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 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315246 Worksheet S Parts I, II & III Peri od: From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/21/2024 3: 24 pm PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: 5/21/2024 Time: 3:24 pm 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. (1) As Submitted use only 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 MC - WEST DEPTFORD OF PAULSBORO NJ (315246) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	77, 106	5, 513	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100. 00 TOTAL		0	77, 106	5, 513	0	100.00
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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 MC - WEST DEPTFORD OF PAULSBORO NJ In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315246 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/21/2024 3:24 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: Street: 550 JESSUP ROAD 1.00 PO Box: 1.00 2.00 City: WEST DEPTFORD State: NJ Zi p Code: 08066 2.00 3.00 County: GLOUCESTER CBSA Code: 15804 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 MC - WEST DEPTFORD OF 315246 01/01/1967 N Р Ν 4.00 PAULSBORO NJ 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) 01/01/2023 12/31/2023 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 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 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 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 16, 942 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 23.00 16, 942 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) Ν 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 N 29.00 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) 38.00 Are you legally-required to carry mal practice insurance? (Y/N) Ν 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 41.00 List malpractice premiums and paid losses:

0

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41.00

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Heal th	Financial Systems	MC - WEST DEPTFORD OF	PAULSBORO NJ	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSIN X INDENTIFICATION DATA	G FACILITY HEALTH CARE	Provi der No.: 315246	Peri od: From 01/01/2023	Worksheet S-2 Part I	2
COMPLE	A INDENTIFICATION DATA					
					Y/N	
					1.00	
	Are malpractice premiums and paid los center? Enter Y or N. If yes, check bamounts.				N	42. 00
43.00	Are there any home office costs as de	efined in CMS Pub. 15-1, Ch	apter 10?		N	43.00
	If line 43 is yes, enter the home off office on lines 45, 46 and 47.	ice chain number and enter	the name and address	of the home		44. 00
	1.00	2. 00		3. 00		
	If this facility is part of a chain obelow.	organization, enter the nam	ne and address of the h	ome office on the	lines	
45.00	Name:	Contractor's Name:	Contrac	tor's Number:		45. 00
46.00	Street:	PO Box:				46.00
47.00	Ci tv	State:	Zi p Code	۵٠		47.00

Seneral Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses, the format vil 1 be (mw/dd/yyyy) provider forganization and Gyeration 10 lias the provider changed cowership insendiately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2 (see Instructions) 10 lias the provider changed cowership insendiately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2 (see Instructions) 10 lia 10 lia		D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der	No.: 315246	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pro 5/21/2024 3::	epared
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Provider Organization and Operation Illist The provider changed ownership imediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2, (see N Instructions)		responses the format will be (mm/dd/yyyy)						
Sea the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2 (see)		Provider Organization and Operation						-
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Name			the date of the ch	ange in col	umn 2. (see			
Max the provider terminated participation in the Medicare Program? If column 1 is yee, enter in column 2 the date of termination and in column 3. "V" for voluntary or "I" for involuntary or "I" for "I f		instructions)			V/N	Date	V/I	
column 1 is yes, enter in column 2 the date of termination and in column 3, "" For voluntary or "" for involuntary." Is the provider involved in business transactions, including management of the provider involved in business transactions, including management or medical supply companies) that are related to the provider or its or medical supply companies) that are related to the provider or its of directors, with individuals or entitle (e.g., deal none offices, drug or medical supply companies) that are related to the provider or its of directors, through ownership, control, or family and other similar or relationships? (see instructions) and of directors, through ownership, control, or family and other similar or relationships? (see instructions) and office of the control								
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officers, medical staff, management personnel, or members of the board of directors through womership, control, or family and other similar relationships? (see instructions) Name								
of directors through ownership, control, or family and other similar relationships? (see instructions) Financial Data and Reports Column 1: Where the Financial statements prepared by a Certified Public Y C C Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no. see instructions. Are the cost report total expenses and total revenues different from N								
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Financial Data and Reports 1.00 2.00 3.00								
Elancial Data and Reports Do Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Subint complete copy or enter date available in column 3. (see Instructions) If no, see instructions. Are the cost report total expenses and total revenues different from N								+
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available in column 3. (see instructions) if no, see instructions on the filed financial statements? If column 1 is "Y", submit reconcilitation. Approved Educational Activities 1.00 2.00		Accountant? (Y/N) Column 2: If yes, enter "A'	' for Audited, "C"	for				"
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	000	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) see Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt 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 adjustments made to PS&R Report information? If yes, see instructions. If line 13 or 14 is "Y", then were	s? (Y/N) see instructions the cost reportions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instructions dinstructions dinstruction dinstructions dins	ns. ring this cos Y", see instru ", see instru Y/N 1.00 N	N N N St reporting Fuctions. actions. art A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	7 8 9 10 11 12 13 13 14 15
provi der's records? If "Y" see Instructions.	000 000 000 000 000 000 000 000 000	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) see Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt 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 adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?	s? (Y/N) see instructions the cost reportions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instructions dinstructions dinstruction dinstructions dins	ns. ring this cos Y", see instru ", see instru Y/N 1.00 N	N N N St reporting Fuctions. actions. art A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	7 8 9 100 111 122 133 134 144 155 166

Health Financ	cial Systems	MC - WEST DEPTFOR	D OF	PAULSBORO	NJ	In Li	eu of Form CMS-	2540-10
SKILLED NURS	ING FACILITY AND SKILLED NURSING FA	CILITY HEALTH CAR		Provi der	No.: 315246	Peri od:	Worksheet S-2)
COMPLEX REIMBURSEMENT QUESTIONNAIRE					From 01/01/2023 To 12/31/2023		narodi	
						10 12/31/2023	B Date/Time Pro 5/21/2024 3:2	24 pm
				1.	00	2	. 00	
Cost F	Report Preparer Contact Information							
	the first name, last name and the		CHRI	S		GUI LBAULT		19. 00
hel d l	by the cost report preparer in colum	mns 1, 2, and 3,						
respe	cti vel y.							
20.00 Enter	the employer/company name of the co	ost report	HEAL	TH CARE RE	SOURCES			20. 00
prepai	rer.							
	the telephone number and email addi		609-	987-1440		CHRI S. GUI LBAUI	_T@HCRNJ. NET	21. 00
repor	t preparer in columns 1 and 2, respe	ecti vel y.						

Describe the other adjustments:

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

18.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315246 Peri od: Worksheet S-2 From 01/01/2023 To 12/31/2023 Part II Date/Time Prepared: COMPLEX REIMBURSEMENT QUESTIONNAIRE 5/21/2024 3:24 pm Part B Date 4.00 PS&R Data 13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to 02/19/2024 13.00 prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R 14.00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 15.00 If line 13 or 14 is "Y", were adjustments 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were 17.00 adjustments made to PS&R data for Other?

		3. 00	
	Cost Report Preparer Contact Information		
19. 00	Enter the first name, last name and the title/position	PREPARER	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		20.00
	preparer.		
21. 00	Enter the telephone number and email address of the cost		21. 00
	report preparer in columns 1 and 2, respectively.		

Health Financial Systems MC - WEST DEPTFORD

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

Provi der No.: 315246

						5/21/2024 3: 24	
				I npa	atient Days/Vis	its	
	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 5. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	156 0 0	56, 940 0 0	0	7, 188	31, 106 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00	SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	0 156	0 56, 940	0	0 7, 188	0 31, 106	6. 00 7. 00 8. 00
0.00	Total (cam of times try)	Inpatient D			Di scharges	0.17.100	0.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	6. 00	7. 00	8.00	9. 00	10.00	
1. 00 2. 00 3. 00 4. 00 5. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	8, 166 0 0	46, 460 0 0	0	217	177 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00	SNF-Based CMHC HOSPICE	0	0	0	0	o	6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	8, 166	46, 460	Ö	217	177	8. 00
		Di scha	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	CVILLED NUDCLING FACILLETY	11.00	12. 00	13. 00	14. 00 33. 12	15. 00	1.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	430 0 0 0 0 0 430	824 0 0 0 0 0 824	0. 00 0. 00 0. 00 0. 00 0. 00	0. 00 33. 12	175. 74 0. 00 0. 00 0. 00 175. 74	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
		Average Length		Admi s	si ons		
	Component	of Stay Total 16.00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	56. 38 0. 00 0. 00 0. 00	0	275	177 0 0	382 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	56. 38	0	275	177	382	8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total 21.00	Employees on Payroll 22.00	Nonpai d Workers 23.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	834 0 0 0 0 0 834	123. 90 0. 00 0. 00 0. 00 0. 00 0. 00 123. 90	0. 00 0. 00 0. 00 0. 00 0. 00			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00

20.00 Physician Part A - WRC

21.00 Physician Part B - WRC

instructions)

Total Adjusted Wage Related cost (see

22.00

20.00

21.00

22.00

SNF WAGE INDEX INFORMATION Provi der No.: 315246 Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/21/2024 3: 24 pm Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Reported Wage (col. 3 col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 6, 897, 379 6, 897, 379 257, 934. 00 26. 74 1.00 Physician salaries-Part A 0.00 2.00 0 0 0 0.00 2.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 3.00 Home office personnel 0 0 0 0.00 4.00 0.00 4.00 Sum of lines 2 through 4 0 0.00 5.00 0 0.00 5.00 0 257, 934. 00 6, 897, 379 0 26.74 6.00 Revised wages (line 1 minus line 5) 6, 897, 379 6.00 7.00 Other Long Term Care 0.00 0.00 7.00 HOME HEALTH AGENCY COST 8.00 8.00 9.00 CMHC 0 0.00 0.009.00 0 10.00 HOSPI CE 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0.00 0.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 0 0.00 0.00 12.00 12.00 through 11) Total Adjusted Salaries (line 6 minus line 13.00 6, 897, 379 C 6, 897, 379 257, 934. 00 26.74 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 14.00 1, 223, 704 1, 223, 704 20, 516. 00 59. 65 14.00 15.00 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0.00 0.00 16.00 WAGE-RELATED COSTS 1, 115, 546 17.00 Wage-related costs core (See Part IV) 17.00 1, 115, 546 18.00 Wage-related costs other (See Part IV) 0 18.00 Ω Wage related costs (excluded units) 0 19.00 0

0

0

1, 115, 546

0

0

0

0

0

1, 115, 546

Other General Service

14.00 Total (sum lines 1 thru 13)

13.00

19. 03

25. 39 14. 00

13.00

Worksheet S-3 Part III Date/Time Prepared: SNF WAGE INDEX INFORMATION Provi der No.: 315246 Peri od: From 01/01/2023 To 12/31/2023 5/21/2024 3:24 pm Amount Reclass. of Adj usted Paid Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 ÷ Reported col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 5.00 1.00 2.00 3.00 4.00 PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0.00 0.00 1.00 2.00 Administrative & General 21.85 333, 537 0 333, 537 15, 263. 00 2.00 3.00 Plant Operation, Maintenance & Repairs 100, 546 0 100, 546 4, 224. 00 23.80 3.00 4.00 Laundry & Linen Service 127, 150 127, 150 8, 395. 00 15.15 4.00 5.00 Housekeepi ng 312, 830 0 312, 830 17, 908. 00 17.47 5.00 0 23, 846, 00 19.86 Di etary 473, 590 473, 590 6.00 6.00 24, 978. 00 Nursing Administration 1, 099, 783 1, 099, 783 44.03 7.00 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 0.00 Medical Records & Medical Records Library 10.00 0 0 O 0.00 10.00 Social Service 11.00 106, 910 106, 910 4, 125. 00 25.92 11.00 12.00 Nursing and Allied Health Ed. Act. 12.00

140, 137

2, 694, 483

0

0

140, 137

2, 694, 483

7, 364. 00

106, 103. 00

Health Financial Systems	MC - WEST DEPTFORD OF PAULS	BORO NJ	ONJ In Lieu		
SNF WAGE RELATED COSTS	Prov	vi der No.: 315246	Peri od:	Worksheet S-3	
			From 01/01/2023		

		From To	01/01/2023 12/31/2023	Part IV Date/Time Pre 5/21/2024 3:2	
				Amount	4 piii
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			10, 357	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
4. 00	Prior Year Pension Service Cost			0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6.00
7. 00	Employee Managed Care Program Administration Fees			0	7. 00
	HEALTH AND INSURANCE COST				
8. 00	Health Insurance (Purchased or Self Funded)			185, 574	8.00
9. 00	Prescription Drug Plan			0	9. 00
10.00	Dental, Hearing and Vision Plan			348	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)			0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)			0	12. 00
	Disability Insurance (If employee is owner or beneficiary)			0	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14.00
	Workers' Compensation Insurance			212, 709	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraor	dinary accrual required by	FASB 106.	0	16. 00
	Non cumulative portion)	, ,			
	TAXES				
17.00	FICA-Employers Portion Only			510, 041	17. 00
18.00	Medicare Taxes - Employers Portion Only			0	18. 00
19.00	Unemployment Insurance			182, 765	19.00
20.00	State or Federal Unemployment Taxes			13, 752	20.00
	OTHER				
21. 00	Executive Deferred Compensation			0	21. 00
22. 00	Day Care Cost and Allowances			0	22. 00
23. 00	Tuition Reimbursement			0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 - 23)			1, 115, 546	24. 00
				Amount	
				Reported	
				1. 00	
	Part B - Other than Core Related Cost				
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00

SNF REPORTING OF DIRECT CARE EXPENDITURES Provi der No.: 315246 Peri od: Worksheet S-3 From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/21/2024 3:24 pm 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) 313, 304 53, 105 366, 409 6. 301. 00 58. 15 1.00 Licensed Practical Nurses (LPNs) 1, 914, 573 324, 520 2, 239, 093 56, 264. 00 39.80 2.00 2.00 3.00 Certified Nursing Assistant/Nursing 1, 852, 124 313, 935 2, 166, 059 85, 316. 00 25.39 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 4, 080, 001 691, 560 4, 771, 561 147, 881. 00 32.27 4.00 5.00 2, 718. 00 38. 32 Physical Therapists 89,053 15, 094 104, 147 5 00 Physical Therapy Assistants 0.00 6.00 C 0.00 6.00 7.00 Physical Therapy Aides 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 8.00 30, 157 967.00 31.19 8.00 25 786 4, 371 0.00 9.00 0 C 0.00 9.00 10.00 Occupational Therapy Aides 0.00 0.00 10.00 11.00 Speech Therapists 8,056 1, 365 9, 421 265.00 35.55 11.00 12.00 Respiratory Therapists 0.00 12 00 0 00 C 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 14 00 Registered Nurses (RNs) 380.00 68 92 14 00 26, 189 26, 189 15.00 Licensed Practical Nurses (LPNs) 499, 230 499, 230 7, 715. 00 64.71 15.00 Certified Nursing Assistant/Nursing 73, 691 73, 691 2, 279. 00 32.33 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 599, 110 599, 110 10, 374. 00 57.75 17.00 18.00 Physical Therapists 207, 736 207, 736 3, 406. 00 60.99 18.00 19.00 Physical Therapy Assistants 0.00 0.00 19.00 0 Physical Therapy Aides 20.00 0.00 0.00 20.00 Occupational Therapists 21.00 344, 825 5, 103. 00 67.57 21.00 344, 825 Occupational Therapy Assistants 22.00 0 0.00 0.00 22.00 Occupational Therapy Aides 0.00 0.00 23.00

68, 898

3, 135

68, 898

3, 135

1, 595. 00

38.00

0.00

43. 20

82.50

24.00

25.00

0.00 26.00

23. 00 24. 00

25.00

Speech Therapists

26.00 Other Medical Staff

Respiratory Therapists

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provi der No.: 315246 Peri od: Worksheet S-7 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 3: 24 pm 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 HC2 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38, 00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB₂ 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52 00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 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 PA₂

Health Financial Systems	MC - WEST DEPTFORD OF	PAULSB0R0	NJ	In Lie	u of Form CM	S-2540-10	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der		Peri od:	Worksheet S	5-7	
				From 01/01/2023 To 12/31/2023			
				Group	Days		
				1. 00	2. 00		
76. 00				PA1		76. 00	
99. 00				AAA		99. 00	
100. 00 TOTAL						100. 00	
			Expenses	Percentage	Y/N		
			1.00	2. 00	3.00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part	I, line 1, column 3)					101. 00 102. 00 103. 00 104. 00 105. 00 106. 00	

Heal th	Financial Systems MC -	WEST DEPTFORD	OF PAULSBORO I	NJ	In Lie	u of Form CMS-2	2540-10
	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315246 F	Peri od:	Worksheet A	
					rom 01/01/2023	5	
					o 12/31/2023	Date/Time Pre 5/21/2024 3: 2	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	4 piii
	oust defiter beschiptron	our ur res	Other	+ col . 2)	ons	Trial Balance	
					Increase/Decre		
					ase (Fr Wkst	col . 4)	
					A-6)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	_	2, 940, 288			2, 940, 288	1. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 169, 214	1, 169, 214			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	333, 537	2, 330, 532	2, 664, 069		2, 664, 069	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	100, 546	469, 190	569, 736		569, 736	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	127, 150	25, 556	152, 706		152, 706	6. 00
7.00	00700 HOUSEKEEPI NG	312, 830	30, 632	343, 462		343, 462	7. 00
8.00	00800 DI ETARY	473, 590	379, 203	852, 793		852, 793	8. 00
9.00	00900 NURSING ADMINISTRATION	1, 099, 783	104, 251	1, 204, 034		., == ., == .	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	203, 682	203, 682		203, 682	10.00
13.00	01300 SOCIAL SERVICE	106, 910	2, 024	108, 934		108, 934	•
15. 00	01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	140, 137	22, 674	162, 811	0	162, 811	15. 00
30. 00	03000 SKILLED NURSING FACILITY	4, 080, 001	636, 256	4, 716, 257	0	4, 716, 257	30.00
31. 00	03100 NURSING FACILITY	4,000,001	030, 230	4,710,237			31.00
32. 00	03200 CF/11D		0		-	_	32.00
33. 00	03300 OTHER LONG TERM CARE		0		-		33. 00
33. 00	ANCILLARY SERVICE COST CENTERS	<u> </u>	J		,		33.00
40. 00	04000 RADI OLOGY	ol	30, 956	30, 956	0	30, 956	40. 00
41. 00	04100 LABORATORY	o	37, 329	37, 329			•
42. 00	04200 I NTRAVENOUS THERAPY	l ol	0	(o		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	o	10, 602	10, 602	0	10, 602	1
44.00	04400 PHYSI CAL THERAPY	89, 053	262, 439	351, 492	0	351, 492	44.00
45.00	04500 OCCUPATI ONAL THERAPY	25, 786	345, 074	370, 860	0	370, 860	45. 00
46.00	04600 SPEECH PATHOLOGY	8, 056	81, 990	90, 046	0	90, 046	46. 00
47.00	04700 ELECTROCARDI OLOGY	O	0	(0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29, 310	29, 310	0	29, 310	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	341, 964	341, 964	0	341, 964	49. 00
51. 00	05100 SUPPORT SURFACES	0	0	(0	0	51. 00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	61, 454	61, 454			1
73. 00	07300 CMHC	0	0	(0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS		0				00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	(_	0	80.00
81.00	08100 NTEREST EXPENSE		0	(0	0	81.00
82. 00	08200 UTILIZATION REVIEW - SNF	0	0		0	0	82. 00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	6, 897, 379	9, 514, 620	1, 411 000	0	17 411 000	83. 00 89. 00
89.00	NONREI MBURSABLE COST CENTERS	0,897,379	9, 514, 620	16, 411, 999	, 0	16, 411, 999	89.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0) 0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		2, 245	2, 245	_	2, 245	
91.00	09200 PHYSI CLANS PRI VATE OFFI CES		Z, Z43	2, 243			91.00
93. 00	09300 NONPAID WORKERS		0			0	93.00
94. 00	09400 PATIENTS LAUNDRY		0			0	94.00
100.00		6, 897, 379	9, 516, 865	16, 414, 244		_	
. 50. 00	1	-, 3,,,, 3,,,	., 5.5, 500		١		,

46.00

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100.00

In Lieu of Form CMS-2540-10 Health Financial Systems MC - WEST DEPTFORD OF PAULSBORO NJ RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provider No.: 315246 Peri od: Worksheet A From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 3:24 pm Cost Center Description Adjustments to Net Expenses Expenses (Fr For Allocation (col. 5 +-col. 6) Wkst A-8) 6.00 7.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 2, 929, 926 1.00 -10, 362 1.00 1, 169, 214 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL -548, 299 4.00 2, 115, 770 4 00 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 569, 736 5.00 00600 LAUNDRY & LINEN SERVICE 0 6.00 152, 706 6.00 00700 HOUSEKEEPI NG 0 7.00 343, 462 7.00 00800 DI ETARY 8.00 -96 852, 697 8.00 9.00 00900 NURSING ADMINISTRATION 0 1, 204, 034 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 0 203, 682 10.00 0 01300 SOCIAL SERVICE 13.00 108, 934 13.00 01500 PATIENT ACTIVITIES 15.00 162, 811 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 30.00 4, 716, 257 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 30, 956 40.00 41.00 04100 LABORATORY 0 37, 329 41.00 42. 00 04200 I NTRAVENOUS THERAPY 000000 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 10, 602 43 00 44.00 04400 PHYSI CAL THERAPY 351, 492 44.00 04500 OCCUPATIONAL THERAPY 45.00 370, 860 45.00

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2, 245

15, 853, 242

15, 855, 487

341, 964

46 00

47.00

49.00

51.00

71.00

73.00

80.00

81.00

82.00

83.00

89.00

90.00

91.00

92.00

100.00

04600 SPEECH PATHOLOGY

04700 ELECTROCARDI OLOGY

05100 SUPPORT SURFACES

08100 INTEREST EXPENSE

07100 AMBULANCE

|08300| H0SPI CE

93.00 09300 NONPALD WORKERS

94. 00 09400 PATIENTS LAUNDRY

TOTAL

07300 CMHC

48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS

08000 MALPRACTICE PREMIUMS & PAID LOSSES

SUBTOTALS (sum of lines 1-84)

09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN

04900 DRUGS CHARGED TO PATIENTS

OTHER REIMBURSABLE COST CENTERS

SPECIAL PURPOSE COST CENTERS

08200 UTILIZATION REVIEW - SNF

NONREI MBURSABLE COST CENTERS

09100 BARBER AND BEAUTY SHOP

09200 PHYSICIANS PRIVATE OFFICES

Health Financial Sys	stems MC -	WEST DEPTFORD C	F PAULSBORO	NJ	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS			Provi der	No.: 315246	Peri od:	Worksheet A-6	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 3:2	
				Increases			
		Cost Cei	nter	Li ne #	Sal ary	Non Salary	
		2.00)	3.00	4. 00	5. 00	
TOTALS							
100.00		Total Reclassifi	cations (Sum		0	0	100.00
		of columns 4 and 5 must					
		equal sum of col	umns 8 and				
		9)					

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

Health Financial Systems MC	- WEST	DEPTFORD OF	PAULSB0R0	NJ	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS			Provi der	No.: 315246	Peri od:	Worksheet A-6	,
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre	
						5/21/2024 3: 2	4 pm
				Decreases			
		Cost Cente	er	Li ne #	Sal ary	Non Salary	
		6. 00		7. 00	8. 00	9. 00	
TOTALS							
100. 00					0	0	100. 00

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

Health Financial Systems MC - WEST DEPTFORD OF PAULSBORO NJ In Lieu of Form CMS-2540-10 RECONCILIATION OF CAPITAL COSTS CENTERS Provi der No.: 315246 Peri od: Worksheet A-7 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/21/2024 3:24 pm Acqui si ti ons Description Begi nni ng Purchases Donati on Total Di sposal s and Bal ances 1.00 Retirements 5.00 2.00 3.00 4. 00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 0 0 0 0 0 0 2. 00 2.00 Land Improvements 0 0 0 0 0 Buildings and Fixtures Building Improvements 3.00 3. 00 0 4.00 4.00 61, 503 61, 503 0 5.00 Fi xed Equipment 0 5.00 6. 00 7. 00 Movable Equipment Subtotal (sum of lines 1-6) 102, 778 0 0 0 0 102, 778 6.00 164, 281 0 7.00 164, 281 Reconciling Items 8.00 0 8.00 Total (line 7 minus line 8)

Description 9.00 164, 281 0 164, 281 0 9.00 Endi ng Bal ance Ful I y Depreci ated

		6.00	7.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
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	61, 503	0	4. 00
5.00	Fi xed Equipment	0	0	5. 00
6.00	Movable Equipment	102, 778	0	6. 00
7.00	Subtotal (sum of lines 1-6)	164, 281	0	7. 00
8.00	Reconciling Items	0	0	8. 00
9.00	Total (line 7 minus line 8)	164, 281	0	9. 00

Assets

ADJUSTMENTS TO EXPENSES

Provi der No.: 315246

Peri od: From 01/01/2023 To 12/31/2023

Worksheet A-8
Date/Time Prepared:

5/21/2024 3:24 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Description (1) (2) Basis For Amount Cost Center Li ne No. Adjustment 2.00 3.00 4.00 1.00 -2, 856 ADMI NI STRATI VE & GENERAL 1 00 1 00 Investment income on restricted funds 4 00 В (chapter 2) 2.00 Trade, quantity, and time discounts (chapter 0.00 2.00 3.00 Refunds and rebates of expenses (chapter 8) 0.00 3.00 Rental of provider space by suppliers 0 0 00 4 00 4 00 (chapter 8) 5.00 Telephone services (pay stations excluded) Ω 0 00 5.00 (chapter 21) Television and radio service (chapter 21) 6.00 0.00 6.00 Parking Lot (chapter 21) 0.00 7.00 7.00 Remuneration applicable to provider-based 8.00 A-8-2 8.00 physician adjustment 9.00 Home office cost (chapter 21) 0.00 9.00 10.00 Sale of scrap, waste, etc. (chapter 23) 0.00 10.00 Nonallowable costs related to certain 0.00 11.00 11.00 Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with A-8-1 -222, 806 12.00 related organizations (chapter 10) 13.00 Laundry and linen service 0.00 13.00 14 00 Revenue - Employee meals 0.00 14 00 Cost of meals - Guests 15.00 В -96DI ETARY 8.00 15.00 16.00 Sale of medical supplies to other than 0.00 16.00 pati ents 17 00 Sale of drugs to other than patients 0.00 17.00 4.00 Sale of medical records and abstracts -177 ADMINISTRATIVE & GENERAL 18.00 18.00 В 19.00 Vending machines 0.00 19.00 Income from imposition of interest, finance 20.00 20.00 0.00 or penalty charges (chapter 21) Interest expense on Medicare overpayments 0.00 21.00 21 00 and borrowings to repay Medicare overpayments 22.00 Utilization review--physicians' compensation OUTILIZATION REVIEW - SNF 82.00 22.00 (chapter 21) 23.00 Depreciation--buildings and fixtures OCAP REL COSTS - BLDGS & 1.00 23.00 FIXTURES 0 *** Cost Center Deleted *** Depreciation--movable equipment 24.00 2 00 24.00 -10, 362 CAP REL COSTS - BLDGS & 25.00 GAIN LOSS ON DISPOSALS OF ASSETS 1.00 25.00 FI XTURES 25. 01 -231, 000 ADMI NI STRATI VE & GENERAL 4.00 25.01 Α -1, 509 ADMINISTRATIVE & GENERAL SUPPLIES NON MED APPAREL PERSONAL CA 4.00 25. 02 Α 25.02 -39, 733 ADMI NI STRATI VE & GENERAL 25.03 MARKETI NG Α 4.00 25.03 25. 04 NON DEDUCTIBLE ASSOC DUES Α -115 ADMINISTRATIVE & GENERAL 4.00 25.04 25. 05 CUSTOMER REIMBURSEMENT -17 ADMINISTRATIVE & GENERAL 4.00 25.05 Α 25. 06 FINES & PENALTIES -499 ADMINISTRATIVE & GENERAL 4.00 25.06 Α 25. 07 | CORPORATE SERVICES FEE -49, 587 ADMINISTRATIVE & GENERAL 4.00 25.07 100.00 Total (sum of lines 1 through 99) (Transfer -558, 757 100.00 to Worksheet A, col. 6, line 100)

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

MC - WEST DEPTFORD OF PAULSBORO NJ

Health Financial Systems MC - WEST DEPTFORD OF STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315246 OFFICE COSTS

OFFICE COSTS				o 12/31/2023		
	Li ne No.	Cost	Center	Expense		, p
	1. 00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR	
CLAIMED HOME OFFICE COSTS:						
1. 00		ADMI NI STRATI VE	& GENERAL	MANAGEMENT		1.00
2.00	0. 00					2. 00
3.00	0. 00					3.00
4.00	0. 00					4. 00
5. 00	0. 00	l .				5. 00
6.00	0. 00	l .				6. 00
7. 00	0. 00	l .				7. 00
8.00	0. 00					8. 00
9. 00	0. 00					9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column						10. 00
6, line 100 to Worksheet A-8, column 3, line						
12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minus			
	Cost	Wkst. A, col.	col. 5)			
		5		-		
DART I COOTO INCURRED AND AD MOTHER DECIME	4.00	5.00	6.00	D 0004111 7471 0110		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR	
CLAIMED HOME OFFICE COSTS:	550.074	700.070				1.00
1.00	558, 064	780, 870	-222, 806			1.00
2.00	0	0				2. 00
3.00	0	0	0			3.00
4.00	0	0				4. 00
5. 00	0	0	0			5. 00
6.00	0	0	0			6. 00
7.00	0	0	0)		7. 00
8.00	0	0	0]		8. 00
9.00	0	0	0	'		9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column	558, 064	780, 870	-222, 806	1		10. 00
6, line 100 to Worksheet A-8, column 3, line						
12.			1	1		1

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315246 Peri od: Worksheet A-8-1 From 01/01/2023 Parts I-II Date/Time Prepared: OFFICE COSTS 12/31/2023 5/21/2024 3:24 pm

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00 PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

1.00	В	ATLAS MANAGEMENT	0.00	1.00
2. 00			0.00	2. 00
3. 00			0.00	3. 00
4. 00			0.00	4. 00
5. 00			0.00	5. 00
6. 00			0.00	6. 00
7. 00			0.00	7. 00
8. 00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100. 00
speci fy:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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	Rel ated Organization(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	•	ATLAS HEALTHCARE LLC	100.00	MANAGEMENT	1.00
2.00			0.00		2.00
3.00			0.00		3. 00
4.00			0.00		4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial)		0.00		100.00
	speci fy:				

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

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315246 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 3: 24 pm CAPI TAL RELATED COSTS ADMI NI STRATI VE Cost Center Description Net Expenses **EMPLOYEE** Subtotal BLDGS & **FIXTURES** for Cost BENEFITS & GENERAL Allocation (from Wkst A col. 7) 1.00 3.00 ЗА 4.00 GENERAL SERVICE COST CENTERS 2, 929, 926 1 00 00100 CAP REL COSTS - BLDGS & FIXTURES 2, 929, 926 1 00 3.00 00300 EMPLOYEE BENEFITS 1, 169, 214 108, 276 1, 277, 490 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 2, 115, 770 61,776 2, 177, 546 2, 177, 546 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 115, 049 5 00 569, 736 134 304 18, 623 722, 663 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 152, 706 58, 897 23, 550 235, 153 37, 437 6.00 7.00 00700 HOUSEKEEPI NG 343, 462 19, 112 57, 940 420, 514 66, 946 7.00 8.00 00800 DI ETARY 852, 697 319, 177 87, 715 1, 259, 589 200, 528 8.00 00900 NURSING ADMINISTRATION 9 00 1, 204, 034 203, 695 1. 432. 418 228.042 9 00 24, 689 10.00 01000 CENTRAL SERVICES & SUPPLY 203, 682 123, 075 326, 757 52,020 10.00 01300 SOCIAL SERVICE 108, 934 8, 998 19, 801 137, 733 13.00 21, 927 13.00 01500 PATIENT ACTIVITIES 246, 399 39, 227 15.00 162.811 57,633 25, 955 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 4, 716, 257 1, 895, 801 755, 673 7, 367, 731 1, 172, 953 30.00 03100 NURSING FACILITY 31.00 31.00 03200 | CF/IID 0 32.00 0 0 0 32.00 0 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 30, 956 30, 956 4, 928 40.00 41.00 04100 LABORATORY 37, 329 0 0 37, 329 5, 943 41.00 04200 I NTRAVENOUS THERAPY 42.00 Ω O Λ 42.00 04300 OXYGEN (INHALATION) THERAPY 10,602 10,602 1,688 43.00 43.00 0 04400 PHYSI CAL THERAPY 44.00 351, 492 90, 726 16, 494 458, 712 73, 027 44.00 66, 988 45.00 04500 OCCUPATIONAL THERAPY 370.860 45, 140 4,776 420, 776 45.00 46.00 04600 SPEECH PATHOLOGY 90,046 9, 742 1, 492 101, 280 16, 124 46.00 04700 ELECTROCARDI OLOGY 47.00 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 29, 310 14, 129 0 43, 439 6, 916 48.00 04900 DRUGS CHARGED TO PATIENTS 49 00 341, 964 0 341, 964 54, 441 49.00 05100 SUPPORT SURFACES 51.00 0 0 51.00 OTHER REIMBURSABLE COST CENTERS 07100 AMBULANCE 71.00 9, 784 71.00 61, 454 0 0 61, 454 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 83.00 2, 173, 968 89 00 SUBTOTALS (sum of lines 1-84) 15.853.242 2, 909, 699 1, 277, 490 15, 833, 015 89 00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 2, 245 20, 227 22, 472 3, 578 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92 00 92 00 0 0 0 93.00 09300 NONPALD WORKERS 0 C 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 0 0 98.00 Cross Foot Adjustments 0 0 0 0 98.00 0 99 00 Negative Cost Centers 0 0 0 99 00 100.00 TOTAL 15, 855, 487 2, 929, 926 1, 277, 490 15, 855, 487 2, 177, 546 100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315246

				10	12/31/2023	5/21/2024 3:2	
	Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	4 ріп
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	837, 712	,				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	18, 360	l control of the cont				6.00
7. 00	00700 HOUSEKEEPING	5, 958		493, 418			7.00
8. 00	00800 DI ETARY	99, 495	l control of the cont	60, 355	1 410 047		8.00
9. 00			l control of the cont		1, 619, 967	1 (72 025	9.00
	00900 NURSI NG ADMI NI STRATI ON	7, 696	I .	4, 669	0	1, 672, 825	10.00
10.00	01000 CENTRAL SERVICES & SUPPLY	38, 365	l l	23, 273	0	0	
13. 00	01300 SOCIAL SERVICE	2, 805	l control of the cont	1, 702	0	0	13.00
15. 00	01500 PATIENT ACTIVITIES	17, 966	0	10, 898	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	500.070	000 050	250 400	4 (40 0(7	4 (70 005	00.00
30.00	03000 SKILLED NURSING FACILITY	590, 968	1	358, 490	1, 619, 967	1, 672, 825	30.00
31.00	03100 NURSING FACILITY	0	1	0	0	1	31.00
32. 00	03200 CF/ D	0	1		0		32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40.00	ANCILLARY SERVICE COST CENTERS						40.00
40.00	04000 RADI OLOGY	0	1	0	0	1	40.00
41. 00	04100 LABORATORY	0	7	0	0	1	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	1	0	0	1	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	1	17.45	Ü	0	43.00
44.00	04400 PHYSI CAL THERAPY	28, 282	1	17, 156	Ü	0	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	14, 071	1	8, 536	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	3, 037	1	1, 842	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	1	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 404	1	2, 672	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	1	0	0		49. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
	OTHER REIMBURSABLE COST CENTERS	_				1 -	
71. 00	07100 AMBULANCE	0			0		71.00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS		1	Г		Г	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 - SNF						82.00
83.00	08300 HOSPI CE	004 407	0	400 500	4 (40 0(7	0	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	831, 407	290, 950	489, 593	1, 619, 967	1, 672, 825	89. 00
00.00	NONREI MBURSABLE COST CENTERS					1 0	00 00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	1	-	0	1	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	6, 305		3, 825	0	0	91.00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES		0	0	0	0	92.00
93.00	09300 NONPALD WORKERS		0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY		0	0	0	0	94. 00
98. 00	Cross Foot Adjustments		0	0	0	0	98. 00
99. 00	Negative Cost Centers	027 740	0	102 110	1 (10 0)	0	99.00
100.00	D TOTAL	837, 712	290, 950	493, 418	1, 619, 967	1, 672, 825	1100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315246

					10	12/31/2023	5/21/2024 3:2	
	,			<u> </u>	OTHER GENERAL		0,21,2021 012	, jo
					SERVI CE			
	Cost Ce	enter Description	CENTRAL	SOCIAL SERVICE		Subtotal	Post Stepdown	
			SERVICES & SUPPLY		ACTI VI TI ES		Adjustments	
			10. 00	13.00	15. 00	16. 00	17. 00	
	GENERAL SERV	ICE COST CENTERS	10.00	10.00	10.00	10.00	17.00	
1.00	00100 CAP REL	_ COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYE	EE BENEFITS						3. 00
4.00	00400 ADMI NI S	STRATIVE & GENERAL						4. 00
5.00	00500 PLANT (OPERATION, MAINT. & REPAIRS						5. 00
6.00		/ & LINEN SERVICE						6. 00
7.00	00700 HOUSEKE							7. 00
8.00	00800 DI ETARY							8. 00
9.00		G ADMINISTRATION						9. 00
10.00		_ SERVICES & SUPPLY	440, 415	l .				10. 00
13. 00	01300 SOCI AL		0		1 1			13. 00
15. 00	01500 PATI ENT		0	0	314, 490			15. 00
		UTINE SERVICE COST CENTERS					_	
30. 00	1	NURSING FACILITY	385, 012			13, 937, 553	0	30. 00
31. 00	03100 NURSI NO		0			0	0	31. 00
32. 00	03200 CF/I E		0		1	0	0	
33. 00		_ONG_TERM_CARE	0	0	0	0	0	33. 00
40.00		RVI CE COST CENTERS				25.004		40.00
40.00	04000 RADI 0L0		0			35, 884	0	
41.00	04100 LABORAT		0	0	- 1	43, 272 0	0	41.00
42. 00 43. 00	04200 NTRAVE			0		O	0	42. 00 43. 00
44. 00	04400 PHYSI CA	(INHALATION) THERAPY			1	12, 290 577, 177	0	44.00
45. 00		TIONAL THERAPY			1 9	510, 371		45.00
46. 00	04600 SPEECH				1	122, 283	0	46.00
47. 00	04700 ELECTRO				0	122, 203	0	47. 00
48. 00	1 1	_ SUPPLIES CHARGED TO PATIENTS	55, 403			112, 834	0	48.00
49. 00		CHARGED TO PATIENTS	35, 403			396, 405	Ö	49. 00
51. 00	05100 SUPPORT			l o	- 1	070, 100	Ö	51.00
011.00		RSABLE COST CENTERS			<u> </u>			0 00
71.00	07100 AMBULAN		0	C	0	71, 238	0	71. 00
73.00	07300 CMHC		0	o c	0	0	0	73. 00
	SPECIAL PURPO	OSE COST CENTERS						
80.00		CTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 NTERES							81. 00
82. 00	08200 UTI LI ZA	ATION REVIEW - SNF						82. 00
83.00	08300 HOSPI CE		0	0	0	0	0	83. 00
89. 00		ALS (sum of lines 1-84)	440, 415	164, 167	314, 490	15, 819, 307	0	89. 00
		BLE COST CENTERS	_					
90.00	1	FLOWER, COFFEE SHOPS & CANTEEN	0	_		0	0	90. 00
91. 00	1 1	AND BEAUTY SHOP	0	0		36, 180	0	91. 00
92.00		ANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALE		0	0	0	0	0	93.00
94. 00	09400 PATI ENT				0	0	0	94.00
98. 00	1 1	Foot Adjustments				0	0	98. 00
99.00	1 0	ve Cost Centers	440 415	1/4 1/7	214 400	15, 855, 487	0	99. 00 100. 00
100.00	I TOTAL		440, 415	164, 167	314, 490	10, 800, 487	ı 0	1100.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Provi der No.: 315246

Cost Center Description				To 12/31/2023 Date/Time Pro 5/21/2024 3:3	
SEMERAL SERVICE COST CENTERS		Cost Center Description	Total	0,21,2021 011	
CENERAL SERVICE COST CENTERS 1.00		, and the second			
1. 00		GENERAL SERVICE COST CENTERS	<u>'</u>		
3. 00	1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 6.00 00500 LAUNDRY & LINEN SERVICE 8.00 0.00 00700 HOUSEKEEPING 8.00 0.00 00900 LAUNDRY & SERVICE 8.00 0.00 00900 LAUNDRY & SERVICE 8.00 0.00 00900 DIETARY 10.00 0.00 0.00 00900 DIETARY 10.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0		00300 EMPLOYEE BENEFITS			3.00
6.00 00600 LAUNDRY & LINEN SERVICE 6.00 7.00 8.00 00800 DIETARY 8.00 8.00 00800 DIETARY 9.00 00900 NURSING ADMINISTRATION 9.00 00900 NURSING ADMINISTRATION 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 11.00 10.00 10.00 01000 CENTRAL SERVICES & SUPPLY 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00	4.00	00400 ADMINISTRATIVE & GENERAL			4. 00
7. 00 00700 HOUSEKEEPI NG 8. 00 9. 00 00900 NIFRSI NG ADMIN ISTRATION 9. 00 00900 NIFRSI NG ADMIN ISTRATION 9. 00 01. 00 01000 01000 01000 01000 01000 01000 01000 01000 01000 01000 01000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 0110000 011000 0110000 0110000 0110000 011000 0110000 0110000 0110	5.00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
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90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 91. 00 92. 00 9200 PHYSI CI ANS PRI VATE OFFICES 0 92. 00 9300 9300 9300 94. 00 94. 00 94. 00 94. 00 98. 00 99. 00 Negative Cost Centers 0 99. 00 99. 00 99. 00 Negative Cost Centers 0 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99.			12/21/7221		
91. 00 09100 BARBER AND BEAUTY SHOP 36, 180 91. 00 92. 00 93. 00 93. 00 94. 00 94. 00 98. 00 98. 00 99. 00 Negative Cost Centers 0 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99.	90.00		0		90.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 92. 00 93. 00 94. 00 94. 00 94. 00 98. 00 98. 00 99. 00 Nonpai D Workers 0 94. 00 98. 00 99. 00 Negative Cost Centers 0 99. 00 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400 09400			1		
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94. 00 94. 00 98. 00 98. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00	93.00	09300 NONPALD WORKERS	0		93.00
99.00 Negative Cost Centers 0 99.00	94.00		0		94.00
	98.00	Cross Foot Adjustments	0		98. 00
100. 00 TOTAL 15, 855, 487 100. 00	99. 00	Negative Cost Centers	0		99. 00
	100.00	TOTAL	15, 855, 487		100.00

Provider No.: 315246

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS

From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/21/2024 3: 24 pm CAPI TAL RELATED COSTS Directly ADMI NI STRATI VE Cost Center Description BLDGS & Subtotal **EMPLOYEE** Assigned New **FIXTURES** BENEFITS & GENERAL Capi tal Related Costs 0 1.00 2A 3.00 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 00300 EMPLOYEE BENEFITS 3.00 108, 276 108, 276 108, 276 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 0 5, 236 5, 236 4.00 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 0 0 0 134, 304 134, 304 1,578 277 5.00 00600 LAUNDRY & LINEN SERVICE 58. 897 1, 996 90 6.00 58, 897 6 00 7.00 00700 HOUSEKEEPI NG 19, 112 19, 112 4, 911 161 7.00 8.00 00800 DI ETARY 319, 177 319, 177 7, 434 482 8.00 00900 NURSING ADMINISTRATION 0 0 24, 689 24, 689 549 9.00 9 00 17, 264 01000 CENTRAL SERVICES & SUPPLY 10.00 123, 075 123, 075 125 10.00 13.00 01300 SOCIAL SERVICE 8, 998 8, 998 1, 678 53 13.00 01500 PATIENT ACTIVITIES 2, 200 15.00 0 57, 633 57, 633 94 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 1, 895, 801 1, 895, 801 64,050 2,818 30.00 03100 NURSING FACILITY 0 0 31.00 31.00 0 32.00 03200 | CF/IID 0 0 o 32.00 0 0 0 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 12 40.00 0 0 04100 LABORATORY 0 0 0 14 41.00 41.00 00000 04200 I NTRAVENOUS THERAPY 0 42.00 42.00 Ω 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 90, 726 90, 726 1, 398 44.00 176 44.00 04500 OCCUPATIONAL THERAPY 45.00 45. 140 45. 140 405 161 45.00 04600 SPEECH PATHOLOGY 46.00 9, 742 9, 742 126 39 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 C 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS o 48.00 14, 129 14, 129 17 48.00 0 04900 DRUGS CHARGED TO PATIENTS 0 49.00 49.00 0 131 05100 SUPPORT SURFACES 51.00 0 0 0 0 51.00 OTHER REIMBURSABLE COST CENTERS 0 71.00 07100 AMBULANCE 0 0 24 71.00 07300 CMHC 0 0 73.00 Ω 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 83.00 SUBTOTALS (sum of lines 1-84) 0 2, 909, 699 2, 909, 699 108, 276 5, 227 89.00 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 20, 227 20, 227 91.00 09200 PHYSICIANS PRIVATE OFFICES 92.00 92.00 0 0 09300 NONPALD WORKERS 0 93.00 93.00 C 0 0 94.00 09400 PATIENTS LAUNDRY C 0 0 0 94.00 98.00 Cross Foot Adjustments 0 98.00 99 00 Negative Cost Centers 0 99.00 0 0

0

2, 929, 926

2, 929, 926

108, 276

5, 236 100.00

100.00

TOTAL

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MC - WEST DEPTFORD OF PAULSBORO NJ Provider No.: 315246

				То	12/31/2023	Date/Time Prep 5/21/2024 3: 24	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	4 DIII
	cost center bescription	OPERATION,	LINEN SERVICE	HOUSEKEELLING	DILIANI	ADMI NI STRATI ON	
		MAINT. &	LINEN SERVICE			ADMINI STRATTON	
		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	136, 159					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	2, 984	63, 967				6.00
7.00	00700 HOUSEKEEPI NG	968	0	25, 152			7.00
8.00	00800 DI ETARY	16, 172	. 0	3, 077	346, 342		8.00
9.00	00900 NURSING ADMINISTRATION	1, 251	0	238	. 0	43, 991	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	6, 236	0	1, 186	0	0	10.00
13. 00	01300 SOCIAL SERVICE	456	1	87	0	0	13.00
15. 00	01500 PATIENT ACTIVITIES	2, 920	•	556	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 SKILLED NURSING FACILITY	96, 053	63, 967	18, 273	346, 342	43, 991	30.00
31.00	03100 NURSING FACILITY		1	0	. 0	0	31.00
32.00	03200 CF/IID	0	0	o	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	o	0		33. 00
	ANCILLARY SERVICE COST CENTERS	_					
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00	04100 LABORATORY	0	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	o	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	o	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	4, 597	ď	875	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	2, 287	1	435	0	0	45.00
46. 00	04600 SPEECH PATHOLOGY	494		94	0	Ö	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	1	0	0	Ö	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	716		136	0	Ö	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	1	0	0	Ö	49. 00
51. 00	05100 SUPPORT SURFACES		1	-	0		51. 00
	OTHER REIMBURSABLE COST CENTERS			'			
71. 00	07100 AMBULANCE	0	0	0	0	0	71.00
73.00	07300 CMHC	0	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0	0	0	0	0	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	135, 134	63, 967	24, 957	346, 342	43, 991	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	1	· · · · · · · · · · · · · · · · · · ·	0	- 1	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	1, 025	0	195	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
98. 00	Cross Foot Adjustments		0	0	0	0	98.00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	D TOTAL	136, 159	63, 967	25, 152	346, 342	43, 991	100. 00

In Lieu of Form CMS-2540-10
Worksheet B
Part II
B1/2023 Date/Time Prepared:
5/21/2024 3:24 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MC - WEST DEPTFORD OF PAULSBORO NJ Provi der No.: 315246 Peri od: From 01/01/2023 To 12/31/2023 OTHER GENERAL SERVI CE

	Cost Center Description	CENTRAL SERVI CES & SUPPLY	SOCIAL SERVICE	ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	
	I	10. 00	13. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	T	1				
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 SERVICES & SUPPLY	130, 622					10. 00
13. 00	01300 SOCI AL SERVI CE	0	,				13. 00
15. 00	01500 PATIENT ACTIVITIES	0	0	63, 403			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	114, 190	· ·	63, 403	2, 720, 160		30. 00
31. 00	03100 NURSING FACILITY	0	_	0	C	0	31. 00
32. 00	l l	0		0	C	1	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	C	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1	1				
40. 00	04000 RADI OLOGY	0		0	12		40.00
41. 00	04100 LABORATORY	0	0	0	14	1	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	C	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0		0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	97, 772	1	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	48, 428	1	45. 00
46. 00		0	0	0	10, 495	i .	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 432		0	31, 430	l .	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	131	1	49. 00
51. 00	05100 SUPPORT SURFACES	0	0	l O	C)	51. 00
71. 00	OTHER REIMBURSABLE COST CENTERS 07100 AMBULANCE	0	0	0	24	. 0	71. 00
73.00	07300 CMHC			- 1	24	l .	73.00
73.00	SPECIAL PURPOSE COST CENTERS		0	U		<u> </u>	73.00
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 - SNF						82. 00
83. 00	08300 H0SPI CE		0	0	C	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	130, 622		63, 403	2, 908, 470	1	89. 00
07.00	NONREI MBURSABLE COST CENTERS	100,022	11,212	00, 100	2, 700, 170	,	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	C	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	21, 456	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0	0	_ · · · · · · · · · · · · · · · · · · ·	ol o	92.00
93. 00	09300 NONPAI D WORKERS		0	0	C	ol o	93. 00
94. 00	09400 PATIENTS LAUNDRY		l o	o	C.		94. 00
98. 00	Cross Foot Adjustments			o	C.		98. 00
99. 00	Negative Cost Centers	0	0	o	C.	o o	99. 00
100.00		130, 622	11, 272	63, 403	2, 929, 926		100.00
		•	•			•	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315246

			10 12/31/2023 Date/IIMe Pre 5/21/2024 3:2	
	Cost Center Description	Total	072172021 012	, p
		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 SERVICES & SUPPLY			10.00
13.00	01300 SOCIAL SERVICE			13.00
15.00	01500 PATIENT ACTIVITIES			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 SKILLED NURSING FACILITY	2, 720, 160		30.00
31. 00	03100 NURSING FACILITY	0		31. 00
32.00	03200 I CF/I I D	0		32. 00
33.00		0		33. 00
	ANCILLARY SERVICE COST CENTERS			
40. 00	04000 RADI OLOGY	12		40. 00
41. 00	04100 LABORATORY	14		41. 00
42.00	04200 I NTRAVENOUS THERAPY	0		42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	4		43. 00
44. 00	04400 PHYSI CAL THERAPY	97, 772		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	48, 428		45. 00
46. 00	04600 SPEECH PATHOLOGY	10, 495		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 430		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	131		49. 00
51.00	05100 SUPPORT SURFACES	0		51. 00
74 00	OTHER REIMBURSABLE COST CENTERS	0.4		74 00
		24		71. 00
/3.00	07300 CMHC	0		73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			00.00
80.00	08100 NTEREST EXPENSE			80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF			82. 00
83. 00	08300 HOSPI CE	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	2, 908, 470		89. 00
69.00	NONREI MBURSABLE COST CENTERS	2, 900, 470		09.00
90 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00	09100 BARBER AND BEAUTY SHOP	21, 456		91. 00
	09200 PHYSICIANS PRIVATE OFFICES	21, 430		92. 00
93. 00	09300 NONPALD WORKERS	0		93. 00
94. 00	09400 PATIENTS LAUNDRY	0		94. 00
98. 00	Cross Foot Adjustments	0		98. 00
99. 00	Negative Cost Centers	0		99.00
100.00		2, 929, 926		100.00
	1	, , , , , , , , , ,		

			- WEST DEPTFORD				Washabaat D 1	
COST A	LLUCA	TION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2023	Worksheet B-1	
						o 12/31/2023	Date/Time Pre	pared:
							5/21/2024 3: 2	
			CAPI TAL					
			RELATED COSTS					
		Cost Center Description	BLDGS &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	PLANT	
			FI XTURES	BENEFITS		& GENERAL	OPERATI ON,	
			(SQUARE FEET)	(GROSS		(ACCUM COST)	MAINT. &	
				SALARI ES)			REPAI RS	
							(SQUARE FEET)	
			1.00	3. 00	4A	4. 00	5. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS - BLDGS & FLXTURES	39, 399					1.00
3.00		EMPLOYEE BENEFITS	1, 456	6, 897, 379	1			3. 00
4.00	00400	ADMINISTRATIVE & GENERAL	0	333, 537	-2, 177, 546	13, 677, 941		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	1, 806	100, 546	0	722, 663	36, 137	5. 00
6.00	00600	LAUNDRY & LINEN SERVICE	792	127, 150	0	235, 153	792	6. 00
7.00	00700	HOUSEKEEPI NG	257	312, 830	0	420, 514	257	7. 00
8.00	00800	DI ETARY	4, 292	473, 590	0	1, 259, 589	4, 292	8. 00
9.00	00900	NURSING ADMINISTRATION	332	1, 099, 783	0	1, 432, 418	332	9. 00
10.00	01000	CENTRAL SERVICES & SUPPLY	1, 655	0	0	326, 757	1, 655	10.00
13.00	01300	SOCIAL SERVICE	121	106, 910	0	137, 733	121	13.00
15.00	01500	PATIENT ACTIVITIES	775	140, 137	0	246, 399	775	15. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		SKILLED NURSING FACILITY	25, 493	4, 080, 001	0	7, 367, 731	25, 493	30. 00
31.00	03100	NURSING FACILITY	0	0	0		0	31.00
32.00	03200	ICF/IID	ol	0	0	0	0	32.00
		OTHER LONG TERM CARE	o	0	l .		0	ı
		LARY SERVICE COST CENTERS	,					
40.00	04000	RADI OLOGY	0	0	0	30, 956	0	40.00
41.00	04100	LABORATORY	o	0	0	37, 329	0	41.00
42.00		INTRAVENOUS THERAPY	o	0		0	0	42.00
	1	OXYGEN (INHALATION) THERAPY	0	0	0	10, 602	0	43. 00
44. 00		PHYSI CAL THERAPY	1, 220	89, 053	0	458, 712	1, 220	•
45. 00		OCCUPATIONAL THERAPY	607	25, 786	l .	420, 776	607	1
46. 00		SPEECH PATHOLOGY	131	8, 056	l .	101, 280	131	1
47. 00		ELECTROCARDI OLOGY	0	0	1	0	0	1
		MEDICAL SUPPLIES CHARGED TO PATIENTS	190	0			190	•
49. 00		DRUGS CHARGED TO PATIENTS	0	0			0	
		SUPPORT SURFACES	ا	0			ő	1
01.00		REI MBURSABLE COST CENTERS	<u>ا</u>		1	<u> </u>		01.00
71. 00		AMBULANCE	O	0	0	61, 454	0	71. 00
	07300			0	1		Ö	
70.00		AL PURPOSE COST CENTERS	<u> </u>					70.00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81. 00
82. 00	1	UTILIZATION REVIEW - SNF	1					82. 00
83. 00		HOSPI CE	0	0		0	0	ı
89. 00		SUBTOTALS (sum of lines 1-84)	39, 127	6, 897, 379	-2, 177, 546	13, 655, 469	35, 865	•
07.00	NONRE	IMBURSABLE COST CENTERS	37, 127	0,071,317	2, 177, 540	13, 033, 407	33, 003	07.00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	0	0	0	90. 00
	1	BARBER AND BEAUTY SHOP	272	0		22, 472		91.00
		PHYSICIANS PRIVATE OFFICES	0	0	Ö		0	
93. 00		NONPALD WORKERS		0			Ö	
94. 00	1	PATIENTS LAUNDRY		0		0	0	94. 00
98. 00	07400	Cross Foot Adjustments		0	ĺ		·	98. 00
99. 00		Negative Cost Centers						99.00
102.00	1	Cost to be allocated (per Wkst. B,	2, 929, 926	1, 277, 490		2, 177, 546	837, 712	ł
102.00		Part I)	2, 727, 720	1, 277, 490		2, 177, 340	037,712	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	74. 365492	0. 185214		0. 159201	23. 181559	103 00
103.00	1	Cost to be allocated (per Wkst. B,	7 7. 303472	108, 276	1	5, 236	136, 159	1
104.00		Part II)		100, 270		5, 230	130, 139	104.00
105.00		Unit cost multiplier (Wkst. B, Part		0. 015698		0. 000383	3. 767856	105, 00
. 55. 50		II)		3. 010070		3.00000	3.707000	
	Į.	1	1 1		I .	1 1	1	1

PAULSBORO NJ In Lieu of Form CMS-2540-10
Provider No.: 315246 | Period: | Worksheet B-1 | From 01/01/2023 | To 12/21/2022 | Description | Period: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					F	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/21/2024 3:2	
		Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT	CENTRAL SERVI CES & SUPPLY (COSTED	4 (2)11
			6.00	7. 00	8. 00	NURSI NG) 9. 00	REQUIS.) 10.00	
	GENER	AL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00		EMPLOYEE BENEFITS						3. 00
4.00	1	ADMINISTRATIVE & GENERAL						4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00		LAUNDRY & LINEN SERVICE	46, 460	l e				6. 00
7. 00		HOUSEKEEPI NG	0	35, 088				7. 00
8.00		DIETARY	0	4, 292				8. 00
9.00		NURSI NG ADMI NI STRATI ON	0	332				9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	1, 655		-	232, 992	1
13.00	1	SOCIAL SERVICE	0	121	0		0	
15. 00		PATIENT ACTIVITIES	0	775	0	0	0	15. 00
20.00		I ENT ROUTINE SERVICE COST CENTERS	14 140	25 402	120 200	150 255	202 402	30.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	46, 460	25, 493 0			203, 682 0	1
32. 00	1	ICF/IID	0				0	•
33. 00	1	OTHER LONG TERM CARE	0				0	
33.00		LARY SERVICE COST CENTERS			10	l ol		33.00
40. 00		RADI OLOGY	1	0	0	ol	0	40. 00
41. 00		LABORATORY	0	0			0	41. 00
42. 00	1	I NTRAVENOUS THERAPY	0		Ö		0	
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	
44. 00		PHYSI CAL THERAPY	0	1, 220	0	o	0	1
45. 00	1	OCCUPATI ONAL THERAPY	0	607	0	o	0	1
46. 00		SPEECH PATHOLOGY	0	131	l o	o	0	1
47. 00	1	ELECTROCARDI OLOGY	0	0		o	0	47. 00
48.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	190	0	o	29, 310	48. 00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	o	0	49. 00
51.00	05100	SUPPORT SURFACES	0	0	0	o	0	51.00
	OTHER	REIMBURSABLE COST CENTERS						
71. 00	1	AMBULANCE	0	0	0		0	71. 00
73. 00	07300		0	0	0	0	0	73. 00
		AL PURPOSE COST CENTERS	1					1
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	1	I NTEREST EXPENSE						81. 00
82. 00	1	UTILIZATION REVIEW - SNF	_	_	_	_	_	82. 00
83.00	08300	HOSPI CE	0	0	100 000	0	0	
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	46, 460	34, 816	139, 380	158, 255	232, 992	89. 00
00.00		I MBURSABLE COST CENTERS	1		1 0			00.00
90.00	1	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		_	0	
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0	272		0	0	
93. 00		NONPALD WORKERS	0	0		0	0	1
		PATIENTS LAUNDRY	0	0	0	0	0	1
98. 00	1	Cross Foot Adjustments	0	٥		o o	O	98.00
99. 00	1	Negative Cost Centers						99. 00
102.00	1	Cost to be allocated (per Wkst. B,	290, 950	493, 418	1, 619, 967	1, 672, 825	440, 415	1
		Part I)						
103.00		Unit cost multiplier (Wkst. B, Part I)	6. 262376	l e			1. 890258	1
104.00	ו	Cost to be allocated (per Wkst. B, Part II)	63, 967	25, 152	346, 342	43, 991	130, 622	104. 00
105.00		Unit cost multiplier (Wkst. B, Part	1. 376819	0. 716826	2. 484876	0. 277975	0. 560629	105 00
100.00	1		1. 373017	0.713020	2. 404070	0.277773	0. 300027	1.55. 55
	1		1	'	1			•

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315246 Peri od:

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

5/21/2024 3:24 pm OTHER GENERAL SERVI CE Cost Center Description SOCIAL SERVICE PATI ENT ACTI VI TI ES (PATIENT (PATI ENT CENSUS) CENSUS) 13.00 15.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 00300 EMPLOYEE BENEFITS 3.00 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 00900 NURSING ADMINISTRATION 9.00 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 13. 00 01300 SOCIAL SERVICE 46, 460 13.00 01500 PATIENT ACTIVITIES 15.00 15.00 46, 460 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 46, 460 46, 460 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 32.00 0 0 03300 OTHER LONG TERM CARE 33.00 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 0 04100 LABORATORY 0 41.00 00000000 41.00 04200 I NTRAVENOUS THERAPY 42.00 42.00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 45.00 04600 SPEECH PATHOLOGY 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 0 48.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 49.00 0 05100 SUPPORT SURFACES 51.00 0 0 51.00 OTHER REIMBURSABLE COST CENTERS 0 71.00 07100 AMBULANCE 0 71.00 07300 CMHC 0 73.00 Λ 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 83.00 89.00 SUBTOTALS (sum of lines 1-84) 46, 460 89.00 46, 460 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 0 91.00 09100 BARBER AND BEAUTY SHOP 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 92.00 09300 NONPALD WORKERS 0 93.00 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 94.00 98.00 Cross Foot Adjustments 98.00 99 00 99 00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, 164, 167 314, 490 102.00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 3. 533513 6.769049 103.00 104.00 104.00 Cost to be allocated (per Wkst. B, 11, 272 63, 403 Part II) Unit cost multiplier (Wkst. B, Part 105.00 105.00 0.242617 1. 364679 II)

Health Financial Systems MC - WEST DEPTFORD OF F	PAULSBORO 1	NJ	In Lie	eu of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS			Peri od:	Worksheet C	
			rom 01/01/2023		
			o 12/31/2023	Date/Time Prep 5/21/2024 3:24	pared:
Cost Center Description		Total (from	Total Charges		4 PIII
oust defiter bescription		Wkst. B, Pt I,		di vi ded by	
		col . 18)		col. 2	
		1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS					
40. 00 04000 RADI OLOGY		35, 884	4, 339	8. 270108	40.00
41. 00 04100 LABORATORY	l	43, 272	30, 212	1. 432279	41.00
42. 00 04200 I NTRAVENOUS THERAPY	l	(0	0.000000	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY		12, 290	4, 525	2. 716022	43.00
44. 00 O4400 PHYSI CAL THERAPY		577, 177	488, 678	1. 181099	44.00
45. 00 04500 OCCUPATI ONAL THERAPY		510, 371	639, 982	0. 797477	45.00
46. 00 O4600 SPEECH PATHOLOGY		122, 283	218, 190	0. 560443	46.00
47. 00 04700 ELECTROCARDI OLOGY		(0	0.000000	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		112, 834	18, 743	6. 020061	48. 00
49.00 O4900 DRUGS CHARGED TO PATIENTS	ļ	396, 405	233, 754		49. 00
51. 00 O5100 SUPPORT SURFACES		(0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
71. 00 07100 AMBULANCE		71, 238		0. 000000	
100.00 Total		1, 881, 754	1, 638, 423		100. 00

	- WEST DEPTFORD				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/21/2024 3: 2	pareu. 4 pm
		Title	XVIII (1)	Skilled Nursing		
				Facility		
		Health Care Pr	rogram Charges	Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col 1	
	to Charges	l lait A	l lait b	x col. 2)	x col. 3)	
	(Fr. Wkst. C			X 661. 2)	X 601. 0)	
	Col umn 3)					
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST		•			
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	8. 270108			20, 857	0	40. 00
41. 00 04100 LABORATORY	1. 432279	12, 888	(18, 459	0	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000		(0	0	42. 00
43.00 O4300 OXYGEN (INHALATION) THERAPY	2. 716022	902	(2, 450	0	43.00
44. 00 04400 PHYSI CAL THERAPY	1. 181099			317, 873		44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 797477		(270, 094		10.00
46. 00 04600 SPEECH PATHOLOGY	0. 560443		(73, 598	0	10.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000		(0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	6. 020061	6, 221	(37, 451	0	10.00
49. 00 O4900 DRUGS CHARGED TO PATIENTS	1. 695821	185, 978	(315, 385	0	
51. 00 05100 SUPPORT SURFACES	0. 000000	0	(0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
71. 00 07100 AMBULANCE (2)	0. 000000			O		71. 00
100.00 Total (Sum of lines 40 - 71)		947, 651	(1, 056, 167	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	y.					

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

Health Financial Systems MC	- WEST DEPTFORD	OF PAULSBORO	N J	In lie	eu of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315246	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III	pared:
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1, 00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of co 2.00 Program vaccine charges (From your reco	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) Program vaccine charges (From your records, or the PS&R) Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet					1. 00 2. 00 3. 00
Cost Center Description		Nursing & Allied Health (From Wkst. B, Part I, Col. 14)		I I, Col. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 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 41. 00 04100 LABORATORY 42. 00 04200 INTRAVENOUS THERAPY 43. 00 04300 0XYGEN (INHALATION) THERAPY 44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 0CCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 49. 00 04900 DRUGS CHARGED TO PATI ENTS 51. 00 05100 SUPPORT SURFACES	35, 884 43, 272 0 12, 290 577, 177 510, 371 122, 283 0 112, 834 396, 405		0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000	0 18, 459 0 0 2, 450 0 317, 873 0 270, 094 0 73, 598 0 0 37, 451 0 315, 385	0 0 0 0 0 0	40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 51. 00
100.00 Total (Sum of Lines 40 - 52)	1, 810, 516	(C	1	1, 056, 167	0	100. 00

	Financial Systems MC - WEST DEPTFORD OF ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315246	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2023 To 12/31/2023	Parts I-II Date/Time Prep 5/21/2024 3:24	
		Title XVIII	Skilled Nursing Facility	PPS	
			racritty	1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	INPATIENT DAYS				1
1.00	Inpatient days including private room days			46, 460	1.0
2. 00	Private room days			0	2.0
3. 00	Inpatient days including private room days applicable to the P			7, 188	
1.00	Medically necessary private room days applicable to the Progra	.m		0	•
5. 00	Total general inpatient routine service cost			13, 937, 553	5.0
5. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			16, 373, 741	6.00
7. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 d	ivided by line 6)		0. 851214	
3. 00	Enter private room charges from your records	TVI dea by Time 0)		0.031214	1
9. 00	Average private room per diem charge (Private room charges lin	e 8 divided by private	room davs. line	0.00	
	2)				
10.00	Enter semi-private room charges from your records			0	1
11. 00	Average semi-private room per diem charge (Semi-private room	charges line 10, divide	d by	0. 00	11. 0
12 00	semi -private room days)			0.00	12.0
12.00	Average per diem private room charge differential (Line 9 minu Average per diem private room cost differential (Line 7 times	0. 00 0. 00			
14. 00	Private room cost differential adjustment (Line 2 times line 1	0.00			
15. 00					
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16. 00	Adjusted general inpatient service cost per diem (Line 15 div	ided by line 1)		299. 99	
17. 00	Program routine service cost (Line 3 times line 16)			2, 156, 328	
	Medically necessary private room cost applicable to program (0	1
19.00	Total program general inpatient routine service cost (Line 17 Capital related cost allocated to inpatient routine service co		+ II column 10	2, 156, 328 2, 720, 160	
20. 00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	StS (ITOIII WKSt. B, Fai	t II Corumii 16,	2, 720, 100	20.0
21. 00	Per diem capital related costs (Line 20 divided by line 1)			58. 55	21.0
22. 00	Program capital related cost (Line 3 times line 21)			420, 857	22. 0
23. 00	Inpatient routine service cost (Line 19 minus line 22)			1, 735, 471	
	Aggregate charges to beneficiaries for excess costs (From pro			0	
25. 00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	1, 735, 471	
26. 00	Enter the per diem limitation (1)	or diam limitation line	2() (1)		26. 0
	Inpatient routine service cost limitation (Line 3 times the pe Reimbursable inpatient routine service costs (Line 22 plus) th				27. 00 28. 00
20.00	(Transfer to Worksheet E, Part II, line 4) (See instructions)	e resser of title 25 of	11116 27)		20.00
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be us	ed for title V and or t	itle XIX	J	1
	DADT II CALCIIIATION OF INDATIENT NUDCING & ALLIED USALTU COCTO	FOR DRC DACC TURCUCU		1. 00	
1. 00	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS Total SNF inpatient days	FUK PPS PASS-THKUUGH		46, 460	1.00
2. 00	Program inpatient days (see instructions)			7, 188	1
3.00	Total nursing & allied health costs. (see instructions)(Do not	complete for titles V	or XLX)	7, 188	1
4. 00	Nursing & allied health ratio. (line 2 divided by line 1)		=: :::///	0. 154714	
	Program nursing & allied health costs for pass-through. (line 3 times line 4)				

Health Financial Systems	MC - WEST DEPTFORD OF F	PAULSBORO NJ	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII		From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/21/2024 3:24 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	EMEIV1		4, 787, 609	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	3		4, 787, 609	
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			820, 712	5. 00
6.00	Allowable bad debts (From your records)			299, 325	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		169, 078	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			194, 561	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			4, 161, 458	11. 00
12.00	Interim payments (See instructions)			4, 001, 123	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	55 Demonstration payment adjustment amount after sequestration				14. 55
14. 75	75 Sequestration for non-claims based amounts (see instructions)				14. 75
14. 99	Sequestration amount (see instructions)			79, 338 77, 106	
15. 00					
16. 00	16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)				16. 00
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		4 - 00
17. 00	Ancillary services Part B				17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			12, 388	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			12, 388	
20. 00 21. 00	Medicare Part B ancillary charges (See instructions)			7, 305 7, 305	
21.00	Cost of covered services (Lesser of line 19 or line 20) Primary payor amounts			7, 305	
23. 00	Coinsurance and deductibles			0	
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 00	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	
24. 01	Adjusted reimbursable bad debts (see instructions)	etions)		0	
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			7, 305	
26. 00	Interim payments (See instructions)			1, 646	
27. 00	Tentative adjustment			0	
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)			146	
29. 00	Balance due provider/program (see instructions)			5, 513	
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	section 115.2	0,010	
	1 Comment of the desired and t			٦	

Health Financial Systems MC - WEST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der No.: 315246 Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/21/2024 3:24 pm Title XVIII Skilled Nursing PPS

				Facility		
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		4, 022, 004		1, 646	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	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		_1		_	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3. 05			0		0	3. 05
2 50	Provi der to Program	0/ /15 /2022	20, 001			2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM	06/15/2023	20, 881		0	3. 50 3. 51
3. 51			0			3. 51
3. 52			0			3. 52
3. 54			0			3. 53 3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-20, 881			3. 99
3. 77	- 3.98)		-20, 661		ا	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 001, 123		1, 646	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 04	Program to Provider					E 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Provider to Program		U		U	5. 03
5. 50	TENTATI VE TO PROGRAM		O		0	5. 50
5. 51	TENTATI VE TO TROUVAIN		Ö		l ől	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
0. 77	- 5. 98)		Ŭ		Ĭ	0. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	PROGRAM TO PROVIDER		77, 106		5, 513	6. 01
6.02	PROVI DER TO PROGRAM		0		o	6. 02
7.00	Total Medicare program liability (see instructions)		4, 078, 229		7, 159	7. 00
			Contract	or Name	Contractor	
					Number	
			1.	00	2.00	
	Name of Contractor					8. 00

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

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

Provi der No.: 315246

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/21/2024 3: 24 pm

ıı y)					5/21/2024 3: 2	<u>24 p</u> r
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	Assets CURRENT ASSETS					4
00	Cash on hand and in banks	828, 126	ol C	0	0	1
00	Temporary investments	020, 120				
00	Notes receivable	0	Ö	Ö	Ö	
OC	Accounts receivable	3, 487, 795	C	0	0) 4
00	Other receivables	-825	1	0	0	
00	Less: allowances for uncollectible notes and accounts	-150, 628	C	0	0	
00	recei vabl e I nventory				0	
00	Prepai d expenses	137, 771	1) 0		
00	Other current assets	0	, c		ő	
00	Due from other funds	0	o c	0	0	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4, 302, 239	C	0	0	1
	FI XED ASSETS				1	4
00	Land	0	0	-	1	
00	Land improvements				0	
00	Less: Accumulated depreciation Buildings			-	0	
00	Less Accumulated depreciation) c		ő	
00	Leasehold improvements	61, 503	c	Ö	Ō	
00	Less: Accumulated Amortization	-2, 238		0	0	1
. 00	Fi xed equipment	0	C	0	0	
00	Less: Accumulated depreciation	0	0	0	0	
. 00	Automobiles and trucks	0	C	0	0	
. 00	Less: Accumulated depreciation	0		-	0	
00	Major movable equipment Less: Accumulated depreciation	102, 778 -14, 704		-	0	
. 00	Mi nor equi pment - Depreci abl e	-14, 704) 0		
. 00	Mi nor equi pment nondepreci abl e	0) c		ő	
00	Other fixed assets	Ö		o o	Ö	. _
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	147, 339	o c	0	0	
	OTHER ASSETS					
00	Investments	0	0	-	1	
00	Deposits on Leases	51, 077		0	1	
. 00	Due from owners/officers	2, 127, 259		0	0	
. 00	Other assets TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	2, 178, 336		0	0	
. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	6, 627, 914		-	1	
	Liabilities and Fund Balances	0,027,711		7		1 ~
	CURRENT LIABILITIES	_				
00	Accounts payable	846, 249				
. 00	Salaries, wages, and fees payable	391, 335	1		1	
. 00	Payrol I taxes payable	20, 302		0	0	
. 00	Notes & loans payable (Short term) Deferred income	2, 000, 000 105, 853		0	0	
. 00	Accel erated payments	105, 655)		4
. 00	Due to other funds) (0	0	
. 00	Other current liabilities	2, 906, 314	C	o o	1	1
. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	6, 270, 053		0	0) 4
	LONG TERM LIABILITIES					
. 00	Mortgage payable	0	0		1	
. 00	Notes payable	0	0		1	
. 00	Unsecured Loans	0		0	0	
. 00	Loans from owners: Other long term liabilities				0	
. 00	OTHER (SPECIFY)	0	,		0	
. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		o n	o o	
. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	6, 270, 053			0	
	CAPI TAL ACCOUNTS					
00	General fund balance	357, 861	•			5
00	Specific purpose fund		C	7		5
00	Donor created - endowment fund balance - restricted			0]	5
00	Donor created - endowment fund balance - unrestricted			0	,	5
00	Governing body created - endowment fund balance Plant fund balance - invested in plant		1		0	5 5 5
. 00	Plant fund balance - reserve for plant improvement,		1		0	
. 50	replacement, and expansion]
	the contract of the contract o	1	1	J 0) 5
. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	357, 861	(ا ل	0	ין י

STATEMENT OF CHANGES IN FUND BALANCES Provi der No.: 315246 Peri od: Worksheet G-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 3:24 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 94, 599 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) 263, 265 2.00 3.00 Total (sum of line 1 and line 2) 357, 864 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0000 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 357, 864 11.00 0 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 ROUNDI NG 0 13.00 0 0 0 14.00 0 14.00 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance 357, 861 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 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 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 0 10.00 0 0 11.00 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00 ROUNDI NG 13.00 13.00 14.00 0 14.00 15.00 15.00 0 16.00 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00

sheet (Line 11 - line 18)

Heal th	Financial Systems MC - WEST DEPTFORD OF	PAULSBORO	NJ	In Lie	eu of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315246	Peri od: From 01/01/2023 To 12/31/2023		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		16, 373, 7	41	16, 373, 741	
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		16, 373, 7	41	16, 373, 741	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		1, 638, 4	24 0	1, 638, 424	6. 00
7.00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	8. 00
9.00	AMBULANCE			0	0	9. 00
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
12.00	HOSPI CE			0 0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD		323, 3	11 0	323, 311	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	18, 335, 4	76 0	18, 335, 476	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)				16, 414, 244	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 14)				16, 414, 244	15. 00

Heal th	Financial Systems MC - WEST DEPTFORD OF	PAULSBORO NJ	In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315246	Peri od:	Worksheet G-3	
			From 01/01/2023	D-+- /T: D	
			To 12/31/2023	Date/Time Prep 5/21/2024 3: 24	
				072172021 0.2	ı pııı
				1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		18, 335, 476	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	S		1, 662, 675	2. 00
3.00	Net patient revenues (Line 1 minus line 2)			16, 672, 801	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, II	ine 15)		16, 414, 244	4.00
5.00	Net income from service to patients (Line 3 minus 4)			258, 557	5.00
	Other income:				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			2, 856	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
	Rebates and refunds of expenses			0	
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			96	14. 00
15. 00	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other the	an 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			177	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
	Rental of vending machines			0	
22. 00	Rental of skilled nursing space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	NON PATIENT REVENUE			340	24. 00
24. 01	BARBER BEAUTY			1, 239	
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)			4, 708	
26. 00	Total (Line 5 plus line 25)			263, 265	
27. 00	Other expenses (specify)			0	27. 00
28. 00				0	28. 00
29. 00	Total ather avnonces (Sum of Lines 27, 20)			0	
	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)			263, 265	31.00