44. 00	04400 PHYSI CAL THERAPY	37, 394		30, 226	0	ő	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	21, 598		17, 458	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	3, 069	l .	2, 481	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	3,007		2, 401	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	4, 435		3, 585	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	4, 433		3, 303	0	0	50.00
51. 00	05100 SUPPORT SURFACES			0	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS		1	0	0	0	52.00
32.00	OUTPATIENT SERVICE COST CENTERS		0	<u> </u>			32.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
03.00	OTHER REIMBURSABLE COST CENTERS		0	١			03.00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
72. 00	07200 CORF	0	1	0	0		72.00
73. 00	07300 CMHC	0	_	0	0	o o	73.00
74. 00	07400 OTHER REIMBURSABLE COST	0	_	Ö	0	o o	74.00
74.00	SPECIAL PURPOSE COST CENTERS		· · · · · ·	<u> </u>			74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0		0	0	ő	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 071, 391	112, 001	838, 666	2, 198, 401		89. 00
07.00	NONREI MBURSABLE COST CENTERS	1,071,371	112,001	030, 000	2, 170, 401	1, 117, 132	07.00
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	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0		0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0		0	0	ő	93. 00
94. 00	09400 PATIENTS LAUNDRY				0	0	94.00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS			0	0	0	95.00
98. 00					0	0	98.00
99. 00		0	_		0	0	99.00
100.00		1, 071, 391	_	838, 666	2, 198, 401		
100.00	51 1.01/1E	1,071,371	1 112,001	1 050, 000	2, 170, 401	1, 1, 1, 1, 132	1.00.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315157

						5/10/2023 9: 2	9 am
					OTHER GENERAL		
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	PATI ENT	Subtotal	
		SERVICE &	RECORDS &		ACTI VI TI ES		
		SUPPLY	LI BRARY				
	1	10. 00	12. 00	13. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	T T					
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10.00	01000 CENTRAL SERVI CE & SUPPLY	0					10. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	74, 279				12. 00
13.00	01300 SOCIAL SERVICE	0	C	184, 137			13. 00
15. 00	01500 PATIENT ACTIVITIES	0	C	0	286, 662		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	74, 279	184, 137	286, 662	19, 473, 397	30. 00
31. 00	03100 NURSING FACILITY	0	C	0	0	0	31. 00
32. 00	03200   CF/IID	0	C	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	C	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	C	0	0	10, 104	40. 00
41. 00	04100 LABORATORY	0	C	0	0	104, 047	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	C	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	0	0	34, 623	43. 00
44.00	04400 PHYSI CAL THERAPY	0	C	0	0	872, 679	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	C	0	0	749, 713	45. 00
46.00	04600 SPEECH PATHOLOGY	0	C	0	0	310, 981	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	C	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	C	0	0	436, 347	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	0	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	C	0	0	0	51. 00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	C	0	0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS						
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	C	0	0	48, 827	71. 00
72. 00	07200 CORF	0	C	_	- 1	0	72. 00
73. 00	07300 CMHC	0	C	0	- 1	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	C	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW						82. 00
83. 00	08300 H0SPI CE	0	C	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	C	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	74, 279	184, 137	286, 662	22, 040, 718	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	C	0	0	4, 963	
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES	0	C	0	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	C	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	C	0	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0	0	95. 00
98. 00	Cross Foot Adjustments	0			0	0	98. 00
99. 00	Negative Cost Centers	0	C	0	0	0	99. 00
100.00	) TOTAL	0	74, 279	184, 137	286, 662	22, 045, 681	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315157

| In Lieu of Form CMS-2540-10 | Period: Worksheet B | From 01/01/2022 Part | | To 12/31/2022 Date/Time Prepared: | 5/10/2023 9: 29 am

				5/10/2023 9: 2	<u>9 am</u>
	Cost Center Description	Post Stepdown	Total		
		Adjustments			
		17. 00	18. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				1. 00
3.00	00300 EMPLOYEE BENEFITS				3. 00
4.00	00400 ADMINISTRATIVE & GENERAL				4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE				6. 00
7.00	00700 HOUSEKEEPI NG				7.00
8.00	00800 DI ETARY				8. 00
9.00	00900 NURSING ADMINISTRATION				9. 00
10.00	01000 CENTRAL SERVICE & SUPPLY				10.00
12.00	01200 MEDICAL RECORDS & LIBRARY				12.00
13.00	01300 SOCIAL SERVICE				13. 00
15. 00	01500 PATIENT ACTIVITIES				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				1
30. 00	03000 SKILLED NURSING FACILITY	0	19, 473, 397		30.00
31. 00	03100 NURSING FACILITY	o	0		31.00
32. 00	03200   CF/11D	l o	o		32. 00
33. 00	03300 OTHER LONG TERM CARE		0		33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	O <sub>I</sub>		33.00
40. 00	04000 RADI OLOGY	0	10, 104		40. 00
41. 00	04100 LABORATORY		104, 047		41.00
42. 00	04200 I NTRAVENOUS THERAPY		0		42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY		34, 623		43.00
44. 00	04400 PHYSI CAL THERAPY				44. 00
		0	872, 679		1
45. 00	04500 OCCUPATIONAL THERAPY	1	749, 713		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	310, 981		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40 ( 0.47		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	436, 347		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51.00	05100 SUPPORT SURFACES	0	0		51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		52. 00
	OUTPATIENT SERVICE COST CENTERS				
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		63.00
74 00	OTHER REIMBURSABLE COST CENTERS		10.007		
71. 00	07100 AMBULANCE	0	48, 827		71. 00
72. 00	07200 CORF	0	0		72. 00
73. 00	07300 CMHC	0	0		73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	0		74. 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 UTILIZATION REVIEW				82. 00
83.00	08300 H0SPI CE	0	0		83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	22, 040, 718		89. 00
	NONREI MBURSABLE COST CENTERS				
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	o	4, 963		91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		92. 00
93. 00	09300 NONPALD WORKERS	0	o		93. 00
94.00	09400 PATIENTS LAUNDRY		o		94.00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS		o		95. 00
98. 00	Cross Foot Adjustments	o	o		98. 00
99. 00	Negative Cost Centers		o		99. 00
100.00		o	22, 045, 681		100.00
	1	,			

Health Financial Systems MORRISTOWN POST ACUTE REHAB & NURSIN In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315157 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/10/2023 9: 29 am CAPI TAL RELATED COSTS Di rectly ADMI NI STRATI VE Cost Center Description BLDGS & Subtotal EMPLOYEE Assigned New **FLXTURES** BENEFITS & GENERAL Capi tal Related Costs 1.00 2A 3.00 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS 3.00 65, 314 65, 314 65, 314 4.00 00400 ADMINISTRATIVE & GENERAL 0 622, 048 622, 048 2, 281 624, 329 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 0 0 0 133, 395 133, 395 1,826 30, 342 00600 LAUNDRY & LINEN SERVICE 78, 582 78. 582 2, 474 6 00 7.00 00700 HOUSEKEEPI NG 32,068 32,068 4, 117 23, 466 8.00 00800 DI ETARY 208, 340 208, 340 7, 111 58, 912 56, 298 00900 NURSING ADMINISTRATION 0 0 56, 298 9. 919 49, 481 9 00 01000 CENTRAL SERVICE & SUPPLY 10.00 Λ 12.00 01200 MEDICAL RECORDS & LIBRARY 19, 517 19, 517 247 1, 790 01300 SOCIAL SERVICE 0 16, 239 13.00 16, 239 931 4, 934 01500 PATIENT ACTIVITIES 15 00 0 1, 439 8, 118 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 2, 792, 380 2, 792, 380 37, 443 375, 369 31.00 03100 NURSING FACILITY 0 0 0 03200 | CF/IID O 32 00 Ω 0 0 33.00 033<u>00 OTHER LONG TERM CARE</u> 0 0 0 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 000000 0 286 04100 LABORATORY 0 0 41.00 Ω 2,947 42.00 04200 I NTRAVENOUS THERAPY 0 0 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 0 981 0 04400 PHYSI CAL THERAPY 119, 205 119, 205 44.00 22.799 04500 OCCUPATIONAL THERAPY 45.00 68, 849 68.849 20, 126 9, 784 8, 650 04600 SPEECH PATHOLOGY 0 0 0 9, 784 0 46.00 0 04700 ELECTROCARDI OLOGY 47 00 C 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 0 0 04900 DRUGS CHARGED TO PATIENTS 0 49 00 14, 139 14, 139 12, 130 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 C 0 05100 SUPPORT SURFACES 0 o 51.00 0 0 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 52.00 Λ 0 0 Λ

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				''	3 12/31/2022	5/10/2023 9: 2	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS					
		5. 00	6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	165, 563					5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	3, 809	l .				6. 00
7. 00	00700 HOUSEKEEPI NG	1, 555	l ·	61, 206			7. 00
8. 00	00800 DI ETARY	10, 099	l .	3, 855	288, 317		8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	2, 729	l .	1, 042	200, 317	119, 469	9. 00
10. 00	01000 CENTRAL SERVICE & SUPPLY	2, 727		1,042	0	0	10.00
	01200 MEDI CAL RECORDS & LI BRARY	-			0	0	
12.00	+ I	946		361	0		12.00
13.00	01300 SOCIAL SERVICE	787	0	352	U	0	13.00
15. 00		0	0	0	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	405.070	04.045	F4 (70	000 047	110 110	00.00
30.00	03000 SKILLED NURSING FACILITY	135, 363	84, 865	51, 673	288, 317	119, 469	30.00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00	03200   CF/IID	0	0	0	0	0	32. 00
33. 00		0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	I I	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	5, 779	0	2, 206	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	3, 337	0	1, 274	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	474	0	181	0	0	46. 00
47. 00	1 1	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	Ō	48. 00
49. 00	1 1	685	1 0	262	0	Ö	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0		0	0	Ö	50.00
51. 00	05100 SUPPORT SURFACES		1	o o	0	Ö	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS		1	0	0	ő	52.00
32.00	OUTPATIENT SERVICE COST CENTERS		1 0	0		0	32.00
63. 00		1 0	0	0	0	0	63. 00
03.00	OTHER REIMBURSABLE COST CENTERS		0			0	03.00
71. 00		1 0		0	0	0	71. 00
71.00	+ I		1	0	0		71.00
	07200 CORF	-	_	0	0	0	
73.00	+ I	0	_	0	0	0	73.00
74. 00			0	0	U	U U	74. 00
00.00	SPECIAL PURPOSE COST CENTERS		I			I	00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	I I						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00		0	0	0	0	0	84. 00
89. 00		165, 563	84, 865	61, 206	288, 317	119, 469	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	The state of the s	0	0	0	0	0	90.00
91. 00	I I	0	0	0	0	0	91.00
92.00		0	0	0	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95.00		0	0	0	0	0	95. 00
98.00	Cross Foot Adjustments	1	0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00		165, 563	84, 865	61, 206	288, 317	119, 469	100.00
				'			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MORRISTOWN POST ACUTE REHAB & NURSIN
Provider No.: 315157

						5/10/2023 9: 2	9 am
					OTHER GENERAL		
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	PATI ENT	Subtotal	
		SERVICE &	RECORDS &		ACTIVITIES		
		SUPPLY	LI BRARY				
		10.00	12.00	13.00	15. 00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10.00	01000 CENTRAL SERVICE & SUPPLY	0					10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	22, 861				12.00
13.00	01300 SOCIAL SERVICE	0	0	23, 243			13.00
15.00	01500 PATIENT ACTIVITIES	0	0	0	9, 557		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	22, 861	23, 243	9, 557	3, 940, 540	30. 00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200   CF/IID	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	286	40. 00
41.00	04100 LABORATORY	0	0	0	0	2, 947	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	981	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	0	0	149, 989	
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	93, 586	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	19, 089	
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	27, 216	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	1		0	51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS			1 -			
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
74 00	OTHER REIMBURSABLE COST CENTERS			1		1 000	
71. 00	07100 AMBULANCE	0	0	l .		1, 383	
72. 00	07200 CORF	0	0			0	72. 00
73. 00	07300 CMHC	0	0		0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	U	0	0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW		0			0	82. 00
83. 00	08300 HOSPI CE	0	0		0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0			0	
89. 00	SUBTOTALS (sum of lines 1-84)	0	22, 861	23, 243	9, 557	4, 236, 017	89. 00
00 00	NONREI MBURSABLE COST CENTERS			1		0	00 00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	1		0 141	
91.00	09200 PHYSI CLANS PRI VATE OFFI CES		0		0	0	
93. 00	09300 NONPALD WORKERS	0	0	•		0	93.00
94. 00	09400 PATIENTS LAUNDRY		0			0	94.00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS		0			0	95.00
98. 00	Cross Foot Adjustments		0			0	98. 00
99. 00	Negative Cost Centers		0	_	ا	0	99.00
100.00		ا	22, 861	23, 243	9, 557	4, 236, 158	
		, 9	, 00 .		., 557	.,,	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315157

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/10/2023 9: 29 am |

				5/10/2023 9: 29	9 am
	Cost Center Description	Post Step-Down	Total		
		Adjustments			
		17. 00	18. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES				1. 00
3.00	00300 EMPLOYEE BENEFITS				3. 00
4.00	00400 ADMINISTRATIVE & GENERAL				4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE				6. 00
7.00	00700 HOUSEKEEPI NG				7. 00
8.00	00800 DI ETARY				8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON				9. 00
10.00	01000 CENTRAL SERVICE & SUPPLY				10.00
12.00	01200 MEDICAL RECORDS & LIBRARY				12. 00
	01300 SOCIAL SERVICE				13. 00
15. 00	01500 PATIENT ACTIVITIES				15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS				13.00
30. 00	03000 SKILLED NURSING FACILITY	0	3, 940, 540		30.00
	03100 NURSING FACILITY		0		31. 00
32. 00	03200   CF/11D		o		32.00
		0	0		33. 00
33.00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	J U	U		33.00
40. 00		O	207		40.00
	04000 RADI OLOGY		286		
41. 00	04100 LABORATORY	0	2, 947		41.00
	04200 I NTRAVENOUS THERAPY	0	0		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	981		43.00
44. 00	04400 PHYSI CAL THERAPY	0	149, 989		44.00
45. 00	04500 OCCUPATI ONAL THERAPY	0	93, 586		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	19, 089		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	27, 216		49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		50. 00
51. 00	05100 SUPPORT SURFACES	0	0		51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		52. 00
	OUTPATIENT SERVICE COST CENTERS				
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		63. 00
	OTHER REIMBURSABLE COST CENTERS				l
71. 00	07100 AMBULANCE	0	1, 383		71. 00
72.00	07200  CORF	0	0		72. 00
73.00	07300  CMHC	0	0		73. 00
74.00	07400 OTHER REIMBURSABLE COST	0	0		74. 00
	SPECIAL PURPOSE COST CENTERS				l
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				82. 00
83.00	08300 HOSPI CE	O	o		83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	o		84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	4, 236, 017		89. 00
	NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91. 00	09100 BARBER AND BEAUTY SHOP	o	141		91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		92.00
93. 00	09300 NONPALD WORKERS		o		93. 00
94. 00	09400 PATIENTS LAUNDRY		o		94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		o		95.00
98. 00	Cross Foot Adjustments		0		98.00
99. 00	Negative Cost Centers		0		99.00
100.00	1 1 0		4, 236, 158		100.00
100.00	1.0	١	1, 200, 100	'	, . 50. 60

Provider No.: 315157 | Period: From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

				T	0 12/31/2022	Date/Time Pre 5/10/2023 9:2	pared: 9 am
	Cost Center Description	CAPITAL RELATED COSTS BLDGS & FIXTURES (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
	GENERAL SERVICE COST CENTERS	1.00	3. 00	4A	4. 00	5. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES	82, 694					1.00
3. 00 4. 00 5. 00 6. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	1, 275 12, 143 2, 604 1, 534	8, 570, 860 299, 386 239, 582 0	-2, 212, 898 0	963, 847	66, 672	3. 00 4. 00 5. 00
7.00	00700 HOUSEKEEPI NG	626	540, 321	1			7. 00
8.00	00800 DI ETARY	4, 067	933, 255			4, 067	8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CE & SUPPLY	1, 099	1, 301, 666	0	1, 571, 817	1, 099 0	9. 00 10. 00
12. 00		381	32, 461	0	56, 862	381	12. 00
13. 00	1	317	122, 122	1			
15.00	1	0	188, 870	1		0	15. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30.00		54, 510	4, 913, 197	1		54, 510	1
31.00	1	0	0	_		0	31.00
32. 00 33. 00		0	0	· ·		0	32. 00 33. 00
33.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		0	<u> </u>	0	33.00
40. 00		0	C	0	9, 090	0	40. 00
41.00	04100 LABORATORY	0	0	0	93, 603	0	41. 00
42.00		0	0	0	0	0	42. 00
43.00	, ,	0	0	0			43. 00
44. 00		2, 327	0	0			44. 00
45. 00 46. 00		1, 344 191	0	0	,	1, 344 191	45. 00 46. 00
47. 00		171	0	0	2/4, //2	0	47.00
48. 00		o	0	Ö	0	Ö	48. 00
49. 00		276	O	Ō	385, 332	276	49. 00
50.00		0	0	0	0	0	50. 00
51.00		0	0	_	_	0	51. 00
52. 00		0	0	0	0	0	52. 00
63. 00	OUTPATIENT SERVICE COST CENTERS  O6300 OTHER OUTPATIENT SERVICE COST CENTER	0	C	0	0	0	63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	1 9		<u> </u>	<u> </u>	0	03.00
71. 00		0	C	0	43, 926	0	71. 00
72.00	07200 CORF	0	0	0	0	0	72. 00
73.00	· · · · · · · · · · · · · · · · · · ·	0	0	· ·		0	
74. 00		0	0	0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES	T		I			00.00
	08100   NTEREST EXPENSE			•			80. 00 81. 00
				•			82. 00
83.00		0	O	0	0	0	
84.00		0	0	0	0	0	
89. 00		82, 694	8, 570, 860	-2, 212, 898	19, 828, 318	66, 672	89. 00
00.00	NONREI MBURSABLE COST CENTERS				0	0	00.00
90. 00 91. 00		0	0		_	-	
92.00		0	0	0		0	92.00
93. 00		0	0	ő	0	Ö	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95.00		0	0	0	0	0	95. 00
98. 00							98. 00
99. 00	1 9	4 227 150	1 200 507		2 212 000	1 071 201	99.00
102.00	O Cost to be allocated (per Wkst. B, Part I)	4, 236, 158	1, 289, 597		2, 212, 898	1, 071, 391	102.00
103.00	1 1 1	51. 226909	0. 150463		0. 111578	16. 069579	103. 00
104.00			65, 314	1	624, 329		1
	Part II)						
105.00			0. 007620	1	0. 031480	2. 483246	105. 00
	11)	1		I		I	I

Provi der No.: 315157

Peri od: From 01/01/2022

Cost Center Description						rom 01/01/2022 o 12/31/2022		
CERNISS   CONTECT NURS   SUPPLY		Cost Center Description					CENTRAL	7 dili
CONTROL   SERVICE COST CINTERS   6.00   7.00   8.00   9.00   10.00				(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON		
EBERBAL SERVICE COST CENTERS			(0211000)			(DIRECT NURS.		
CEMERAL SERVICE COST CENTERS			4 00	7.00	9 00			
1.00		GENERAL SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
0.000   0.00	1.00							1.00
0.0500   PLANT OPERATION, MAINT: & REPAIRS   6.4   6.0   0.0600   0.0500   UNITRY EXPENSE   6.3, 461   6.4, 566   7.00   0.000   UNITRY EXPENSE   7.00   7		1 1						1
0.000   DOGOD   LANDRY & LINEN SERVICE								1
8.00   00000   DIFTARY   0   4, 067   190, 383   8.00   9.00   00000   DISSIN SADINISTRATION   0   1, 099   0   0   0   0   0   0   740, 47   10.00   10.00   10.00   01000   CENTRAL SERVICE & SUPPLY   0   381   0   0   0   740, 47   10.00   13.00   0   0   0   0   0   0   0   13.00			63, 461					1
0.000 (0000) NURSI ING ADMINI STRATION   0   1,009   0   190,860   740,437   100   120   00   0   0   0   0   0   120			0		l .			
10.00   01000 (ENTRAL SERVICE & SUPPLY   0   361   0   0   740, 437   10.00   10.00   13.00			0			I		
12 00   01200   MEDICAL RECORDS & LIBRARY   0   381   0   0   0   12,00			0		ı	190, 860	740 437	
15.00			0	1		Ö		1
INPATI ENT ROUTINE SERVICE COST CENTERS			_		l .	o		
30.00	15. 00		0	0	0	0	0	15. 00
31 00   03300   NURSIN F FACILITY	30. 00		63, 461	54, 510	190, 383	190, 860	369. 244	30.00
33. 00   03300   OTHER LONG TENI CARE   0   0   0   0   0   33. 00							•	1
ANCILLARY SERVICE COST CENTERS			-					
40	33. 00		0	0	<u> </u> C	0	0	33.00
42.00   04200   INTRAVENOUS THERAPY   0	40. 00		0	0	C	ol	0	40. 00
43.00   04300   OXYCOR (I NHALATI ON) THERAPY   0	41. 00		0	0	o c	О		41. 00
44. 00   04400   PHYSI CAL THERAPY   0   2, 327   0   0   0   44. 00			0	0	C	0		1
45. 00   04500   04500   05000   04500   04500   04500   04600   04600   04700			0	2 327	1	0		1
47:00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   0   0			0		1	o		1
ABL DO			0	191	0	o		1
49.00   04900   DRIVES CHARGED TO PATIENTS   0   276   0   0   371, 193   49, 00		1	0	0	C	0		1
50.00			0	276		0		
52.00			0	l .	1	Ö		
OLITPATI ENT SERVICE COST CENTERS   O			-	•				1
63.00	52. 00		] 0	0	<u> </u> C	0	0	52.00
OTHER REIMBURSABLE COST CENTERS	63. 00		0	0	C	ol	0	63. 00
72. 00   07200   CORF   0   0   0   0   0   0   0   72. 00   73. 00   07300   CMHC   0   0   0   0   0   0   0   73. 00   74. 00   74. 00   O7400   OTHER REI MBURSABLE COST   0   0   0   0   0   0   0    80. 00   O8000   MALPRACTI CE PREMI IUMS & PAID LOSSES   81. 00   81. 00   O8000   MALPRACTI CE PREMI IUMS & PAID LOSSES   81. 00   82. 00   O8200   UTI LI ZATI ON REVI EW   82. 00   83. 00   O8300   HOSPI CE   0   0   0   0   0   0   84. 00   O8400   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0   0   0   89. 00   O8400   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0   0   0   89. 00   O9000   OFT, FLOWER, COFFE SHOPS & CANTEEN   0   0   0   0   0   0   91. 00   O9000   OFT, FLOWER, COFFE SHOPS & CANTEEN   0   0   0   0   0   0   0   92. 00   O9000   OPHYSI CI ANS PRI VATE OFFI CES   0   0   0   0   0   0   0   93. 00   O9300   NONPAID WORKERS   0   0   0   0   0   0   0   94. 00   O9400   PATIENTS LAUNDRY   0   0   0   0   0   0   0   95. 00   O9500   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   99. 00   O9500   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   99. 00   O9500   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   99. 00   O9500   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   99. 00   O9500   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   99. 00   OFTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   102. 00   Cost to be allocated (per Wkst. B, Part I)   1. 764879   12. 989282   11. 547255   9. 321660   0. 000000   103. 00   104. 00   Cost to be allocated (per Wkst. B, B4, 865   61, 206   288, 317   119, 469   0   104. 00   105. 00   Unit cost multiplier (Wkst. B, Part I)   1. 337278   0. 947960   1. 514405   0. 625951   0. 000000   105. 00    105. 00   OTHER NONEI MBURSABLE COST CENTERS   0. 947960   1. 514405   0. 625951   0. 0000000   105. 00    105. 00   Unit cost multiplier (Wkst. B, Part I)   1. 337278   0. 947960   1. 514405   0. 625951   0. 0000000   105. 00    105. 00   OTHER NONEI MBURSABLE COST CENTERS   0		OTHER REIMBURSABLE COST CENTERS						
73. 00   07300   CMHC   0   0   0   0   0   0   0   73. 00   74. 00   74. 00   0   0   0   0   0   0   0   0   0								1
74.00								1
80. 00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   80. 00   81. 00   08100   INTEREST EXPENSE   82. 00   08200   UTILIZATION REVIEW   82. 00   08300   HOSPICE   0 0 0 0 0 0 0 0 0 0 83. 00   083. 00   084. 00   08400   0THER SPECI AL PURPOSE COST CENTERS   0 0 0 0 0 0 0 0 0 0 0   0 84. 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						-		1
81. 00			ı	I	ı			
82. 00   08200   UTILIZATION REVIEW   82. 00   08300   HOSPICE   0 0 0 0 0 0 0 0 0 83. 00   84. 00   08400   OTHER SPECIAL PURPOSE COST CENTERS   0 0 0 0 0 0 0 0 0 0 84. 00   89. 00   SUBTOTALS (sum of lines 1-84)   63, 461   64, 566   190, 383   190, 860   740, 437   89. 00   NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
84. 00								
SUBTOTALS (sum of lines 1-84)   63,461   64,566   190,383   190,860   740,437   89.00			0	0	o c	О		1
NONRE   MBURSABLE   COST   CENTERS		1	1	-	100 202	100.000		
90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   90. 00   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   92. 00   93. 00   09300   NONPAID WORKERS   0   0   0   0   0   0   0   93. 00   94. 00   94. 00   94. 00   94. 00   95. 00   00   00   00   00   95. 00   095. 00   00   00   00   00   95. 00   095. 00   00   00   00   00   00   00   00	89.00		63, 461	04, 566	190, 383	190, 860	740, 437	] 89.00 ]
92. 00   09200   PHYSICIANS PRIVATE OFFICES   0   0   0   0   0   92. 00   93. 00   09300   NONPAID   WORKERS   0   0   0   0   0   0   94. 00   09400   PATIENTS   LAUNDRY   0   0   0   0   0   95. 00   09500   OTHER NONREIMBURSABLE COST CENTERS   0   0   0   0   98. 00   Negative Cost Centers   0   0   0   102. 00   Cost to be allocated (per Wkst. B, Part I)   1. 764879   12. 989282   11. 547255   9. 321660   0. 000000   103. 00   104. 00   Cost to be allocated (per Wkst. B, Part II)   1. 764879   12. 989282   11. 547255   9. 321660   0. 000000   103. 00   105. 00   Unit cost multiplier (Wkst. B, Part II)   1. 337278   0. 947960   1. 514405   0. 625951   0. 000000   105. 00	90.00		0	0	C	0	0	90.00
93. 00   09300   NONPAID WORKERS   0   0   0   0   0   0   93. 00   94. 00   09400   PATIENTS LAUNDRY   0   0   0   0   0   0   94. 00   95. 00   09500   OTHER NONREIMBURSABLE COST CENTERS   0   0   0   0   0   95. 00   98. 00   99. 00   Negative Cost Centers   0   0   0   0   0   0   102. 00   Cost to be allocated (per Wkst. B, Part I)   1. 764879   12. 989282   11. 547255   9. 321660   0. 000000   103. 00   104. 00   Cost to be allocated (per Wkst. B, Part II)   1. 764879   1. 337278   0. 947960   1. 514405   0. 625951   0. 000000   105. 00    105. 00   Unit cost multiplier (Wkst. B, Part III)   1. 337278   0. 947960   1. 514405   0. 625951   0. 000000   105. 00    105. 00   Unit cost multiplier (Wkst. B, Part III)   1. 337278   0. 947960   1. 514405   0. 625951   0. 000000   105. 00    106. 00   0   0   0   0   0   0   0   0   0			-	•	1			
94. 00   9400   9400   9400   9400   9500   9500   9500   9600			0	0	1	0		
95. 00   950   OTHER NONREIMBURSABLE COST CENTERS   O   O   O   O   O   95. 00   98. 00   99. 00   Negative Cost Centers   O   Cost to be allocated (per Wkst. B, Part I)   O   O   O   O   O   O   O   O   O						0		
99.00   Negative Cost Centers   99.00   102.00   Cost to be allocated (per Wkst. B, Part I)   1.764879   12.989282   11.547255   9.321660   0.000000   103.00   104.00   Cost to be allocated (per Wkst. B, Part II)   1.764879   12.989282   11.547255   9.321660   0.000000   103.00   104.00   Part II)   105.00   Unit cost multiplier (Wkst. B, Part II)   1.337278   0.947960   1.514405   0.625951   0.000000   105.00   1		1 1	0	0	d	Ö		
102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 106.00 Cost to be allocated (per Wkst. B, Part II) 107.00 Unit cost multiplier (Wkst. B, Part II) 108.00 Unit cost multiplier (Wkst. B, Part II) 109.00 Unit cost multiplier (Wkst. B, Part II) 100.00 Unit cost multiplier (Wkst. B, Part III) 100.00 Unit cost multiplier (Wkst. B, Part IIII) 100.00 Unit cost multiplier (Wkst. B, Part IIII) 100.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII								
Part I) Unit cost multiplier (Wkst. B, Part I) 103.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 1. 764879 84, 865 61, 206 61, 206 288, 317 119, 469 0 104. 00 105. 00 105. 00			112 001	838 444	2 100 /01	1 770 122	0	1
103.00     Unit cost multiplier (Wkst. B, Part I)     1.764879     12.989282     11.547255     9.321660     0.000000     103.00       104.00     Cost to be allocated (per Wkst. B, Part II)     84,865     61,206     288,317     119,469     0 104.00       105.00     Unit cost multiplier (Wkst. B, Part II)     1.337278     0.947960     1.514405     0.625951     0.000000 105.00	102.00		112,001	030, 000	2, 170, 401	1, 117, 132	U	102.00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 1.337278 0.947960 1.514405 0.625951 0.000000 105.00		Unit cost multiplier (Wkst. B, Part I)	1		1			
105.00 Unit cost multiplier (Wkst. B, Part 1.337278 0.947960 1.514405 0.625951 0.000000 105.00	104.00		84, 865	61, 206	288, 317	119, 469	0	104. 00
	105.00		1. 337278	0. 947960	1. 514405	0. 625951	0. 000000	105. 00
		· · · · · · · · · · · · · · · · · · ·						

Health Financial Systems MORF	RISTOWN POST ACL	JTE REHAB & NUR	SIN	In Lieu of Form CM:	S-2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: Worksheet B	
				From 01/01/2022 To 12/31/2022 Date/Time P	roparod:
				5/10/2023 9	
			OTHER GENERAL		
			SERVI CE		
Cost Center Description	MEDI CAL	SOCI AL SERVI CE			
	RECORDS &	(	ACTI VI TI ES		
	LI BRARY	(CENSUS)	(CENSUS)		
	(CENSUS)	12.00	15 00	_	
GENERAL SERVICE COST CENTERS	12.00	13. 00	15. 00		
1. 00 O0100 CAP REL COSTS - BLDGS & FLXTURES		I	Ι		1.00
3. 00 00300 EMPLOYEE BENEFITS					3. 00
4. 00   00400   ADMI NI STRATI VE & GENERAL					4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS					5. 00
6.00 00600 LAUNDRY & LINEN SERVICE					6. 00
7. 00 00700 HOUSEKEEPI NG					7. 00
8. 00   00800   DI ETARY					8. 00
9.00 00900 NURSING ADMINISTRATION					9. 00
10.00 01000 CENTRAL SERVICE & SUPPLY					10. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	63, 461				12. 00
13. 00   01300   SOCI AL   SERVI CE	0				13. 00
15. 00 O1500 PATIENT ACTIVITIES	0	0	63, 46	1	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1	1	1	-1	
30. 00 03000 SKILLED NURSING FACILITY	63, 461	63, 461	1		30.00
31. 00   03100   NURSI NG   FACI LI TY	0		1	0	31.00
32. 00   03200   CF/IID	0		1		32.00
33. 00 03300 OTHER LONG TERM CARE	0	0	)  (	0	33. 00
ANCI LLARY SERVI CE COST CENTERS  40. 00 04000 RADI OLOGY	0		\	ol	40.00
41. 00   04100   KADI OLOGI 41. 00   04100   LABORATORY			1		41. 00
42. 00   04200   NTRAVENOUS THERAPY					42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY					43. 00
44. 00   04400   PHYSI CAL THERAPY					44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	o			45. 00
46. 00   04600   SPEECH PATHOLOGY	0	o			46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0		ol .	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	)	0	49. 00
50.00   05000   DENTAL CARE - TITLE XIX ONLY	0	0	)	0	50. 00
51. 00   05100   SUPPORT SURFACES	0		1	0	51. 00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	) <u> </u>	)  (	0	52. 00
OUTPATIENT SERVICE COST CENTERS	1			-I	
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	) C	)  (	0	63. 00
OTHER REI MBURSABLE COST CENTERS			\	٦	71 00
71. 00   07100   AMBULANCE 72. 00   07200   CORF	0	1	1	) )	71.00
72. 00   07200   CORF 73. 00   07300   CMHC		1	1		72. 00 73. 00
74. 00   07400   OTHER REI MBURSABLE COST			1		74.00
SPECIAL PURPOSE COST CENTERS		,	1	<u> </u>	74.00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES					80.00
81. 00 08100 INTEREST EXPENSE					81. 00
82.00 08200 UTILIZATION REVIEW					82. 00
83. 00 08300 HOSPI CE	0	0		ol .	83. 00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	)	o	84. 00
89.00 SUBTOTALS (sum of lines 1-84)	63, 461	63, 461	63, 46	1	89. 00
NONREI MBURSABLE COST CENTERS					
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	l .	1	0	90. 00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	1	0	91. 00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	92. 00
93. 00   09300   NONPALD   WORKERS	0			0	93. 00
94. 00 09400 PATIENTS LAUNDRY	0				94.00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS	0		'	9	95. 00
98.00   Cross Foot Adjustments 99.00   Negative Cost Centers					98. 00 99. 00
102.00   Cost to be allocated (per Wkst. B,	74, 279	184, 137	286, 662		102.00
Part I)	14,219	104, 137	200, 002		102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	1. 170467	2. 901577	4. 51713	7	103. 00
104.00 Cost to be allocated (per Wkst. B,	22, 861	1	1		104. 00
Part II)			1		
105.00 Unit cost multiplier (Wkst. B, Part	0. 360237	0. 366256	0. 150596	6	105. 00
11)		1	1		

Health Financial Systems	MORRISTOWN POST ACUTE R	EHAB & NURSIN	In Lie	u of Form CMS-2540-10
DATIO OF COCT TO CHARGE FOR	ANGLI LADV AND OUTDATIENT COCT CENTERS	D N- 215157	D! I	W

Peri od: From 01/01/2022 To 12/31/2022 RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Worksheet C Provider No.: 315157 Date/Time Prepared: 5/10/2023 9:29 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col . 18 col. 2 2. 00 3. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 10, 104 0.000000 40.00 04100 LABORATORY 104, 047 0 0.000000 41.00 41.00 42.00 04200 I NTRAVENOUS THERAPY 0 0.000000 42.00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 34, 623 0 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 872, 679 951, 676 0. 916992 44.00 04500 OCCUPATIONAL THERAPY 1, 021, 550 45.00 749, 713 0.733898 45.00 04600 SPEECH PATHOLOGY 592, 566 310, 981 46.00 0. 524804 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 1. 175526 49.00 49.00 436, 347 371, 193 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 0 0.000000 50.00 51.00 05100 SUPPORT SURFACES 0 0.000000 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 52.00 OUTPATIENT SERVICE COST CENTERS 0.000000 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 63.00 71. 00 07100 AMBULANCE 48, 827 0.000000 71.00 100.00 2, 936, 985 100.00

2, 567, 321

Total

	ISTOWN POST ACU				eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315157	Peri od:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/10/2023 9: 2	eparea: 29 am
		Title	XVIII (1)	Skilled Nursing		, diii
			( )	Facility		
		Health Care Pr	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Don't A (ool 1	Dont D (ool 1	
	to Charges	Part A	Part B	Part A (col. 1 x col. 2)	x col. 3)	
	(Fr. Wkst. C			X COI. 2)	X COI. 3)	
	Column 3)					
	1.00	2.00	3.00	4, 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	0.00		0.00	
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0. 000000	0		0 0	O	40.00
41. 00   04100   LABORATORY	0. 000000	0		0	0	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000	0		0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	43.00
44. 00 O4400 PHYSI CAL THERAPY	0. 916992	567, 324		0 520, 232	0	44. 00
45. 00   04500 OCCUPATI ONAL THERAPY	0. 733898	607, 469		0 445, 820	0	45. 00
46.00 04600 SPEECH PATHOLOGY	0. 524804	368, 427		0 193, 352	0	46. 00
47. 00   04700   ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	1 .0.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 175526	0		0 0	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00   05100   SUPPORT SURFACES	0. 000000	0		0 0	0	51. 00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52. 00
OUTPATIENT SERVICE COST CENTERS						
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			0		63.00
71. 00   07100   AMBULANCE (2)	0. 000000	l e		0	0	
100.00   Total (Sum of Lines 40 - 71)		1, 543, 220		0 1, 159, 404	0	100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	y.					

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

Heal th	Financial Systems MORR	ISTOWN POST ACU	ITE REHAB & NUR	RSIN	In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315157	Period: From 01/01/2022 To 12/31/2022	Worksheet D Parts II-III Date/Time Pre 5/10/2023 9:2	pared: 9 am
	Title XVIII Skilled Nursing Facility						
	Cost Center Description				•	1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	ost to charges	(From Workshee	t C, column 3	, line 49)	1. 175526	1.00
2.00	Program vaccine charges (From your reco			·	,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health		Cost (From	& Allied	
			(From Wkst. B,			Heal th Costs	
		18		Costs to Tota		for Pass	
			14)	Costs - Part (Col. 2 / Col		Through (Col. 3 x Col. 4)	
				1)	•	3 X COI. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	10, 104		0. 00000	00	0	40. 00
41.00	04100 LABORATORY	104, 047	C	0.00000		0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	C	0. 00000		0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	34, 623		0.00000		0	
44. 00	04400 PHYSI CAL THERAPY	872, 679		0.00000		0	
	04500 OCCUPATI ONAL THERAPY	749, 713	C	0.00000		0	
46. 00	04600 SPEECH PATHOLOGY	310, 981	C	0.00000		0	
	04700 ELECTROCARDI OLOGY	0		0.00000		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	436, 347		0.00000		0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	430, 347		0.00000		0	
51. 00	05100 SUPPORT SURFACES			0.0000		0	
	05200 OTHER ANCILLARY SERVICE COST CENTERS			0.00000		0	
100.00	l	2, 518, 494		1	1, 159, 404	· · · · · · · · · · · · · · · · · · ·	100.00
		•	•	•		•	

COMPUTATION OF INPATIENT ROUTINE COSTS Provider No.: 315157 Period: Worksheet					
			From 01/01/2022 To 12/31/2022	Parts I-II Date/Time Prep 5/10/2023 9:20	
		Title XVIII	Skilled Nursing Facility	PPS	7 alli
			1 40.11.17	1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	I NPATI ENT DAYS				1
1.00	Inpatient days including private room days			63, 461	1.00
2. 00	Private room days			0	2.00
3. 00	Inpatient days including private room days applicable to the	e Program		12, 143	3. 0
4. 00	Medically necessary private room days applicable to the Prog	gram		0	4.00
5. 00	Total general inpatient routine service cost			19, 473, 397	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
5. 00	General inpatient routine service charges			24, 609, 963	
7. 00	General inpatient routine service cost/charge ratio (Line 5	o divided by line 6)		0. 791281	
3.00	Enter private room charges from your records			0	
9. 00	Average private room per diem charge (Private room charges I 2)	ine 8 divided by private	room days, line	0. 00	
10. 00	Enter semi-private room charges from your records			0	
1. 00	Average semi-private room per diem charge (Semi-private room semi-private room days)	om charges line 10, divide	ed by	0. 00	11. 0
2. 00	· · · · · · · · · · · · · · · · · · ·				
3. 00	.00 Average per diem private room cost differential (Line 7 times line 12)				
4.00	00 Private room cost differential adjustment (Line 2 times line 13)				14.00
15. 00	General inpatient routine service cost net of private room of PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus line 14)	19, 473, 397	15. 0
16. 00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		306. 86	16.0
7. 00	Program routine service cost (Line 3 times line 16)	,		3, 726, 201	17.0
8.00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18. 0
9. 00	Total program general inpatient routine service cost (Line	17 plus line 18)		3, 726, 201	19. 0
20. 00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	3, 940, 540	20. 0
1.00	Per diem capital related costs (Line 20 divided by line 1)			62.09	21.0
2.00	Program capital related cost (Line 3 times line 21)			753, 959	22. 0
23. 00				2, 972, 242	
	Aggregate charges to beneficiaries for excess costs (From p			0	
	Total program routine service costs for comparison to the co	ost limitation (Line 23 mi	nus line 24)	2, 972, 242	
26. 00	, , ,				26. 0
	Inpatient routine service cost limitation (Line 3 times the				27. 00
28. 00	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E, Part II, line 4) (See instructions		line 2/)		28. 0
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be	•	itle XIX	J	1
				1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COS	STS FOR PPS PASS_THPOLICH		1. 00	
1. 00	Total SNF inpatient days	713 1 0K 113 1 A33-111K00011		63, 461	1.00
2. 00	Program inpatient days (see instructions)			12, 143	
3. 00	Total nursing & allied health costs. (see instructions)(Do r	not complete for titles V	or XIX)	0	
4. 00					
				0	5.00

Health Financial Systems	MORRISTOWN POST ACUTE RE	HAB & NURSIN	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTL	EMENT FOR TITLE XVIII	Provi der No.: 315157	From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Prepared: 5/10/2023 9:29 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
	DART A LINDATION OF DELINDING	EMENT		1. 00	
1. 00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSI Inpatient PPS amount (See Instructions)	EMENI	T	9, 108, 602	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	vmonts)		9, 100, 602	2. 00
3.00	Subtotal (Sum of lines 1 and 2)		9, 108, 602	3. 00	
4. 00	Primary payor amounts			9, 100, 002	4. 00
5.00	Coi nsurance			1, 212, 319	5. 00
6.00	Allowable bad debts (From your records)			365, 459	
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		201, 147	7. 00
8. 00	Adjusted reimbursable bad debts. (See instructions)	etions)		237, 548	
9. 00	Recovery of bad debts - for statistical records only			237, 340	
10. 00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			8, 133, 831	
12. 00	Interim payments (See instructions)			7, 964, 583	
13. 00	Tentative adjustment			7, 704, 509	13. 00
14. 00	OTHER adjustment (See instructions)			0	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			9, 865	
14. 75	Seguestration for non-claims based amounts (see instructions)			2, 993	
14. 99	Sequestration amount (see instructions)		97, 666		
15. 00	Balance due provider/program (see Instructions)			58, 724	
16. 00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2.	section 115.2)	0	
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER				
17.00	Ancillary services Part B			0	17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19.00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00
22.00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24.00	Allowable bad debts (From your records)			0	24.00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentati ve adj ustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	
29. 00	Balance due provider/program (see instructions)			0	
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2,	section 115.2	0	30. 00

Health Financial Systems MORRISTOW ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der No.: 315157 Peri od: Worksheet E-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/10/2023 9:29 am Title XVIII Skilled Nursing PPS

		11 (1	e AVIII	Facility	PPS	
		Inpatien	t Part A		rt B	
		mm /dd /\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Amount	mm /dd /> a a a /	Amount	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider	1.00	7, 964, 583	3.00	4.00	1.00
2.00	Interim payments payable on individual bills, either		7, 704, 303		0	2. 00
2.00	submitted or to be submitted to the contractor for		Ü			2.00
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					-
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER		0		0	
3. 03			0		0	
3. 04			0		Ö	
3. 05			0		0	
	Provider to Program		-		•	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	
3.53			0		0	
3.54			0		0	
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		0		0	3. 99
4. 00	- 3.98)		7 0/4 502		0	4. 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line		7, 964, 583		0	4.00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	
5.02			0		0	
5. 03	Provider to Program		0		0	5. 03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROGRAM		0		0	
5. 52			0		0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	
	- 5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		58, 724		0	
6. 02	PROVI DER TO PROGRAM		0 000 007		0	
7. 00	Total Medicare program liability (see instructions)		8, 023, 307	or Nama	Contractor	7. 00
			Contract	.or Name	Contractor Number	
			1.	00	2. 00	
8. 00	Name of Contractor				2.00	8. 00
	lines 2 5 and 6 where an amount is due provider to progr	om chow the e	mount and data	on which the	n may il dam	

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

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

Provi der No.: 315157

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared:

onl y)			10 12/31/202	5/10/2023 9: 2	
		General Fund	Specific Endowment Fun		
		1.00	Purpose Fund 2.00 3.00	4.00	
	Assets				
	CURRENT ASSETS				
1.00	Cash on hand and in banks	2, 477, 022	• I	0	
2. 00 3. 00	Temporary i nvestments Notes receivable	0	0	0 0 0	
4. 00	Accounts recei vable	4, 459, 885	1		
5. 00	Other recei vables	42, 123		ol ö	
6.00	Less: allowances for uncollectible notes and accounts	-193, 207	• I	0 0	
	recei vabl e				
7.00	Inventory	0	0	0	
8. 00 9. 00	Prepaid expenses	175, 335	· · · · · · · · · · · · · · · · · · ·	0 0 0	
10.00	Other current assets Due from other funds	59, 242			
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	7, 020, 400		ol ö	
	FIXED ASSETS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	-1	1
12.00	Land	0	0	0 0	
13. 00	Land improvements	0	0	0 0	
14.00	Less: Accumulated depreciation	0	-	0	
15. 00 16. 00	Buildings	0	0	0 0 0	
17. 00	Less Accumulated depreciation Leasehold improvements	2, 226, 885	-		
18. 00	Less: Accumulated Amortization	-346, 455		ol ö	
19. 00	Fi xed equipment	0	o	o o	
20.00	Less: Accumulated depreciation	0	О	0 0	20. 00
21. 00	Automobiles and trucks	0	О	0 0	1
22. 00	Less: Accumul ated depreciation	0	0	0	
23. 00	Major movable equipment	138, 233		0	
24. 00 25. 00	Less: Accumulated depreciation	-26, 807	0	0 0 0	
26. 00	Minor equipment - Depreciable Minor equipment nondepreciable	0	0		
27. 00	Other fixed assets	0	o o		
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	1, 991, 856	o	o o	
	OTHER ASSETS				
29. 00	Investments	0	-	0 0	
30.00	Deposits on Leases	0	0	0	
31. 00 32. 00	Due from owners/officers Other assets	-1, 137, 160 2, 003, 958	· · · · · · · · · · · · · · · · · · ·	0 0 0	
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	866, 798			
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	9, 879, 054		ol o	
	Liabilities and Fund Balances			1	
	CURRENT LIABILITIES			_	
35. 00	Accounts payable	5, 869, 190	• I	0	
36.00	Salaries, wages, and fees payable Payroll taxes payable	348, 428		0 0	
37. 00 38. 00	Notes & Loans payable (Short term)	8, 344	0		
39. 00	Deferred income	713, 100	o o		
40. 00	Accel erated payments	0		٦	40.00
41.00		0	О	0 0	41.00
42.00	Other current liabilities	35, 452	• I	0 0	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	6, 974, 514	0	0 0	43. 00
44.00	LONG TERM LIABILITIES		0	ol o	44 00
44. 00 45. 00	Mortgage payable Notes payable	0		0 0 0	
46. 00	Unsecured Loans	0	Ö		
47. 00	Loans from owners:	0	Ö	0 0	
48.00	Other long term liabilities	0	О	0 0	
49. 00	OTHER (SPECIFY)	0	О	0 0	
50. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS	6, 974, 514	0	0 0	51.00
52. 00	General fund balance	2, 904, 540			52.00
53. 00	Speci fi c purpose fund	2, 704, 340	0		53.00
54. 00	Donor created - endowment fund balance - restricted			o	54.00
55.00	Donor created - endowment fund balance - unrestricted			o	55.00
56. 00	Governing body created - endowment fund balance			o	56. 00
57. 00	Plant fund balance - invested in plant			0	
58. 00	Plant fund balance - reserve for plant improvement,			0	58. 00
59. 00	replacement, and expansion TOTAL FUND BALANCES (Sum of Lines 52 thru 58)	2, 904, 540	o	o	59.00
60. 00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	9, 879, 054	I		
	59)				

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					10 12/31/2022	5/10/2023 9:2	
		General	Fund	Speci al P	urpose Fund	Endowment Fund	Zili
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		3, 265, 228		(		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-218, 685				2. 00
3.00	Total (sum of line 1 and line 2)		3, 046, 543				3. 00
4.00	Additions (credit adjustments)						4. 00
5. 00	ROUNDI NG	0			0	0	5. 00
6.00		0			0	0	6. 00
7. 00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00	T	0			0	0	9.00
10.00	Total additions (sum of line 5 - 9)					)	10.00
11. 00	Subtotal (line 3 plus line 10)		3, 046, 543			)	11.00
12.00	Deductions (debit adjustments)						12.00
13.00	ROUNDING	3			0	0	13.00
14.00	DI VI DENDS	142, 000			0	0	14.00
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17. 00	T	U	4.40.000		0	0	17. 00
18.00	Total deductions (sum of lines 13 - 17)		142, 003				18.00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)		2, 904, 540			ή	19. 00
	Islieet (Line II - Iiile Io)	Endowment Fund	PI ant	Fund			
		Ziradimiorra i arra		1 4114			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments)						4. 00
5.00	ROUNDING		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 5 - 9)	0			0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments)						12.00
13.00	ROUNDI NG		0				13.00
14. 00	DI VI DENDS		0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 13 - 17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (Line 11 - line 18)						

Health Financial Systems	MORRISTOWN POST ACUTE RE	EHAB & NURSIN			In Lieu of	Form CMS-	-2540-10
OTATEMENT OF BATHERIT BEVENUES AS	ID ODEDATING EVERNOES		045453	n	101		

Health Financial Systems MORRISTOWN POST ACUTE REHAB & NURSI			RSIN	In Lie	eu of Form CMS-2	2540-10
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	_	Period: From 01/01/2022 To 12/31/2022		pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		24, 609, 96	3	24, 609, 963	1. 00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			o	0	3.00
4.00	OTHER LONG TERM CARE			o	0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		24, 609, 96	3	24, 609, 963	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		2, 936, 98	5 0	2, 936, 985	6. 00
7.00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	8. 00
9.00	AMBULANCE			0	0	9. 00
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11.00	CMHC			0	0	11. 00
11. 10	CORF			0	0	11. 10
12.00	HOSPI CE			o o	0	12. 00
13.00	ROUTINE CHARGES / BED HOLD		24	2 0	242	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer colum	n 3 to	27, 547, 19	o o	27, 547, 190	14. 00
	Worksheet G-3, Line 1)					
	Cost Center Description					
				1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				25, 149, 765	1. 00
2.00	Add (Specify)			0		2. 00
3.00				0		3. 00
4.00				0		4. 00
5.00				0		5. 00
6.00				0		6. 00
7.00				0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)				0	8. 00
9.00	Deduct (Specify)			0		9. 00
10.00				0		10.00
11.00				0		11. 00
12.00				0		12. 00
13.00				0		13. 00
14.00	Total Deductions (Sum of lines 9 - 13)				0	14. 00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 1	4)			25, 149, 765	15. 00

Health Financial Systems	MORRISTOWN POST ACUTE RE	EHAB	& NU	RSIN			In Lie	u of For	m CMS-254	0-10
OTATEMENT OF DATIENT DEVENUES AN	D ODEDATI NO EVERNOES	_			045453	<u> </u>				

Heal th	Health Financial Systems MORRISTOWN POST ACUTE REHAB & NURSIN In Lieu of Form CMS-2540-10						
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315157 Period:							
			From 01/01/2022				
			To 12/31/2022	Date/Time Prep 5/10/2023 9: 20			
				3/10/2023 4.2	7 alli		
				1. 00			
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1	4)		27, 547, 190	1. 00		
2.00	Less: contractual allowances and discounts on patients accounts			2, 638, 223	2. 00		
3.00	Net patient revenues (Line 1 minus line 2)			24, 908, 967	3. 00		
4.00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		25, 149, 765	4. 00		
5.00	Net income from service to patients (Line 3 minus 4)			-240, 798	5. 00		
	Other income:						
6.00	Contributions, donations, bequests, etc			0	6. 00		
7.00	Income from investments			6, 441	7. 00		
8.00	Revenues from communications (Telephone and Internet service)			0	8. 00		
9.00	Revenue from television and radio service			0	9. 00		
10.00	Purchase di scounts			0	10.00		
11. 00	Rebates and refunds of expenses			0	11.00		
12.00	Parking Lot receipts			0	12.00		
13.00	Revenue from Laundry and Linen service			0	13. 00		
14.00	Revenue from meals sold to employees and guests			0	14. 00		
	Revenue from rental of living quarters			0	15. 00		
16.00	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16. 00		
17. 00	Revenue from sale of drugs to other than patients			0	17. 00		
18.00	Revenue from sale of medical records and abstracts			1, 425	18. 00		
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00		
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00		
21.00	Rental of vending machines			0	21. 00		
22. 00	Rental of skilled nursing space			0	22. 00		
23. 00	Governmental appropriations			0	23. 00		
24.00	NON PATIENT REVENUE			10, 811	24. 00		
	BARBER BEAUTY			3, 436	24. 01		
24. 50	COVI D-19 PHE Fundi ng			0	24. 50		
25. 00	Total other income (Sum of lines 6 - 24)			22, 113	25. 00		
26. 00	Total (Line 5 plus line 25)			-218, 685	26. 00		
27. 00	Other expenses (specify)			0	27. 00		
28. 00				0	28. 00		
29. 00				0	29. 00		
	Total other expenses (Sum of Lines 27 - 29)			0	30. 00		
31.00	Net income (or loss) for the period (Line 26 minus line 30)			-218, 685	31.00		