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 Worksheet S
Parts I, II & III
Date/Time Prepared: SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315394 Peri od: From 07/01/2022 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 06/30/2023 11/30/2023 1:57 pm

PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	oort Date: 11/30/2023 Time: 1:57 pm				
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report					
	3.01 [] No Medicare Utilization. Enter '	'Y" for yes or leave blank for no.				
Contractor	4.[1]Cost Report Status	6. Contractor No.				
use only	(1) As Submitted	7.[N] First Cost Report for this Provider CCN				
	(2) Settled without audit	8.[N] Last Cost Report for this Provider CCN				
	(3) Settled with audit	9. NPR Date:				
	(4) Reopened	10.[0]If line 4, column 1 is "4": Enter number of times reopened				
	(5) Amended	11. Contractor Vendor Code4				
	5. Date Received:	12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.				

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SHORES AT WESLEY MANOR (315394) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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	Robe	ert Peterson	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	Robert Peterson			2
3	Signatory Title	VICE PRESIDENT OF FINANCE			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	20, 468	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	20, 468	0	0	100.00
Tho ab	pove amounts represent "due to" or "due from" the applicable	program for th	o alamont of the	a above comple	ov indicated	

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 SHORES AT WESLEY MANOR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315394 Peri od: Worksheet S-2 From 07/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 06/30/2023 11/30/2023 1:57 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 2201 BAY AVENUE PO Box: 1.00 2.00 City: OCEAN CITY State: NJ Zi p Code: 08226 2.00 3.00 County: CAPE MAY CBSA Code: 36140 Urban/Rural: U 3.00 3.01 CBSA Code: 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 SHORES AT WESLEY MANOR 315394 02/16/1998 N Р 0 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2022 06/30/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 2, 059, 943 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 2, 059, 943 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart BlOther 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38.00 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 290, 190

Heal th	Financial Systems	SHORES AT WESLE	Y MANOR	In Lie	u of Form CMS-2	2540-10	
	COMPLEX INDENTIFICATION DATA From 07/01/2022 F To 06/30/2023 F			Worksheet S-2 Part I Date/Time Pre 11/30/2023 1:	pared:		
					Y/N 1.00	<i>у.</i> р	
42.00	42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.						
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, C	hapter 10?		Y	43.00	
44. 00	If line 43 is yes, enter the home office on lines 45, 46 and 47.	ce chain number and ente	r the name and address	of the home	H53010	44. 00	
	1.00	2. 00		3. 00			
	If this facility is part of a chain organization, enter the name and address of the home office on the lines below.						
45. 00	Name: UNITED METHODIST HOMES OF NJ	Contractor's Name: UNITE	ED METHODIST Contract S OF NJ	ctor's Number: 1200	1	45. 00	
46.00	Street: 3311 HIGHWAY 33	PO Box:				46. 00	
47. 00	City: NEPTUNE	State: NJ	Zi p Cod	de: 0775	3	47. 00	

	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILITY X REIMBURSEMENT QUESTIONNAIRE	SHORES AT WESLEY TY HEALTH CARE			Period: From 07/01/2022 Fo 06/30/2023	Date/Time Pre	epared:
					Y/N	11/30/2023 1: Date	5/ pm
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	1, "Y" fo	r Yes or "N" 1	1.00 for No. For all	2.00 the date	
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If column 1 is "Y", enter tinstructions)	y prior to the begi the date of the chan	nning of ge in col	the cost umn 2. (see	N		1.00
	THISTI UCTI OHS)			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.			1. 00 N	2.00	3.00	2. 00
3. 00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N 1. 00	Type 2. 00	Date 3.00	
	Financial Data and Reports						
4. 00	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A" Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	' for Audited, "C" f te copy or enter dat	or e	Y	A	12/31/2023	4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If creconciliation.			Y			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Schollegal operator of the program? (Y/N)	ool? (Y/N) Column 2:	Is the	provider the	N	N	6.00
7. 00 8. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) se	ng the cost reportin		for Nursing	N N		7. 00 8. 00
						Y/N 1. 00	
9. 00	Bad Debts Is the provider seeking reimbursement for bac	d dahts2 (V/N) saa i	nstructio	ne		Y	9.00
10. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.	t collection policy	change du	ring this cos		N	10. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wai	ved? If "	Y", see instru	uctions.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting peri	od? If "Y		ctions. rt A	N Part B	12. 00
		Description 0	1	Y/N 1. 00	Date 2.00	Y/N 3. 00	
13. 00	PS&R Data Was the cost report prepared using the PS&R	-		Υ	11/14/2023	l N	13.00
	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)						
14. 00	Was the cost report prepared using the PS&R 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			N		N	14.00
15. 00	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.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report			N		N	16.00
17. 00	information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			N		N	17. 00
	Was the cost report prepared only using the			N		N	18.00

Heal th	Financial Systems	SHORES AT WES	SLEY MANOR		In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAR COMPLEX REIMBURSEMENT QUESTIONNAIRE		HEALTH CARE	Provi der		Period: From 07/01/2022 To 06/30/2023		pared:
			1.	00	2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/p	oosition [DEANDRA		FALLON		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 rep	oort E	BAKER TILLY US	S, LLP			20. 00
	preparer.						
21.00	Enter the telephone number and email address of	f the cost 5	70-820-0301		DEANDRA. FALLON@	BAKERTI LLY. CO	21. 00
	report preparer in columns 1 and 2, respectivel	٧.			M		

Health Financial Systems SHORES AT WESLEY MANOR In Lieu of Form CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE

SHORES AT WESLEY MANOR
In Lieu of Form CMS-2540-10
Provider No.: 315394
Form 07/01/2022
From 07/01/202
From 07/01/202
From

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 06/30/2023		
		Part B				
		Date				
		4. 00				
	PS&R Data					
13. 00	Was the cost report prepared using the PS&R				13. 00	0
	only? If either col. 1 or 3 is "Y", enter					
	the paid through date of the PS&R used to					
	prepare this cost report in cols. 2 and					
14.00	4. (see Instructions.) Was the cost report prepared using the PS&R				14. 00	^
14. 00	for total and the provider's records for				14.00	U
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used					
	to prepare this cost report in columns 2 and					
	4.					
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00	0
	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	0
	adjustments made to PS&R data for					
	corrections of other PS&R Report					
47.00	information? If yes, see instructions.				17.00	_
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?				17. 00	U
	Describe the other adjustments:					
18. 00	Was the cost report prepared only using the				18.00	Λ
10.00	provider's records? If "Y" see Instructions.				10.00	O
	provider a recorder in a contract detroner					
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title		DI RECTOR		19.00	0
	held by the cost report preparer in columns 1	, 2, and 3,				
20. 00	respectively.	conort			20.00	^
20.00	Enter the employer/company name of the cost r preparer.	ерог с			20.00	U
21. 00	1. ·	of the cost			21.00	0
21.00	report preparer in columns 1 and 2, respective				21.00	_
	1	,		1	ı	

Health Financial Systems SHORES AT WESLEY MANOR In Lieu of Form CMS-2540-10 Peri od: Worksheet S-3

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315394

From 07/01/2022 COMPLEX STATISTICAL DATA Part I Date/Time Prepared: 06/30/2023 11/30/2023 1:57 pm Inpatient Days/Visits Title XVIII Number of Beds Bed Days Title V Title XIX Component Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 21, 900 С 5, 103 6, 867 1. 00 60 NURSING FACILITY 0 2.00 0 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 4 00 93, 075 5.00 Other Long Term Care 255 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7.00 7.00 0 0 315 8.00 Total (Sum of lines 1-7) 114, 975 5.103 6,867 8.00 Inpatient Days/Visits Di scharges Title XIX Title XVIII Component Other Total Title V 6.00 7.00 8.00 9.00 10.00 1.00 SKILLED NURSING FACILITY 6, 620 18, 590 0 149 15 1. 00 0 2.00 NURSING FACILITY 0 2.00 0 ICE/LID 0 3 00 3 00 C 0 4.00 HOME HEALTH AGENCY COST 4.00 5.00 Other Long Term Care 42, 412 5.00 42.412 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 7.00 8.00 Total (Sum of lines 1-7) 49,032 61,002 149 15 8.00 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 13.00 11.00 12.00 14.00 15.00 1.00 SKILLED NURSING FACILITY 0.00 457.80 1.00 101 265 NURSING FACILITY 2.00 0.00 0.00 2.00 0 C 3.00 ICF/IID 0 0 0.00 3.00 HOME HEALTH AGENCY COST 4.00 4.00 Other Long Term Care 78 5.00 78 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 0.00 0.00 7.00 Ω 0.00 7.00 8.00 Total (Sum of lines 1-7) 179 343 0.00 34. 25 457.80 8.00 Average Length Admi ssi ons of Stay Title XVIII Title V Title XIX 0ther Component Total 16, 00 17.00 18.00 19 00 20.00 1.00 SKILLED NURSING FACILITY 70. 15 227 84 1. 00 NURSING FACILITY 0.00 0 2.00 2.00 0 ICF/IID 0.00 0 3.00 0 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 543.74 89 5.00 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 00 C Ω 7 00 Total (Sum of lines 1-7) 177.85 227 173 8.00 8.00 Admi ssi ons Full Time Equivalent Total Component Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 314 0.00 40.12 1.00 0.00 2.00 NURSING FACILITY 0 0.00 2.00 3.00 ICF/IID 0 0.00 0.00 3.00

89

403

0.00

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4.00

5.00

6.00

7.00

8.00

4.00

5.00

6.00

7.00

8.00

HOME HEALTH AGENCY COST

Total (Sum of lines 1-7)

Other Long Term Care

SNF-Based CMHC

HOSPI CE

Provi der No.: 315394

Amount Reported Reported Reported Reported Sal ari es (col. Sal ari es (col. 1 ± col. 2) Sal ari es (col. 1 ± col. 2) Nage (col. 3 ± col. 4)						o 06/30/2023		
Reported Sal aries From Sal aries (col. Related to Sal ary in col. Sal a			Amount	Reclass, of	Adi usted	Paid Hours		
PART II - DIRECT SALARIES								
PART II - DIRECT SALARIES								
PART II - DIRECT SALARIES SALARIES SALARIES					ĺ	3	, i	
SALARIES			1. 00	2.00	3. 00	4. 00	5. 00	
1.00		PART II - DIRECT SALARIES						
2.00 Physician salaries-Part A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
3.00 Physician salaries-Part B	1.00	Total salaries (See Instructions)	10, 239, 563	0	10, 239, 563	358, 660. 00	28. 55	1. 00
4.00 Home office personnel 0 0 0 0 0 0 0 0 0	2.00	Physician salaries-Part A	0	0	0			2. 00
5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 5.00 6.00 Revised wages (line 1 minus line 5) 10,239,563 0 10,239,563 358,660.00 28.55 6.00 7.00 Other Long Term Care 2,967,674 0 2,967,674 102,842.00 28.86 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 16.29 11.00 0.00 16.29 11.00 0.00 16.29 11.00 0.00 16.29 11.00	3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3. 00
6.00 Revised wages (line 1 minus line 5) 10, 239, 563 0 10, 239, 563 358, 660.00 28.55 6.00 7.00 Other Long Term Care 2, 967, 674 0 2, 967, 674 102, 842.00 28.86 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 9.00 10.00 10.00 HOSPICE 0 0 0 0 0.00 0.00 10.00 10.00 11.00 Other excluded areas 53, 094 0 53, 094 3, 260.00 16.29 11.00 28.47 12.00 Subtotal Excluded salary (Sum of lines 7 3, 020, 768 106, 102.00 28.47 12.00 11.00 THER WAGES & RELATED COSTS	4.00		0	0	0	0.00	0.00	4.00
7.00 Other Long Term Care 2, 967, 674 0 2, 967, 674 102, 842.00 28.86 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8.00 9.00 CMHC 0 0 0 0 0 0.00 0.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 Other excluded areas 53, 094 0 53, 094 3, 260.00 16.29 11.00 12.00 Subtotal Excluded salary (Sum of lines 7 3, 020, 768 0 3, 020, 768 106, 102.00 28.47 12.00 12.00 Total Adjusted Salaries (line 6 minus line 7, 218, 795 0 7, 218, 795 252, 558.00 28.58 13.00 12.00 12.00 Contract Labor: Patient Related & Mgmt 253, 296 0 23, 808 104.00 228.92 15.00 16.00 1	5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5. 00
8.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8.00 9.00 10.00 10.00 0.00 0.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 10.00 10.00 11.00 10.00 11.00 10.00 10.00 11.00 11.00 10.00	6.00	Revised wages (line 1 minus line 5)	10, 239, 563	0	10, 239, 563	358, 660. 00	28. 55	6. 00
9.00 CMHC	7.00	Other Long Term Care	2, 967, 674	0	2, 967, 674	102, 842. 00	28. 86	7. 00
10. 00 HOSPICE 0 0 0 0 0 0. 00 10. 00 11. 00 11. 00 11. 00 Other excluded areas 53,094 0 53,094 3, 260. 00 16. 29 11. 00 Subtotal Excluded salary (Sum of lines 7 3,020,768 0 3,020,768 106,102. 00 28. 47 12. 00 through 11) 13. 00 Total Adjusted Salaries (line 6 minus line 7, 218,795 0 7, 218, 795 252,558. 00 28. 58 13. 00 12) OTHER WAGES & RELATED COSTS 14. 00 Contract Labor: Patient Related & Mgmt 253,296 0 23,808 104. 00 228. 92 15. 00 16. 00 Home office salaries & wage related costs 998,592 0 998,592 15,779. 00 63. 29 16. 00 WAGE-RELATED COSTS 17. 00 Wage-related costs core (See Part IV) 2,508,988 0 2,508,988 17. 00 3,901 0 3,901 0 3,901 18. 00 Wage related costs (excluded units) 741,326 0 741,326 0 741,326 19. 00 Physician Part A - WRC 0 0 0 Physician Part B - WRC 0 0 0 0 0 21. 00 Physician Part B - WRC 0 0 0 0 0 21. 00	8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
11. 00 Other excluded areas	9.00	CMHC	0	0	0	0.00	0.00	9. 00
12.00 Subtotal Excluded salary (Sum of Lines 7 3,020,768 0 3,020,768 106,102.00 28.47 12.00 through 11) 13.00 Total Adjusted Salaries (Line 6 minus Line 7,218,795 0 7,218,795 252,558.00 28.58 13.00 20.00 20.00 20.00 20.00 20.00 21.00 Physician Part B - WRC 0 0 0 0 0 0 0 0 0 0 0 0 21.00 21.00 21.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 20.00 21.00 20.00 20.00 21.00 20.00 20.00 20.00 20.00 20.00 21.00 252.00	10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
through 11) Total Adjusted Salaries (line 6 minus line 7, 218, 795 0 7, 218, 795 252, 558.00 28.58 13.00 OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 253, 296 0 253, 296 6, 328.00 40.03 14.00 15.00 Contract Labor: Physician services-Part A 23, 808 0 23, 808 104.00 228.92 15.00 16.00 Home office salaries & wage related costs 998, 592 0 998, 592 15, 779.00 63.29 16.00 Wage-related costs core (See Part IV) 2, 508, 988 0 2, 508, 988 17.00 18.00 Wage-related costs other (See Part IV) 3, 901 0 3, 901 18.00 Wage related costs (excluded units) 741, 326 0 741, 326 19.00 Physician Part A - WRC 0 0 0 0 21.00 Physician Part B - WRC 0 0 0 0 21.00	11.00	Other excluded areas	53, 094	0	53, 094	3, 260. 00	16. 29	11. 00
13.00 Total Adjusted Salaries (line 6 minus line 7,218,795 0 7,218,795 252,558.00 28.58 13.00	12.00	Subtotal Excluded salary (Sum of lines 7	3, 020, 768	0	3, 020, 768	106, 102. 00	28. 47	12.00
12 OTHER WAGES & RELATED COSTS		through 11)						
OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 253, 296 0 253, 296 6, 328.00 40.03 14.00 15.00 Contract Labor: Physician services-Part A 23, 808 0 23, 808 104.00 228.92 15.00 16.00 Home office salaries & wage related costs 998, 592 0 998, 592 15, 779.00 63.29 16.00 WAGE-RELATED COSTS	13.00	Total Adjusted Salaries (line 6 minus line	7, 218, 795	0	7, 218, 795	252, 558. 00	28. 58	13.00
14.00 Contract Labor: Patient Related & Mgmt 253, 296 0 253, 296 6, 328.00 40.03 14.00 15.00 Contract Labor: Physician services-Part A 23, 808 0 23, 808 104.00 228.92 15.00 16.00 Home office salaries & wage related costs 998, 592 0 998, 592 15, 779.00 63.29 17.00 Wage-related costs core (See Part IV) 2, 508, 988 0 2, 508, 988 17.00 18.00 Wage-related costs other (See Part IV) 3, 901 0 3, 901 18.00 19.00 Wage related costs (excluded units) 741, 326 0 741, 326 19.00 20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00								
15.00 Contract Labor: Physician services-Part A 23,808 0 23,808 104.00 228.92 15.00						,		
16.00 Home office salaries & wage related costs 998, 592 0 998, 592 15,779.00 63.29 16.00								
WAGE-RELATED COSTS 17. 00 Wage-related costs core (See Part IV) 2,508,988 0 2,508,988 17. 00 18. 00 Wage-related costs other (See Part IV) 3,901 0 3,901 18. 00 19. 00 Wage related costs (excluded units) 741,326 0 741,326 19. 00 20. 00 Physician Part A - WRC 0 0 0 20. 00 21. 00 Physician Part B - WRC 0 0 0 21. 00		,						
17. 00 Wage-related costs core (See Part IV) 2,508,988 0 2,508,988 17. 00 18. 00 Wage-related costs other (See Part IV) 3,901 0 3,901 18. 00 19. 00 Wage related costs (excluded units) 741,326 0 741,326 19. 00 20. 00 Physician Part A - WRC 0 0 0 20. 00 21. 00 Physician Part B - WRC 0 0 0 21. 00	16. 00		998, 592	0	998, 592	15, 779. 00	63. 29	16. 00
18.00 Wage-related costs other (See Part IV) 3,901 0 3,901 19.00 Wage related costs (excluded units) 741,326 0 741,326 20.00 Physician Part A - WRC 0 0 0 21.00 Physician Part B - WRC 0 0 0								
19.00 Wage related costs (excluded units) 741,326 0 741,326 19.00 20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00		, ,		0				
20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00	18. 00	, ,	3, 901	0	3, 901			
21.00 Physician Part B - WRC 0 0 0 21.00	19. 00		741, 326	0	741, 326			
	20.00		0	0	0			
22 00 T-t-1 Additional Warra Dallated and Const. 1 771 5(2) 0 1 771 5(2)	21. 00		0	0	0			
	22. 00	Total Adjusted Wage Related cost (see	1, 771, 563	0	1, 771, 563			22. 00
instructions)		instructions)						

				1	o 06/30/2023		
						11/30/2023 1:	
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1. 00
2.00	Administrative & General	1, 402, 857	0	1, 402, 857	31, 495. 00	44. 54	2. 00
3.00	Plant Operation, Maintenance & Repairs	425, 744	0	425, 744	18, 154. 00	23. 45	3. 00
4.00	Laundry & Li nen Servi ce	76, 472	0	76, 472	4, 797. 00	15. 94	4. 00
5.00	Housekeepi ng	362, 098	0	362, 098	18, 764. 00	19. 30	5. 00
6.00	Di etary	1, 105, 676	0	1, 105, 676	63, 200. 00	17. 49	6. 00
7.00	Nursing Administration	0	0	C	0.00	0.00	7. 00
8.00	Central Services and Supply	0	0	C	0.00	0.00	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	C	0.00	0.00	10.00
11. 00	Soci al Servi ce	70, 932	0	70, 932	2, 350. 00	30. 18	11. 00
12.00	Nursing and Allied Health Ed. Act.						12. 00
13.00	Other General Service	313, 012	0	313, 012	14, 826. 00	21. 11	13. 00
14.00	Total (sum lines 1 thru 13)	3, 756, 791	0	3, 756, 791	153, 586. 00	24. 46	14. 00
			•	•	•	•	•

Health Financial Systems	S	HORES AT WESLEY	MANOR		In Lie	u of Form CMS-2	2540-10
SNF WAGE RELATED COSTS			Provi der	No.: 315394	From 07/01/2022	Worksheet S-3 Part IV Date/Time Prep 11/30/2023 1:	pared:
						Amount	
						Reported	
						1. 00	
PART IV - WAGE RELA	TED COSTS						
Part A - Core List							l
RETIREMENT COST							l
1.00 401K Employer Contr	i buti ons					0	1.00
2.00 Tax Shel tered Annui	ty (TSA) Employer Contribution	n				0	2.00
2 00 Qualified and Non C	ualified Dension Dian Cost					1/2 /02	2 00

		Reported	
		1. 00	
PART	TIV - WAGE RELATED COSTS		
Part	t A - Core List		
RETI	REMENT COST		
1.00 401	K Employer Contributions	0	1.00
2.00 Tax	Sheltered Annuity (TSA) Employer Contribution	0	2.00
	lified and Non-Qualified Pension Plan Cost	162, 402	3. 00
4.00 Pri	or Year Pension Service Cost	0	4.00
PLAN	N ADMINISTRATIVE COSTS (Paid to External Organization)		
	K/TSA Plan Administration fees	0	5. 00
6.00 Leg	al/Accounting/Management Fees-Pension Plan	0	6. 00
	loyee Managed Care Program Administration Fees	0	7. 00
	LTH AND INSURANCE COST		
8. 00 Hea	th Insurance (Purchased or Self Funded)	1, 138, 413	8. 00
	scription Drug Plan	0	9. 00
	tal, Hearing and Vision Plan	10, 535	10.00
	e Insurance (If employee is owner or beneficiary)	0	11. 00
	ident Insurance (If employee is owner or beneficiary)	0	12. 00
	ability Insurance (If employee is owner or beneficiary)	4, 185	
	g-Term Care Insurance (If employee is owner or beneficiary)	0	
	kers' Compensation Insurance	327, 869	15. 00
	irement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	
	cumulative portion)		
TAXE			
17. 00 FIC	A-Employers Portion Only	601, 976	17. 00
18.00 Med	icare Taxes - Employers Portion Only	141, 204	18.00
19. 00 Une	mployment Insurance	122, 404	19.00
20.00 Sta	te or Federal Unemployment Taxes	0	20.00
OTHE	ER		
21.00 Exe	cutive Deferred Compensation	0	21.00
22.00 Day	Care Cost and Allowances	0	22. 00
23. 00 Tui	tion Reimbursement	0	23. 00
24. 00 Tota	al Wage Related cost (Sum of lines 1 - 23)	2, 508, 988	24.00
		Amount	
		Reported	
		1. 00	
	t B - Other than Core Related Cost		
25. 00 OTH	ER WAGE RELATED COST	3, 901	25. 00

Provi der No.: 315394

Peri od: Worksheet S-3
From 07/01/2022 Part V
TO 04/20/2022 Part V
TO 04

				Ť	06/30/2023	Date/Time Prep 11/30/2023 1:	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	57 PIII
	occupational category	Reported		Sal ari es (col.		Wage (col. 3 ÷	
		itopor tou	20.101.10		Salary in col.	col. 4)	
				'	3	,	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	993, 146	243, 718			1	1. 00
2.00	Licensed Practical Nurses (LPNs)	415, 639	101, 998				2.00
3.00	Certified Nursing Assistant/Nursing	1, 063, 690	261, 030	1, 324, 720	47, 655. 00	27. 80	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	2, 472, 475	606, 746		i i		4.00
5.00	Physical Therapists	350, 026	85, 896				5. 00
6.00	Physical Therapy Assistants	0	0	1	0.00		6. 00
7.00	Physical Therapy Aides	68, 548	16, 822		· ·	1	7. 00
8. 00	Occupational Therapists	148, 300	36, 393		i i	1	8. 00
9.00	Occupational Therapy Assistants	0	0		0.00		9. 00
10.00	Occupational Therapy Aides	57, 242	14, 047		i i	1	10.00
11.00	Speech Therapists	34, 544	8, 477		602. 97		11. 00
12.00	Respiratory Therapists	39, 492	9, 691				
13. 00	Other Medical Staff	291, 377	71, 504	362, 881	4, 508. 85	80. 48	13. 00
	Contract Labor						
14.00	Nursing Occupations	14 701		14 701	24/ 00	(0.00	14.00
14. 00	Registered Nurses (RNs)	14, 781		14, 781	246.00		14. 00 15. 00
15.00	Licensed Practical Nurses (LPNs)	121, 907		121, 907	i i		
16. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	116, 608		116, 608	3, 644. 00	32.00	16. 00
17. 00	Total Nursing (sum of lines 14 through 16)	253, 296		253, 296	6, 328. 00	40 03	17. 00
18. 00	Physical Therapists	200, 270		0	0, 00	1	18. 00
19. 00	Physical Therapy Assistants			0	0.00		19. 00
20. 00	Physical Therapy Aides	0			0.00		
21. 00	Occupational Therapists			0	0.00		
22. 00	Occupational Therapy Assistants	0		0	0.00	1	
23. 00	Occupational Therapy Aides	0		l o	0.00		
24. 00	Speech Therapists			1 0	0.00		
25. 00	Respiratory Therapists			l o	0.00	1	
	Other Medical Staff	o		0			26.00
	•	. '		•		. '	

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 1:57 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

PB2

PB1

PA₂

73.00

74. 00 75. 00

73.00

74.00

75. 00

Health Financial Systems	SHORES AT WESLEY	MANOR		In Lie	u of Form CMS-	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315394	Peri od:	Worksheet S-	7
				From 07/01/2022 To 06/30/2023	Date/Time Pro	enared:
					11/30/2023 1:	
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL						100. 00
			Expenses	Percentage	Y/N	
			1.00	2.00	3. 00	
A notice published in the Federal Register Vopayments beginning 10/01/2003. Congress expect expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fowith direct patient care and related expenses (See instructions)	ted this increase column 1 the amou each category to ryes or "N" for n	to be used nt of the total SNF o if the s	for direct pexpense for expense from pending refle	oatient care and each category. En Worksheet G-2, P ects increases as	related Iter in Part I, Issociated	
101. 00 Staffing						101.00
102.00 Recruitment						102. 00 103. 00
103.00 Retention of employees 104.00 Training						103.00
105. 00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, lir	ne 1 column 3)					106. 00
100.00 Total Six Toveride (Worksheet 0-2, Tart 1, TT	ic i, cordilli 3)		I	I I		1100.00

Heal th	Financial Systems	SHORES AT WESL	EY MANOR		In Lie	u of Form CMS-:	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
	Cook Cooks Decoring to	C-1	0+1	T-+-1 (1 1	DI: £:+:	11/30/2023 1:	57 pm
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassificati ons	Reclassified Trial Balance	
				1 (01. 2)	Increase/Decre	(col . 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)		
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES		3, 159, 358	3, 159, 358	3 0	3, 159, 358	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		0, 107, 000	((0, 107, 000	2.00
3.00	00300 EMPLOYEE BENEFITS	0	2, 512, 889	2, 512, 889	e o	2, 512, 889	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	1, 402, 857	2, 986, 825	4, 389, 682	0	4, 389, 682	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	425, 744	1, 433, 635	1, 859, 379		1, 859, 379	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	76, 472	31, 519	107, 99		107, 991	6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	362, 098 1, 105, 676	138, 863 1, 483, 922	500, 96° 2, 589, 598		500, 961 2, 589, 598	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	1, 103, 070	1, 403, 722	2, 307, 370		2, 364, 346	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	O	Ö	(0	10.00
11. 00	01100 PHARMACY	0	0	(o	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	(o	0	12.00
13.00	01300 SOCIAL SERVICE	70, 932	0	70, 932	2 0	70, 932	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(0	0	14. 00
15. 00	O1500 ACTI VI TI ES O1501 CHAPLAI N	251, 115	36, 925	288, 040		288, 040	15.00
15. 01	INPATIENT ROUTINE SERVICE COST CENTERS	61, 897	312	62, 209	9 0	62, 209	15. 01
30. 00	03000 SKILLED NURSING FACILITY	2, 763, 852	624, 364	3, 388, 216	5 0	3, 388, 216	30.00
31. 00	03100 NURSING FACILITY	0	0	(0	31. 00
32.00	03200 CF/IID	0	0	(o o	0	32. 00
33.00	03300 OTHER LONG TERM CARE	2, 967, 674	137, 527	3, 105, 201	1 0	3, 105, 201	33. 00
10.00	ANCILLARY SERVICE COST CENTERS		0 (44	0 (1	4	0 (44	1 40 00
40.00	04000 RADI OLOGY	0	9, 644	9, 644		9, 644	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	13, 048	13, 048		13, 048 0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	39, 492	18, 873	58, 369		58, 365	43. 00
44. 00	04400 PHYSI CAL THERAPY	418, 574	143, 794	562, 368		436, 867	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	205, 542	0	205, 542	101, 124	306, 666	45. 00
46. 00	04600 SPEECH PATHOLOGY	34, 544	0	34, 54	24, 377	58, 921	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	(0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16, 575	16, 575		16, 575	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	216, 628	216, 628		216, 628 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		0	· ·		0	51.00
01.00	OUTPATIENT SERVICE COST CENTERS	0	<u> </u>		<u> </u>		01.00
60.00	06000 CLI NI C	0	0	(0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	(o o	0	61. 00
62. 00	06200 FOHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS		ما			0	70.00
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0			0	70.00
73.00		0	0	(0	71. 00 73. 00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		<u> </u>		70.00
80.00			0	(0	0	80. 00
81. 00	08100 I NTEREST EXPENSE		0	(o o	0	81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	0	0	(0	0	82. 00
83. 00	08300 H0SPI CE	0	0	00 454 474	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	10, 186, 469	12, 964, 701	23, 151, 170	<u>)</u>	23, 151, 170	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	53, 094	23, 833	76, 92	7 0	76, 927	90.00
91. 00		0	25, 555	70, 72		70, 727	91.00
92. 00	1	0	o	(ol ol	0	92. 00
	09300 NONPAID WORKERS	0	o	(이	0	93. 00
	09400 PATIENTS LAUNDRY	0	0	(이	0	94.00
100.00	D TOTAL	10, 239, 563	12, 988, 534	23, 228, 097	/ 0	23, 228, 097	1100.00

SHORES AT WESLEY MANOR In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 SHORES A

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315394

					To 06/	0ate/Time Pre 11/30/2023 1:	
	Cost Center Description	Adjustments to	Net E	xpenses		117 307 2023 1.	J7 pill
	·	Expenses (Fr	For Al	l ocati on			
		Wkst A-8)	(col	. 5 +-			
			col	1. 6)			
	T	6. 00	7	. 00			
4 00	GENERAL SERVICE COST CENTERS	1		450.050			4 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	1	, 159, 358			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	77.240	1	0			2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS	-77, 269		435, 620			3.00
5. 00	00400 ADMINISTRATIVE & GENERAL	-865, 848		, 523, 834			4. 00 5. 00
6.00	00500 PLANT OPERATION, MAINT. & REPAIRS	-23, 426	1	, 835, 953 102, 164			6.00
7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	-5, 827		500, 961			7. 00
8. 00	00800 DI ETARY	-11, 013	2	500, 981			8.00
9. 00	00900 NURSING ADMINISTRATION	-11,013	1 4	., 576, 565			9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY			0			10.00
11. 00	01100 PHARMACY			0			11. 00
	01200 MEDICAL RECORDS & LIBRARY			0			12. 00
	01300 SOCIAL SERVICE		á	70, 932			13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION		á	70, 732			14. 00
15. 00	01500 ACTIVITIES		ó	288, 040			15. 00
	01501 CHAPLAI N		1	62, 209			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS		1	02/207			10.0.
30.00	03000 SKILLED NURSING FACILITY	0) 3	, 388, 216			30.00
	03100 NURSING FACILITY	0	1	0			31. 00
	03200 CF/IID	0		0			32. 00
33. 00	03300 OTHER LONG TERM CARE	0	1	, 105, 201			33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0		9, 644			40.00
41.00	04100 LABORATORY	0		13, 048			41. 00
42.00	04200 I NTRAVENOUS THERAPY	0		0			42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0		58, 365			43. 00
44.00	04400 PHYSI CAL THERAPY	0		436, 867			44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0		306, 666			45. 00
	04600 SPEECH PATHOLOGY	0		58, 921			46. 00
	04700 ELECTROCARDI OLOGY	0		0			47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		16, 575			48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	1	216, 628			49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	1	0			50.00
51. 00	05100 SUPPORT SURFACES	0)	0			51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS		,	0			
	06000 CLINIC	0		0			60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	7	0			61.00
62. 00	OTHER REIMBURSABLE COST CENTERS						62. 00
70.00	07000 HOME HEALTH AGENCY COST	0	1	0			70. 00
	07100 AMBULANCE		1	0			71.00
	07300 CMHC			0			73.00
73.00	SPECIAL PURPOSE COST CENTERS		71	U			73.00
80 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0		0			80.00
	08100 INTEREST EXPENSE			0			81. 00
	1 1	0		0			82. 00
83. 00	08300 HOSPI CE	0		0			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-983, 383	- 1	., 167, 787			89. 00
	NONREI MBURSABLE COST CENTERS						1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		76, 927			90.00
	09100 BARBER AND BEAUTY SHOP			0			91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0		0			92. 00
	09300 NONPALD WORKERS	0		0			93. 00
	09400 PATIENTS LAUNDRY	0)	0			94. 00
100.00	TOTAL	-983, 383	3 22	, 244, 714			100. 00

Health Financial Systems	SHORES AT WESLEY	MANOR		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 07/01/2022 To 06/30/2023	Date/Time Pre	
					11/30/2023 1:	57 pm_
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
(1) A - TO RECLASS OT AND ST						
1.00	OCCUPATIONAL THERAF	γ	45.0	0 42, 068	59, 056	1.00
2. 00	SPEECH PATHOLOGY		46. 0	0 10, 141	14, 236	2.00
TOTALS						
100. 00	Total Reclassificat	ions (Sum		52, 209	73, 292	100.00
	of columns 4 and 5 must					
	equal sum of column					
	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	SHORES AT WESLEY	MANOR		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 07/01/2022		
				To 06/30/2023	Date/Time Pre	pared:
					11/30/2023 1:	57 pm
	Decreases					
	Cost Center		Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
(1) A - TO RECLASS OT AND ST						
1. 00	PHYSICAL THERAPY		44. 0	52, 209	73, 292	1.00
2. 00			0.0	0 0	0	2.00
TOTALS						
100.00				52, 209	73, 292	100.00
·				,		

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS In Lieu of Form CMS-2540-10
Worksheet A-7 SHORES AT WESLEY MANOR Peri od: From 07/01/2022 Provi der No.: 315394

					To 06/30/2023	Date/Time Prep 11/30/2023 1:	
				Acqui si ti ons		117 007 2020 11	<u>у р</u>
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	463, 497	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2. 00
3.00	Buildings and Fixtures	52, 511, 883	501, 410		0 501, 410	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fixed Equipment	3, 954, 013	221, 500		0 221, 500	0	5. 00
6.00	Movable Equipment	95, 787	0		0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	57, 025, 180	722, 910		0 722, 910	0	7. 00
8.00	Reconciling Items	0	0		0	0	8. 00
9. 00	Total (line 7 minus line 8)	57, 025, 180	722, 910		0 722, 910	0	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	463, 497	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	53, 013, 293	0				3. 00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4, 175, 513	0				5. 00
6.00	Movable Equipment	95, 787	0				6.00
7.00	Subtotal (sum of lines 1-6)	57, 748, 090	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	57, 748, 090	o				9. 00

Provi der No.: 315394

From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

				10 06/30/2023	11/30/2023 1:	
				Expense Classification on		J PIII
				To/From Which the Amount is		
				Toy I I om ann on this / mileant I o	to bo haj dotod	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	(-)	Adjustment				
		1.00	2.00	3.00	4. 00	
1. 00	Investment income on restricted funds		0		0.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter	1	0		0.00	2.00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers	В	0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)	В	-20, 001	PLANT OPERATION, MAINT. &	5.00	6. 00
				REPAI RS		
7.00	Parking Lot (chapter 21)		0		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9. 00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	23, 904			12. 00
	related organizations (chapter 10)					
13. 00	Laundry and linen service	В		LAUNDRY & LINEN SERVICE	6.00	1
14.00	Revenue - Employee meals	В	-11, 013	DI ETARY	8. 00	1
15. 00	Cost of meals - Guests		0		0.00	15. 00
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					
17. 00	Sale of drugs to other than patients		0		0.00	1
18. 00	Sale of medical records and abstracts		0		0.00	1
19. 00	Vending machines		0		0.00	1
20. 00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82. 00	22. 00
	(chapter 21)		_			
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2. 00	24. 00
05.00	MARKETING ON ARIES AND STUES			EQUI PMENT		
25. 00	MARKETING SALARIES AND OTHER	A		ADMI NI STRATI VE & GENERAL	4.00	1
25. 01	MARKETING BENEFITS	A		EMPLOYEE BENEFITS	3.00	1
25. 02	NON-ALLOWABLE EXPENSES	A		ADMINISTRATIVE & GENERAL	4.00	ł
	BED TAX ASSESSMENT	A		ADMINISTRATIVE & GENERAL	l	25. 03
25. 04	ELECTRI C REVENUE	В	-2, 065	PLANT OPERATION, MAINT. &	5. 00	25. 04
05.05			=	REPAIRS		05.05
25. 05			0		0.00	25. 05
25. 06	MALATENANOS OSBIGOS	_	0		0.00	
25. 07	MAINTENANCE SERVICE	В		PLANT OPERATION, MAINT. &	5. 00	25. 07
05.00	MI COEL LANEOUS LANOONE			REPAIRS		05.00
25. 08	MI SCELLANEOUS I NCOME	В	-82	ADMINISTRATIVE & GENERAL	4.00	25. 08
29. 00	T + 1 (C + 1 + 20) (T + 5		0		0.00	29. 00
100.00	Total (sum of lines 1 through 99) (Transfer		-983, 383	1		100. 00
	to Worksheet A, col. 6, line 100)	ļ		1	l	l

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

Health Financial Systems SHORES AT WEST STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME SHORES AT WESLEY MANOR

Provi der No.: 315394 OFFICE COSTS

011102	00010			Т	o 06/30/2023	Date/Time Pre 11/30/2023 1:	
		Line No.	Cost (Center	Expense		
		1. 00	2.	00	3. (00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR	
1.00			ADMI NI STRATI VE	& GENERAL	HOME OFFICE COS	ST	1.00
2.00		0.00					2.00
3. 00 4. 00		0. 00 0. 00	l e				3. 00 4. 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	l .				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)			
		4. 00	5 5. 00	4 00			
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR			6.00	D ODCANI ZATI ONC	ΛD	_
	CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	UF TRANSACTIO	NS WITH KELATE	D URGANIZATIONS	UK	1
1.00	CLATIMED HOME OFFICE COSTS.	1, 305, 592	1, 281, 688	23, 904			1.00
2.00		0	0	20,701			2.00
3.00		0	0	o			3. 00
4.00		0	0	0			4.00
5.00		0	0	0			5. 00
6.00		0	0	0			6. 00
7.00		0	0	0			7. 00
8.00		0	0	0			8. 00
9.00		0	0	0			9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1, 305, 592	1, 281, 688	23, 904			10.00

2.00

3.00

Symbol (1) Name Percentage of Ownershi p 1.00

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	G	UNITED METHODIST HOMES OF NJ	100.00	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	zation(s) and/	or Home Office	
Name	Percentage of Ownership	Type of Business	
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	UNITED METHODIST HOMES OF NJ	100.00 SUPPORT SERVICES	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.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315394

							7/01/2022 5/30/2023	Part I Date/Time Pre	
				CAPI TAL REL	ATED COSTS			11/30/2023 1:	o / pili
		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDGS & FIXTURES	MOVABLE EQUI PMENT		PLOYEE NEFI TS	Subtotal	
			col . 7)						
	CENED	AL CEDIUCE COST CENTEDS	0	1. 00	2. 00		3. 00	3A	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	3, 159, 358	3, 159, 358					1. 00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0			0			2. 00
3.00	1	EMPLOYEE BENEFITS	2, 435, 620	0		0 2	2, 435, 620	0 000 550	3. 00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	3, 523, 834 1, 835, 953	97, 721 25, 497		0	267, 003 104, 482	3, 888, 558 1, 965, 932	4. 00 5. 00
6. 00		LAUNDRY & LINEN SERVICE	102, 164	31, 156		0	18, 767	152, 087	6. 00
7.00		HOUSEKEEPI NG	500, 961	14, 163	1	0	88, 862	603, 986	7. 00
8. 00 9. 00	1	DIETARY NURSING ADMINISTRATION	2, 578, 585	59, 483 0		0	271, 344	2, 909, 412 0	8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	0		0	0	0	10. 00
11. 00	1	PHARMACY	0	0		0	O	0	11. 00
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	70, 932	0 7, 082		0	0 17, 407	0 95, 421	12. 00 13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION	70, 432	7,082		0	17, 407	95, 421	14. 00
15. 00		ACTI VI TI ES	288, 040	33, 986		0	61, 626	383, 652	15. 00
15. 01		CHAPLAIN ENT ROUTINE SERVICE COST CENTERS	62, 209	0		0	15, 190	77, 399	15. 01
30. 00		SKILLED NURSING FACILITY	3, 388, 216	474, 835		0	678, 277	4, 541, 328	30. 00
31. 00	03100	NURSING FACILITY	0	0		0	0	0	31. 00
32.00		OTHER LONG TERM CARE	0 3, 105, 201	2 402 403		0	729 209	6 227 102	32.00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	3, 105, 201	2, 403, 603		U	728, 298	6, 237, 102	33. 00
40.00		RADI OLOGY	9, 644	0		0	0	9, 644	40. 00
41. 00 42. 00		LABORATORY I NTRAVENOUS THERAPY	13, 048	0		0	0	13, 048 0	41. 00 42. 00
43. 00		OXYGEN (INHALATION) THERAPY	58, 365	0		0	9, 692	68, 057	42.00
44. 00	04400	PHYSI CAL THERAPY	436, 867	9, 002		0	89, 910	535, 779	44. 00
45. 00		OCCUPATIONAL THERAPY	306, 666	0		0	60, 766	367, 432	
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	58, 921	0		0	10, 966 0	69, 887 0	46. 00 47. 00
48. 00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 575	0		0	ō	16, 575	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	216, 628	0		0	0	216, 628	49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0		0	0	0	50. 00 51. 00
011.00		TIENT SERVICE COST CENTERS	9	<u> </u>			۹۱	3	01.00
60.00	1	CLINIC	0	0		0	0	0	60.00
61. 00 62. 00	06200	RURAL HEALTH CLINIC	0	0		0	0	0	61. 00 62. 00
	OTHER	REIMBURSABLE COST CENTERS							
70.00		HOME HEALTH AGENCY COST	0	0		0	0	0	
	1	AMBULANCE CMHC	0	0		0	0	0	
	SPECI	AL PURPOSE COST CENTERS	-				-		
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF							81. 00 82. 00
83. 00		HOSPI CE	0	0		0	0	0	
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	22, 167, 787	3, 156, 528		0 2	2, 422, 590	22, 151, 927	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	76, 927	0		0	13, 030	89, 957	90. 00
91. 00		BARBER AND BEAUTY SHOP	0	2, 830		0	0	2, 830	
92.00		PHYSICIANS PRIVATE OFFICES	0	0		0	0	0	92.00
93. 00 94. 00	1	NONPALD WORKERS PATIENTS LAUNDRY	0	0		0	0	0	93. 00 94. 00
98. 00	,,,,,,,,	Cross Foot Adjustments		0		o	0	0	98. 00
99.00		Negative Cost Centers	0	0		0	0	0	99.00
100.00	ון	TOTAL	22, 244, 714	3, 159, 358	I	0 2	2, 435, 620	22, 244, 714	100. 00

Peri od: Worksheet B
From 07/01/2022 Part I
To 04/20/2022 Part Jime Propagad: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315394

				T		Date/Time Pre 11/30/2023 1:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	эл рііі
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	3, 888, 558 416, 461 32, 218 127, 948	2, 382, 393 24, 448 11, 114	208, 753 0	743, 048		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8.00	00800 DI ETARY	616, 327	46, 675	0	14, 778	3, 587, 192	8. 00
9. 00 10. 00 11. 00 12. 00 13. 00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 5, 557	0 0	0 0 0 0	0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	20, 214	0, 007		1, 759	0	14. 00
15. 00 15. 01	01500 ACTIVITIES 01501 CHAPLAIN	81, 272 16, 396	26, 668 0	0	8, 444 0	0	15. 00 15. 01
10.01	I NPATIENT ROUTINE SERVICE COST CENTERS	10,070			<u> </u>	0	10.01
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	962, 030 0	372, 593 0	167, 002 0	117, 969 0	2, 757, 811 0	30. 00 31. 00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	1, 321, 271	1, 886, 054	41, 751	597, 158	0 829, 381	32. 00 33. 00
33.00	ANCILLARY SERVICE COST CENTERS	1, 321, 271	1,000,034	41,731	377, 130	027, 301	33.00
40.00	04000 RADI OLOGY	2,043	0	0	0	0	40. 00
41.00	04100 LABORATORY	2, 764	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	14, 417	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	113, 499	7, 064	0	2, 237	0	44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	77, 836	0	0	0	0	45. 00
47. 00	04700 ELECTROCARDI OLOGY	14, 805	0		0	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 511	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	45, 890	0	ő	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	_	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	0	0	61. 00 62. 00
62. 00	OTHER REIMBURSABLE COST CENTERS						62.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00							80. 00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF		0			0	82. 00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	3, 868, 902	2, 380, 173	208, 753	742, 345	0 3, 587, 192	83. 00 89. 00
67.00	NONREI MBURSABLE COST CENTERS	3, 808, 702	2, 360, 173	200, 753	742, 343	3, 307, 172	89.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	19, 056	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	600	2, 220	0	703	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	0	98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	3, 888, 558	2, 382, 393	208, 753	743, 048	0 3, 587, 192	99.00
100.00	DI LIGHT	ا ۵, ۵۵۵, ۵۵۵	∠, 30∠, 393	200, /53	143, 048	3, 301, 192	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315394 Peri od: From 07/01/2022 Part I

06/30/2023 Date/Time Prepared: 11/30/2023 1:57 pm Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON RECORDS & SERVICES & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPI NG 7.00 7 00 8.00 00800 DI ETARY 8.00 9.00 00900 NURSING ADMINISTRATION 9 00 01000 CENTRAL SERVICES & SUPPLY 00000 10.00 10.00 01100 PHARMACY 11.00 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 13.00 01300 SOCIAL SERVICE 0 122, 951 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 0 0 15.00 01500 ACTI VI TI ES C 0 0 15.00 15.01 01501 CHAPLAI N 0 15.01 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 SKILLED NURSING FACILITY 0 0 122, 951 30.00 C 31.00 03100 NURSING FACILITY C 0 0 31.00 03200 | CF/IID 0 0 0 32.00 0 0 32.00 0 03300 OTHER LONG TERM CARE 0 33.00 0 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 0 40.00 04100 LABORATORY 41.00 0000000000 0 0 0 0 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY Ω 0 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 0 44.00 04500 OCCUPATIONAL THERAPY 0 45.00 0 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 0 0 0 48.00 49 00 04900 DRUGS CHARGED TO PATIENTS Ω 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 0 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 OUTPATIENT SERVICE COST CENTERS 60 00 0 n O 60 00 06000 CLI NI C 0 0 06100 RURAL HEALTH CLINIC 61.00 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 83.00 0 0 0 SUBTOTALS (sum of lines 1-84) 122, 951 0 89.00 0 0 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 000000 91.00 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 93.00 0 09400 PATIENTS LAUNDRY 0 94.00 94.00 0 0

0

0

98 00

99.00

122, 951 100. 00

98.00

99.00

100.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL

| Peri od: | Worksheet B | From 07/01/2022 | Part | | To 06/30/2023 | Date/Time Prepared: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315394

				T	06/30/2023	Date/Time Pre 11/30/2023 1:	
			OTHER GENER	RAL SERVICE		1173072023 1.	J7 pili
			OTTIER GENE	WIE SERVICE			
	Cost Center Description	NURSING AND	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Stepdown	
	·	ALLI ED HEALTH				Adjustments	
		EDUCATI ON					
		14. 00	15. 00	15. 01	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS			I		T	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	OO5OO PLANT OPERATION, MAINT. & REPAIRS OO6OO LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7.00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13.00	01300 SOCIAL SERVICE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15.00	01500 ACTI VI TI ES	0	500, 036				15. 00
15. 01	01501 CHAPLAI N	0	0	93, 795			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS					_	
30.00	03000 SKILLED NURSING FACILITY	0	500, 036		9, 570, 303		30.00
31. 00	03100 NURSING FACILITY	0	0	_	0	1	31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0		10, 977, 929	0	32. 00 33. 00
33.00	ANCILLARY SERVICE COST CENTERS	l o	0	05, 212	10, 977, 929	0	33.00
40. 00	04000 RADI OLOGY	0	0	0	11, 687	0	40. 00
41. 00	04100 LABORATORY	0	0		15, 812	-	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	o	0	Ö	.0,0.2		42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	O	0	Ō	82, 474	-	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	0	658, 579		44. 00
45.00	04500 OCCUPATI ONAL THERAPY	O	0	0	445, 268	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	0	84, 692	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	-	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20, 086		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	262, 518		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	-	50.00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
60. 00	OUTPATIENT SERVICE COST CENTERS O6000 CLINIC	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0		0		61.00
62. 00	06200 FQHC		O		0	0	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	0	0		0		71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	_	_	_	_	_	82. 00
83.00	08300 H0SPI CE	0	0	_	0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	500, 036	93, 795	22, 129, 348	0	89. 00
90. 00	NONREI MBURSABLE COST CENTERS O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0		109, 013	0	90.00
90.00	09100 BARBER AND BEAUTY SHOP		0	0	6, 353		90.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	ا	0	1	0, 333 N	0	92.00
93. 00	09300 NONPAID WORKERS		0	ا م	n	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	l ől	0	ا o	0	Ö	94. 00
98. 00	Cross Foot Adjustments		0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	TOTAL	0	500, 036	93, 795	22, 244, 714	0	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2540-10 SHORES AT WESLEY MANOR Provi der No.: 315394

| Peri od: | Worksheet B | From 07/01/2022 | Part I | To 06/30/2023 | Date/Time Prepared:

			11/30/2023 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/2022 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/202 11/30/	
	Cost Center Description	Total	117 667 2020 11	J , p
	'	18. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			6. 00
7.00	00700 HOUSEKEEPI NG			7. 00
8.00	00800 DI ETARY			8. 00
9.00	00900 NURSING ADMINISTRATION			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00	01100 PHARMACY			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY			12.00
13.00	01300 SOCIAL SERVICE			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15.00	01500 ACTI VI TI ES			15. 00
15. 01	01501 CHAPLAI N			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 SKILLED NURSING FACILITY	9, 570, 303		30. 00
31.00	03100 NURSING FACILITY	0		31.00
32.00	03200 CF/IID	0		32. 00
33.00	03300 OTHER LONG TERM CARE	10, 977, 929		33.00
	ANCILLARY SERVICE COST CENTERS			
40.00	04000 RADI OLOGY	11, 687		40. 00
41.00	04100 LABORATORY	15, 812		41. 00
42.00	04200 I NTRAVENOUS THERAPY	o		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	82, 474		43.00
44.00	04400 PHYSI CAL THERAPY	658, 579		44.00
	04500 OCCUPATI ONAL THERAPY	445, 268		45. 00
46.00	04600 SPEECH PATHOLOGY	84, 692		46. 00
	04700 ELECTROCARDI OLOGY	0		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 086		48. 00
	04900 DRUGS CHARGED TO PATIENTS	262, 518		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	O		50.00
	1 1	o		51.00
	OUTPATIENT SERVICE COST CENTERS			
60.00	06000 CLI NI C	0		60.00
61.00	06100 RURAL HEALTH CLINIC	o		61. 00
62.00	06200 FQHC			62. 00
	OTHER REIMBURSABLE COST CENTERS			
70.00	07000 HOME HEALTH AGENCY COST	0		70. 00
71.00	07100 AMBULANCE	0		71. 00
73.00	07300 CMHC	0		73. 00
	SPECIAL PURPOSE COST CENTERS			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
81.00	08100 I NTEREST EXPENSE			81. 00
82.00	08200 UTILIZATION REVIEW - SNF			82. 00
83.00	08300 H0SPI CE	0		83. 00
89.00	SUBTOTALS (sum of lines 1-84)	22, 129, 348		89. 00
	NONREI MBURSABLE COST CENTERS			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	109, 013		90. 00
91.00	09100 BARBER AND BEAUTY SHOP	6, 353		91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0		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		22, 244, 714		100. 00
		·		

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315394

				1	Го 06/30/2023	Date/Time Pre 11/30/2023 1:	pared:
			CAPI TAL REI	LATED COSTS		11/30/2023 1.	37 pili
	Cost Center Description	Dimontly	DI DCC ®	MOVABLE	Cubtatal	EMPLOYEE	
	cost center bescription	Directly Assigned New	BLDGS & FIXTURES	MOVABLE EQUI PMENT	Subtotal	BENEFI TS	
		Capi tal					
		Related Costs		0.00	0.4		
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	2A	3.00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES					I	1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	(o c	0	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	97, 721		97, 721	1	4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0	25, 497 31, 156		25, 497 31, 156	1	5. 00 6. 00
7. 00	00700 HOUSEKEEPING	0	14, 163		14, 163	1	7. 00
8. 00	00800 DI ETARY	o	59, 483		59, 483	1	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	(o c	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	(0	0	10.00
11. 00 12. 00	O1100 PHARMACY O1200 MEDI CAL RECORDS & LI BRARY	0	0	(0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	0	7, 082		7, 082		13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	1	0 0	1	14. 00
15. 00	01500 ACTI VI TI ES	0	33, 986	(33, 986	0	15. 00
15. 01	01501 CHAPLAI N	0	0	(O C	0	15. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY		474 O2E	Ι ,	474, 835	0	30. 00
31. 00	03100 NURSING FACILITY	0	474, 835 0		0 474, 835 0 0	1	31. 00
32. 00	03200 CF/IID	o	0	•		1	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	2, 403, 603	(2, 403, 603	0	33. 00
	ANCILLARY SERVICE COST CENTERS			T .	-T	1 -	
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0	•		1	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0			_	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	o	0			Ö	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	9, 002		9, 002	. 0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	(45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY		0			0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			ő	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	(o c	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		o c		50. 00
51. 00	05100 SUPPORT SURFACES	0	0	(O C	0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0		ol c	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0			1	61. 00
62. 00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS			1	_1	1 -	
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	•			70. 00 71. 00
71.00	07300 CMHC		0			•	71.00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>		70.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 INTEREST EXPENSE						81. 00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	o	0			0	82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	3, 156, 528	•	3, 156, 528	1	89. 00
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	0, 100, 020		5, 5, 100, 020		07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		C	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	2, 830	(2, 830	1	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0]		0	92. 00 93. 00
94.00	09400 PATI ENTS LAUNDRY		0				94.00
98. 00	Cross Foot Adjustments		9	Ì	ď	ol .	98. 00
99. 00	Negative Cost Centers		0		o c	0	
100.00	TOTAL	0	3, 159, 358	(3, 159, 358	0	100. 00

Health Financial Systems SHORES AT WESLEY MANOR In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315394 Peri od: Worksheet B From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/30/2023 1:57 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3 00 00400 ADMINISTRATIVE & GENERAL 97, 721 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 10, 467 35, 964 5.00 00600 LAUNDRY & LINEN SERVICE 810 32, 335 6.00 369 00700 HOUSEKEEPI NG 3.216 168 C 17, 547 7.00 00800 DI ETARY 15, 490 705 0 349 76, 027 8.00 00900 NURSING ADMINISTRATION 0 9.00 0 01000 CENTRAL SERVICES & SUPPLY 0 Λ 0 0 10.00 Ω 01100 PHARMACY 0 C 0 0 11.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 01300 SOCIAL SERVICE 508 84 0 13.00 42 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C 0 0 14.00 01500 ACTIVITIES 2,043 403 0 199 0 15.00 01501 CHAPLAI N 412 0 0 15.01 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 24, 178 5, 625 25,868 2, 786 58, 449 30.00 03100 NURSING FACILITY 31.00 0 03200 | CF/IID 32.00 0

MCRI F32 - 10. 15. 177. 0

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared:

			To	06/30/2023	Date/Time Prep 11/30/2023 1:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	J7 piii
p	ADMI NI STRATI ON	SERVICES &	-	RECORDS &		
		SUPPLY		LI BRARY		
	9. 00	10. 00	11. 00	12. 00	13. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3. 00 00300 EMPLOYEE BENEFITS						3. 00
4. 00 00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00 00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00 00700 HOUSEKEEPI NG						7. 00
8. 00 00800 DI ETARY 9. 00 00900 NURSI NG ADMI NI STRATI ON						8. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY		0				9. 00 10. 00
11. 00 01100 PHARMACY		0	0			11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY		0	0	0		12. 00
13. 00 01300 SOCIAL SERVICE		0	0	0	7, 716	13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION		0	0	ol Ol	7, 710	14. 00
15. 00 01500 ACTIVITIES		0	0	ol Ol	0	15. 00
15. 01 01501 CHAPLAI N		Ö	0	ol	0	15. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>		0	10.01
30. 00 03000 SKI LLED NURSI NG FACI LI TY	0	0	0	O	7, 716	30. 00
31. 00 03100 NURSING FACILITY	o	o	0	ol	0	31. 00
32. 00 03200 CF/IID	o	o	0	ol	0	32. 00
33.00 03300 OTHER LONG TERM CARE	O	0	0	o	0	33. 00
ANCI LLARY SERVI CE COST CENTERS		-,	- "	· .		
40. 00 04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00 04100 LABORATORY	0	0	0	o	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	o	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	o	0	43.00
44.00 04400 PHYSI CAL THERAPY	0	0	0	O	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00 O4900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
OUTPATIENT SERVICE COST CENTERS		-1		_1		
60. 00 06000 CLI NI C	0	0	0	0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 06200 FQHC						62. 00
OTHER REIMBURSABLE COST CENTERS		ما	0	٥	0	70.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 07100 AMBULANCE 73. 00 07300 CMHC	0	0	0	0	0	71. 00 73. 00
SPECIAL PURPOSE COST CENTERS	J V	U _I	U	υ	U	73.00
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00 08100 INTEREST EXPENSE						81. 00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF		•				82. 00
83. 00 08300 HOSPI CE	o	0	0	О	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)		ő	Ö	ő		89. 00
NONREI MBURSABLE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>	777.10	07.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	O	0	0	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	o	ol	Ö	ol	0	91. 00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	0	o	0	o	0	92.00
93. 00 09300 NONPALD WORKERS	0	o	0	o	0	93. 00
94.00 09400 PATIENTS LAUNDRY	0	o	0	o	0	94.00
98.00 Cross Foot Adjustments	0	o	0			98. 00
99.00 Negative Cost Centers	O	o	0	o	0	99. 00
100. 00 TOTAL	o	O	0	o	7, 716	100. 00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315394

						То	06/30/2023	Date/Time Prep 11/30/2023 1:	
				OTHER GENER	RAL SERVICE			11/30/2023 1.	37 pili
		Cost Center Description	NURSING AND	ACTI VI TI ES	CHAPLAI N		Subtotal	Post Step-Down	
			ALLIED HEALTH EDUCATION					Adjustments	
			14. 00	15. 00	15. 01		16. 00	17. 00	
		AL SERVICE COST CENTERS							
1.00		CAP REL COSTS - BLDGS & FIXTURES							1. 00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS							2. 00
4. 00	1	ADMINISTRATIVE & GENERAL							3. 00 4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS							5. 00
6.00	1	LAUNDRY & LINEN SERVICE							6. 00
7.00	1	HOUSEKEEPI NG							7. 00
8.00	00800	DI ETARY							8.00
9.00		NURSING ADMINISTRATION							9. 00
10.00		CENTRAL SERVICES & SUPPLY							10.00
11.00	1	PHARMACY							11. 00
12. 00 13. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE							12. 00 13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0						14. 00
15. 00	1	ACTIVITIES	0	36, 631					15. 00
15. 01	1	CHAPLAI N	0	0		412			15. 01
		ENT ROUTINE SERVICE COST CENTERS							
30.00	1	SKILLED NURSING FACILITY	0	36, 631		126	636, 214	0	30.00
31. 00		NURSING FACILITY	0	0		0	0	0	31. 00
32.00	1	ICF/IID	0	0		0	0 502 704	0	32. 00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	l O	0		286	2, 503, 704	0	33. 00
40. 00		RADI OLOGY	0	0		0	51	0	40. 00
41. 00	1	LABORATORY	ő	0		0	69	0	41. 00
42.00	1	INTRAVENOUS THERAPY	0	0		0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	O	0		0	362	0	43.00
44. 00		PHYSI CAL THERAPY	0	0		0	12, 014	0	44.00
45. 00	1	OCCUPATIONAL THERAPY	0	0		0	1, 956	0	45. 00
46. 00 47. 00	1	SPEECH PATHOLOGY	0	0		0	372 0	0	46. 00 47. 00
48. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	88	0	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0		0	1, 153	o o	49. 00
50. 00		DENTAL CARE - TITLE XIX ONLY	o	0	•	0	0	0	50. 00
51.00		SUPPORT SURFACES	0	0		0	0	0	51.00
		TIENT SERVICE COST CENTERS							
60.00	1	CLINIC	0	0		0	0	0	60.00
61.00	1	RURAL HEALTH CLINIC	0	0		0	0	0	61.00
62. 00	06200	REIMBURSABLE COST CENTERS							62. 00
70. 00		HOME HEALTH AGENCY COST	0	0		0	0	0	70. 00
71.00	1	AMBULANCE	ő	0		0	Ö	0	71. 00
73. 00	07300		0	0		0	0	0	73. 00
		AL PURPOSE COST CENTERS							
80.00		MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81. 00		I NTEREST EXPENSE							81. 00
82.00	1	UTILIZATION REVIEW - SNF	0	0		0	0	0	82. 00 83. 00
83. 00 89. 00	08300	HOSPICE SUBTOTALS (sum of lines 1-84)	0	36, 631		412	3, 155, 983	0	89. 00
57.00	NONRF	IMBURSABLE COST CENTERS	<u> </u>	30, 031			5, 155, 765	U	37.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	479	0	90.00
91.00		BARBER AND BEAUTY SHOP	o	0		0	2, 896	0	91.00
92.00		PHYSICIANS PRIVATE OFFICES	0	0		0	0	0	92.00
93.00	1	NONPAID WORKERS	0	0		0	0	0	93.00
94. 00 98. 00	09400	PATIENTS LAUNDRY		0		U	0	0	94. 00 98. 00
98.00		Cross Foot Adjustments Negative Cost Centers		O O		0	0	0	
100.00		TOTAL		36, 631		412	3, 159, 358		100.00
	1	ı	۱	,,	1	-1	,	٦	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS SHORES AT WESLEY MANOR

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: | Provi der No.: 315394

			10 06/30/2023 Date/Time Pre	
	Cost Center Description	Total	117 307 2023 1.	57 piii
	5551 551151 55551 Pt. 511	18. 00		
	GENERAL SERVICE COST CENTERS	10.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS			1
	1			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			6.00
7.00	00700 HOUSEKEEPI NG			7. 00
8.00	00800 DI ETARY			8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON			9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00	01100 PHARMACY			11. 00
	01200 MEDICAL RECORDS & LIBRARY			12. 00
13. 00	01300 SOCI AL SERVI CE			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	01500 ACTI VI TI ES			15. 00
15. 01	01501 CHAPLAI N			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			1
30.00	03000 SKILLED NURSING FACILITY	636, 214		30.00
31.00	03100 NURSING FACILITY	0		31.00
32.00	03200 CF/IID	o		32.00
33.00	03300 OTHER LONG TERM CARE	2, 503, 704		33. 00
	ANCILLARY SERVICE COST CENTERS	,		1
40.00	04000 RADI OLOGY	51		40. 00
41. 00	04100 LABORATORY	69		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0		42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	362		43. 00
44. 00	04400 PHYSI CAL THERAPY	12, 014		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	1, 956		45. 00
46. 00	04600 SPEECH PATHOLOGY	372		46. 00
	04700 ELECTROCARDI OLOGY	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	88		48. 00
	1	1		1
	04900 DRUGS CHARGED TO PATIENTS	1, 153		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	05100 SUPPORT SURFACES	0		51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS			(0.00
60.00	06000 CLINIC	0		60.00
61.00	06100 RURAL HEALTH CLINIC	0		61.00
62. 00	06200 FOHC			62. 00
70.00	OTHER REIMBURSABLE COST CENTERS			70.00
70. 00	07000 HOME HEALTH AGENCY COST	0		70.00
71.00	07100 AMBULANCE	0		71.00
73. 00	07300 CMHC	0		73. 00
	SPECIAL PURPOSE COST CENTERS			
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81. 00	08100 I NTEREST EXPENSE			81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	_		82. 00
83. 00	08300 H0SPI CE	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	3, 155, 983		89. 00
	NONREI MBURSABLE COST CENTERS			1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	479		90.00
91. 00	09100 BARBER AND BEAUTY SHOP	2, 896		91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0		92. 00
93.00	09300 NONPALD WORKERS	0		93. 00
94.00	09400 PATIENTS LAUNDRY	o		94.00
98.00	Cross Foot Adjustments	o		98. 00
99. 00	Negative Cost Centers	0		99. 00
100.00	1 1 3	3, 159, 358		100.00
	•			•

Heal th	Fi nan	cial Systems	SHORES AT WE	SLEY	MANOR		In Lie	u of Form CMS-	2540-10
COST A	LLOCAT	TION - STATISTICAL BASIS	Provi der No.				Worksheet B-1		
							From 07/01/2022 Fo 06/30/2023	Date/Time Pre	pared:
								11/30/2023 1:	57 pm
			CAPITAL REL	_ATED	COSTS				
		Cost Center Description	BLDGS &	M	OVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		oost denter beserretren	FIXTURES		UI PMENT	BENEFITS	neconcili del on	& GENERAL	
			(SQUARE FEET)	(\$ VA	ALUE OR SC	(GROSS		(ACCUM COST)	
					FT)	SALARI ES)			
	CENED	AL CEDVICE COST CENTERS	1.00		2.00	3.00	4A	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FLXTURES	215, 483						1.00
2. 00	1	CAP REL COSTS - MOVABLE EQUIPMENT	213, 403		C				2.00
3. 00		EMPLOYEE BENEFITS	0		C	9, 924, 69!	5		3. 00
4.00	00400	ADMINISTRATIVE & GENERAL	6, 665		C	1, 087, 989	-3, 888, 558	18, 356, 156	4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS	1, 739		C	425, 74		1, 965, 932	
6.00		LAUNDRY & LINEN SERVICE	2, 125		C	76, 472		152, 087	
7.00		HOUSEKEEPI NG	966		C	362, 098		603, 986	
8. 00 9. 00		DI ETARY NURSI NG ADMI NI STRATI ON	4, 057		(1, 105, 67	0	2, 909, 412 0	1
		CENTRAL SERVICES & SUPPLY	0		0			0	1
		PHARMACY	0		C		o o	0	1
		MEDICAL RECORDS & LIBRARY	0		C		0	0	12. 00
	1	SOCIAL SERVICE	483		C	70, 932	2 0	95, 421	13. 00
		NURSING AND ALLIED HEALTH EDUCATION	0		C	054 44	0	0	
	1	ACTIVITIES CHAPLAIN	2, 318			251, 11! 61, 89		383, 652 77, 399	1
15. 01		IENT ROUTINE SERVICE COST CENTERS	J O			01,09	0	11, 399	15.01
30. 00		SKILLED NURSING FACILITY	32, 386		C	2, 763, 852	2 0	4, 541, 328	30.00
		NURSING FACILITY	0		C	, , , , ,		0	31.00
		ICF/IID	0		C		0	0	
33. 00		OTHER LONG TERM CARE	163, 937		C	2, 967, 67	1 0	6, 237, 102	33. 00
40.00		LARY SERVICE COST CENTERS				.I		0.744	40.00
		RADI OLOGY LABORATORY	0		C	1	0 0	9, 644 13, 048	1
		INTRAVENOUS THERAPY	0					13, 048	1
		OXYGEN (INHALATION) THERAPY	O		C	39, 49	2 0	68, 057	1
		PHYSI CAL THERAPY	614		C	366, 36!	5 0	535, 779	•
		OCCUPATI ONAL THERAPY	0		C	247, 610		367, 432	•
		SPEECH PATHOLOGY	0		C	44, 68		69, 887	•
		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0					0 16, 575	
		DRUGS CHARGED TO PATIENTS	0					216, 628	
		DENTAL CARE - TITLE XIX ONLY	0		C		o o	0	1
		SUPPORT SURFACES	0		C	1	o o	0	
		TIENT SERVICE COST CENTERS							
		CLI NI C	0		C	1	0	0	
	1	RURAL HEALTH CLINIC	0		C	9	0	0	
62. 00	06200	REIMBURSABLE COST CENTERS							62.00
70. 00	-	HOME HEALTH AGENCY COST	0			1	0	0	70. 00
		AMBULANCE	0		C		o o	0	71.00
73.00	07300		0		C	(0	0	73. 00
		AL PURPOSE COST CENTERS							
	1	MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF							81. 00 82. 00
83. 00	1	HOSPICE	0		(,	0	0	1
89. 00		SUBTOTALS (sum of lines 1-84)	215, 290		C	9, 871, 60 ⁻	-		1
	NONRE	MBURSABLE COST CENTERS]
		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		C	53, 094		89, 957	
		BARBER AND BEAUTY SHOP	193		C		0	2, 830	•
		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS	0				0	0	1
94.00	1	PATIENTS LAUNDRY	0					0	1
98. 00	07100	Cross Foot Adjustments				`		9	98.00
99. 00		Negative Cost Centers							99.00
102.00		Cost to be allocated (per Wkst. B,	3, 159, 358		C	2, 435, 620		3, 888, 558	102. 00
100.00		Part I)	14 //475		0.000000	0.045.11		0.044633	100.00
103. 00 104. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	14. 661751		0. 000000	0. 245410		0. 211839 97 721	1
104.00		Part II)						91, 121	104. 00
105.00		Unit cost multiplier (Wkst. B, Part				0. 000000		0. 005324	105.00
		II)							

Provi der No.: 315394

| Peri od: | Worksheet B-1 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

				T	0 06/30/2023	Date/Time Pre 11/30/2023 1:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	J7 piii
	'	OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(POUNDS OF			(DI DEOT	
		REPAIRS	LAUNDRY)			(DI RECT NURSI NG)	
		(SQUARE FEET) 5.00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	2.00			2.22		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00 5. 00	OO4OO ADMINISTRATIVE & GENERAL OO5OO PLANT OPERATION, MAINT. & REPAIRS	207, 079					4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	2, 125	1				6.00
7. 00	00700 HOUSEKEEPING	966		203, 988			7. 00
8.00	00800 DI ETARY	4, 057	0	4, 057			8. 00
9.00	00900 NURSING ADMINISTRATION	0	0	0	0	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00	01100 PHARMACY	0	0	0	0	0	11.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	483	0	483	0	0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	٥	0	o	0	14. 00
15. 00	01500 ACTIVITIES	2, 318	0	2, 318	0	0	15. 00
15. 01	01501 CHAPLAI N	0	0	0	0	0	15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	32, 386	1	32, 386		0	30.00
31. 00 32. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00 32. 00
32.00	03300 OTHER LONG TERM CARE	163, 937	40, 966	163, 937	18, 112	0	33. 00
33. 00	ANCI LLARY SERVI CE COST CENTERS	103, 737	1 40, 700	103, 737	10, 112		33.00
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	1	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	1	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	614	0	614	0	0	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	Ō	Ō	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	1	1	0	0	50.00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	51.00
60. 00	06000 CLINIC	0	0	0		0	60.00
61.00	06100 RURAL HEALTH CLINIC	0		0	0	0	61.00
62. 00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS	1		1			
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0				0	70. 00 71. 00
73.00	07300 CMHC				0	0	•
70.00	SPECIAL PURPOSE COST CENTERS						70.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF					0	82. 00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	206, 886	204, 830	203, 795	78, 337	0	83. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	200, 880	204, 830	203, 793	70, 337	0	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	193	0	193	0	0	91. 00
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	1	0	0	92. 00
93. 00	09300 NONPAI D WORKERS	0	0	0	0	0	93. 00
94. 00 98. 00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0	0	U	0	94. 00 98. 00
99. 00	Negative Cost Centers	1					99.00
102.00		2, 382, 393	208, 753	743, 048	3, 587, 192	0	102. 00
	Part I)						
103.00		11. 504754		1		0. 000000	1
104.00		35, 964	32, 335	17, 547	76, 027	0	104. 00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 173673	0. 157863	0. 086020	0. 970512	0. 000000	105. 00
. 55. 50	II)	3. 170070	2. 107303	3.000020	3. 770012	3. 000000	
					•		

	N FINANCIAL SYSTEMS	SHORES AT WES		No.: 315394 F		Workshoot P 1	
COST	ALLOCATION - STATISTICAL BASIS		Provider	F	Period: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Pre	
	Cost Contag Decement on	CENTRAL	DHADMACV			11/30/2023 1:	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	NURSING AND ALLIED HEALTH	
		SUPPLY (COSTED	REQUIS)	LIBRARY (TIME SPENT)	(PATIENT DAYS)	EDUCATION (ASSI GNED	
		REQUIS)		, ,		TIME)	
	GENERAL SERVICE COST CENTERS	10. 00	11. 00	12. 00	13. 00	14. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	1					2. 00 3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10.00	+ I	0					10.00
11.00		0	0				11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0	0		18, 590		12. 00 13. 00
14. 00		0	0	C	0	0	
15. 00 15. 01	01500 ACTI VI TI ES 01501 CHAPLAI N	0	0		-	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		0	0			0	30.00
	03200 CF/IID	0	0	Č		0	
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	C	0	0	33. 00
40. 00		0	0	C	0	0	40. 00
41.00	1	0	0	(0	
42.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	0	0			0	42. 00 43. 00
	04400 PHYSI CAL THERAPY	0	0	C	0	0	44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0			0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	C	0	0	47. 00
48. 00 49. 00		0	0		0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	Ö	0	C	0	0	50. 00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	(0	0	51.00
60. 00	06000 CLI NI C	0		C	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	C	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	I I	0	0	_		0	
	07100 AMBULANCE	0 0	0		0		71. 00 73. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	1 1			_			82. 00
83. 00 89. 00	1	0 0	0			0	
	NONREI MBURSABLE COST CENTERS						
90. 00 91. 00	1 1 1	0 0	0			0	
92. 00	09200 PHYSICIANS PRIVATE OFFICES	O	0	C	0	0	92. 00
93. 00 94. 00	· · · · · · · · · · · · · · · · · · ·	0	0		0	0	
98. 00	Cross Foot Adjustments	1	_			_	98. 00
99. 00 102. 00	1 1 9	0	0		122, 951	0	99. 00 102. 00
	Part I)		0				
103. 00 104. 00		0. 000000	0. 000000	0. 000000	6. 613825 7, 716	0. 000000	103. 00 104. 00
	Part II)		0				
105.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 415062	0. 000000	105. 00
	1	ı		1	1		1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2540-10 SHORES AT WESLEY MANOR

| Peri od: | Worksheet B-1 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: Provi der No.: 315394

					10	06/30/2023	11/30/2023 1:57 p	
			OTHER GENER	RAL SERVICE			.,, ., .,	
		Cost Contor Description	ACTIVITIES	CHAPLAI N				
		Cost Center Description	(PATIENT DAYS)					
			15. 00	15. 01				
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS - BLDGS & FIXTURES					1	. 00
2. 00 3. 00	1	CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS						2. 00 3. 00
4. 00	1	ADMINISTRATIVE & GENERAL						1. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS					5	5. 00
6.00		LAUNDRY & LINEN SERVICE					1	5. 00
7. 00 8. 00		HOUSEKEEPI NG DI ETARY					1	7. 00 3. 00
9. 00	1	NURSING ADMINISTRATION					ı	9. 00
10.00	1	CENTRAL SERVICES & SUPPLY						0. 00
11. 00	1	PHARMACY					ı	. 00
12.00	1	MEDICAL RECORDS & LIBRARY					ı	2. 00
13. 00 14. 00		SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION					ı	3. 00 1. 00
15. 00	1	ACTIVITIES	18, 590				ı	5. 00
15. 01		CHAPLAI N	0	61, 002			15	5. 01
00.00		I ENT ROUTI NE SERVI CE COST CENTERS	10 500	40.500	T		20	
30. 00 31. 00	1	SKILLED NURSING FACILITY NURSING FACILITY	18, 590	18, 590 0	1		ı). 00 . 00
32. 00		ICF/IID		0	•		ı	2. 00
33. 00	03300	OTHER LONG TERM CARE	0	42, 412			33	3. 00
		LARY SERVICE COST CENTERS	T		T			
40.00	1	RADI OLOGY	0	0	1		l	0.00
41. 00 42. 00	1	LABORATORY INTRAVENOUS THERAPY	0	0	i .		l	1. 00 2. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	O	0	ł		l	3. 00
44.00	1	PHYSI CAL THERAPY	O	0			1	1. 00
45. 00	1	OCCUPATIONAL THERAPY	0	0	1		1	5. 00
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	ł		•	6. 00 7. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	1		1	3. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	o	0			1	9. 00
50.00	1	DENTAL CARE - TITLE XIX ONLY	0	0	•		ı	0. 00
51. 00		SUPPORT SURFACES TIENT SERVICE COST CENTERS	0	0			51	. 00
60. 00		CLINIC	l ol	0			60	0. 00
61. 00	1	RURAL HEALTH CLINIC	o	0	i e		ı	. 00
62. 00	06200						62	2. 00
70.00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	l ol	0	I		70	
70. 00 71. 00		AMBULANCE	0	0	•		ı). 00 . 00
73. 00	07300	l e e e e e e e e e e e e e e e e e e e	0	0			ı	3. 00
		AL PURPOSE COST CENTERS			·			
		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE). 00 . 00
82. 00		UTILIZATION REVIEW - SNF					ı	2. 00
83. 00	1	HOSPI CE	o	0				3. 00
89. 00		SUBTOTALS (sum of lines 1-84)	18, 590	61, 002			89	9. 00
00.00		I MBURSABLE COST CENTERS	l					
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0	0	1		l). 00 . 00
92. 00		PHYSICIANS PRIVATE OFFICES	O	0	•			2. 00
93. 00	1	NONPALD WORKERS	0	0	1			3. 00
94.00	09400	PATIENTS LAUNDRY	0	0				1.00
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers					•	3. 00 9. 00
102.00		Cost to be allocated (per Wkst. B,	500, 036	93, 795			•	2. 00
		Part I)						
103.00	1	Unit cost multiplier (Wkst. B, Part I)	26. 898117	1. 537573	1			3. 00
104.00	,	Cost to be allocated (per Wkst. B, Part II)	36, 631	412			104	1. 00
105.00)	Unit cost multiplier (Wkst. B, Part	1. 970468	0. 006754			105	5. 00
		11)						

	0050 AT W50151				6.5. 040.6	
	ORES AT WESLEY				u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT CO	OST CENTERS	Provi der		Peri od:	Worksheet C	
				From 07/01/2022 To 06/30/2023	Date/Time Pre	oorod.
				10 00/30/2023	11/30/2023 1:	57 nm
Cost Center Description			Total (from	Total Charges	Ratio (col. 1	or piii
0001 0011101 20001 pti 011			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			11, 68	7, 064	1. 654445	40.00
41. 00 04100 LABORATORY			15, 81	2 15, 669	1. 009126	41.00
42.00 04200 INTRAVENOUS THERAPY				0 0	0. 000000	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY			82, 47	4 58, 365	1. 413073	43.00
44. 00 04400 PHYSI CAL THERAPY			658, 57	9 647, 662	1. 016856	44.00
45. 00 04500 OCCUPATI ONAL THERAPY			445, 26	8 542, 514	0. 820749	45.00
46. 00 04600 SPEECH PATHOLOGY			84, 69	2 130, 802	0. 647482	46.00
47. 00 04700 ELECTROCARDI OLOGY				0 0	0. 000000	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			20, 08	16, 575	1. 211825	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS			262, 51	8 218, 179	1. 203223	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY				0 0	0. 000000	50.00
51.00 05100 SUPPORT SURFACES				0 0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C				0 0	0.000000	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62. 00
71. 00 07100 AMBULANCE				0 0	0. 000000	71. 00
100. 00 Total			1, 581, 11	6 1, 636, 830		100. 00

Health Financial Systems	SHORES AT WE				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od: From 07/01/2022	Worksheet D Part I	
				To 06/30/2023		narod.
				10 00/30/2023	11/30/2023 1:	57 pm
		Title	XVIII (1)	Skilled Nursing		
			, ,	Facility		
		Health Care Pr	ogram Charges	Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					1
ANCILLARY SERVICE COST CENTERS			T		Г	-
40. 00 04000 RADI OLOGY	1. 654445			0 10, 208	•	
41. 00 04100 LABORATORY	1. 009126			0 14, 407	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 413073			0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 016856			0 355, 606	•	1
45. 00 04500 OCCUPATI ONAL THERAPY	0. 820749			0 292, 784	l	
46. 00 04600 SPEECH PATHOLOGY	0. 647482			0 46, 837	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	1
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 211825			0	0	1 .0.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 203223			0 220, 189	0	1
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0. 000000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 000000			0	0	71. 00
100.00 Total (Sum of lines 40 - 71)		982, 222		0 940, 031	0	100.00
(1) For title V and XLX use columns 1 2 and 4 onl	V	,				

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

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

Heal th	Financial Systems	SHORES AT WE	SLEY MANOR		In Lie	u of Form CMS-2	2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315394	Peri od: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/30/2023 1:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		·		•	1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co			t C, column 3	, line 49)	1. 203223	
2.00	Program vaccine charges (From your reco					0	
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18) Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	5551 551161 25551 Pt. 511	(From Wkst. B,			Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,			Health Costs	
		18		Costs to Tota		for Pass	
			14)	Costs - Part		Through (Col.	
				(Col . 2 / 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	11, 687				0	
41. 00	04100 LABORATORY	15, 812	0	0.00000		0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0.00000		0	
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY	82, 474 658, 579		0. 00000 0. 00000		0 0	10.00
45. 00	04500 OCCUPATIONAL THERAPY	445, 268		0.00000		0	
	04600 SPEECH PATHOLOGY	84, 692	0	0.00000		0	
	04700 ELECTROCARDI OLOGY	04, 072		0. 00000		Ö	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 086	ĺ	0. 00000		ő	
	04900 DRUGS CHARGED TO PATIENTS	262, 518		0.00000		0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	O	0. 00000	00	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0.00000	00	0	51. 00
100.00	Total (Sum of lines 40 - 52)	1, 581, 116	0		940, 031	0	100. 00

Ith Financial Systems	SHORES AT WESLEY			u of Form CMS-2	
MPUTATION OF INPATIENT ROUTINE COSTS		Provi der No.: 315394	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D-1 Parts I-II Date/Time Pre 11/30/2023 1:	pare
		Title XVIII	Skilled Nursing Facility	PPS	<u> 57 р</u>
				4 00	
PART I CALCULATION OF INPATIENT ROUTIN	F COSTS			1. 00	
INPATIENT DAYS	2 00010				
On Inpatient days including private room	days			18, 590	1.
OO Private room days				0	2
On Inpatient days including private room		ogram		5, 103	
Medically necessary private room days				0	
Total general inpatient routine service	ce cost			9, 570, 303	5
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service char	caoe			8, 257, 606	6
O General inpatient routine service cost		vided by line 6)		1. 158968	
Enter private room charges from your r	· ·	rued by rine of		0	
O Average private room per diem charge (8 divided by private	room days, line	0. 00	
2)			,		
00 Enter semi-private room charges from y				8, 257, 606	
OO Average semi-private room per diem cha	irge (Semi-private room c	narges line 10, divide	d by	444. 20	11
semi-private room days) ON Average per diem private room charge of	lifforontial (Lino 0 minus	Lino 11)		0. 00	12
00 Average per diem private room cost dif				0.00	
00 Private room cost differential adjustm				0.00	1
00 General inpatient routine service cost			minus line 14)	9, 570, 303	
PROGRAM INPATIENT ROUTINE SERVICE COST					
00 Adjusted general inpatient service cos		ded by line 1)		514. 81	
OO Program routine service cost (Line 3		4.11 11 40		2, 627, 075	
00 Medically necessary private room cost 00 Total program general inpatient routin				0 (27 075	1
00 Total program general inpatient routing 00 Capital related cost allocated to inpatient			t II column 19	2, 627, 075 636, 214	
line 30 for SNF; line 31 for NF, or li		ts (110m wkst. b, 1a	t II cordiiii Io,	030, 214	20
00 Per diem capital related costs (Line				34. 22	21
00 Program capital related cost (Line 3	times line 21)			174, 625	22
00 Inpatient routine service cost (Line				2, 452, 450	
00 Aggregate charges to beneficiaries for				0	
OO Total program routine service costs fo	or comparison to the cost	imitation (Line 23 mi	nus line 24)	2, 452, 450	
00 Enter the per diem limitation (1) 00 Inpatient routine service cost limitat	ion (line 2 times the ner	diam limitation line	24) (1)		26
00 Reimbursable inpatient routine service					28
(Transfer to Worksheet E, Part II, Iir		1 0 1 1 1 1 1 1 0 2 0 0 1	11110 27)		-
Lines 26 and 27 are not applicable for ti		d for title V and or t	itle XIX	'	
	•				
DADT II CALCIU ATLON OF LUBATION	NO A ALLED LIST THE COST	OD DDG DAGG TUDQUG:		1. 00	
PART II CALCULATION OF INPATIENT NURSI Total SNF inpatient days	NG & ALLIED HEALIH COSIS I	-UR PPS PASS-THROUGH		18, 590	1
00 Program inpatient days (see instruction	nns)			5, 103	
700 Total nursing & allied health costs. (complete for titles V	or XLX)	5, 103	
Nursing & allied health ratio. (line 2		55p. 510 101 111103 V	S,	0. 274502	
Program nursing & allied health costs	,	times line 4)		0	

	Financial Systems ATION OF INPATIENT ROUTINE COSTS	SHORES AT WESLEY	Provi der No.: 315394	Peri od: From 07/01/2022 To 06/30/2023	u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Pre 11/30/2023 1:	pared
			Title XIX	Skilled Nursing Facility	Cost	<u>07 pi</u>
					1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COST	S			1.00	
	INPATIENT DAYS					
00	Inpatient days including private room days				18, 590	
00	Private room days				0	l
00 00	Inpatient days including private room days a Medically necessary private room days applic		ogram		6, 867 0	1
00	Total general inpatient routine service cost				9, 570, 303	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				7, 070, 000	0.
00	General inpatient routine service charges				8, 257, 606	6.
00	General inpatient routine service cost/charg	e ratio (Line 5 di	vided by line 6)		1. 158968	7.
00	Enter private room charges from your records				0	1 -
00	Average private room per diem charge (Privat	e room charges line	8 divided by private	room days, line	0. 00	9.
. 00	2) Enter semi-private room charges from your re	acords			8, 257, 606	10
. 00	Average semi-private room per diem charge (narges line 10 divide	d by	444. 20	
	semi-private room days)	John Private room o	larges into 10, arvide	u 23	111.20	' '
00	Average per diem private room charge differe	ential (Line 9 minus	line 11)		0.00	12
. 00	Average per diem private room cost different	ial (Line 7 times I	ne 12)		0. 00	13
. 00	Private room cost differential adjustment (L				0	1
. 00	General inpatient routine service cost net of PROGRAM INPATIENT ROUTINE SERVICE COSTS	f private room cost	differential (Line 5	minus line 14)	9, 570, 303	15
. 00	Adjusted general inpatient service cost per	diem (line 15 divid	ded by line 1)		514. 81	16
00	Program routine service cost (Line 3 times		ied by Title Ty		3, 535, 200	
00	Medically necessary private room cost applic		ne 4 times line 13)		0	
00	Total program general inpatient routine serv				3, 535, 200	19
. 00	Capital related cost allocated to inpatient		ts (From Wkst. B, Par	t II column 18,	636, 214	20
00	line 30 for SNF; line 31 for NF, or line 32				04.00	0.4
00	Per diem capital related costs (Line 20 div Program capital related cost (Line 3 times				34. 22 234, 989	
00	Inpatient routine service cost (Line 3 times				3, 300, 211	
00	Aggregate charges to beneficiaries for exces		der records)		0, 300, 211	1
00	Total program routine service costs for comp	` '	•	nus line 24)	3, 300, 211	
00	Enter the per diem limitation (1)		•	<i></i>	0.00	26
00	Inpatient routine service cost limitation (L				0	
00	Reimbursable inpatient routine service costs		lesser of line 25 or	line 27)	3, 535, 200	28
	(Transfer to Worksheet E, Part II, line 4) (•				l
LI	nes 26 and 27 are not applicable for title XV	/III, but may be use	d for title V and or t	itle XIX		
					1. 00	
	PART II CALCULATION OF INPATIENT NURSING & A	LLIED HEALTH COSTS I	OR PPS PASS-THROUGH			
00	Total SNF inpatient days				18, 590	
00	Program inpatient days (see instructions)			VI V	6, 867	
00	Total nursing & allied health costs. (see in		complete for titles V	or XIX)	0 3/0303	-
00	Nursing & allied health ratio. (line 2 divid	ieu by iinė I)			0. 369392	4

Health Financial Systems		SHORES AT WESLEY	MANOR	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT F	FOR TITLE X	VIII	Provi der No.: 315394	From 07/01/2022	Date/Time Prepared:
			Title XVIII	Skilled Nursing	11/30/2023 1:57 pm PPS
				Fooilitus	

				11/30/2023 1:	5/ pm_
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSE	EMENT			
1.00	Inpatient PPS amount (See Instructions)			3, 083, 556	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pay	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)			3, 083, 556	
4.00	Primary payor amounts			0	4. 00
5. 00	Coi nsurance			470, 594	
6.00	Allowable bad debts (From your records)			32, 132	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instruc	ctions)		31, 010	
8.00	Adjusted reimbursable bad debts. (See instructions)			20, 886	
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)			2, 633, 848	11. 00
12.00	Interim payments (See instructions)			2, 560, 703	12. 00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			418	14. 75
14. 99	Sequestration amount (see instructions)			52, 259	14. 99
15.00	Balance due provider/program (see Instructions)			20, 468	15. 00
16.00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2,	section 115.2)	0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (OF COST OR CHARGES -	TITLE XVIII ONLY		
17.00	Ancillary services Part B			0	17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19.00	Total reasonable costs (Sum of Lines 17 and 18)			0	19. 00
20.00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23.00	Coinsurance and deductibles			0	23. 00
24.00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instruc	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26.00	Interim payments (See instructions)			0	26. 00
27.00	Tentati ve adjustment			0	27. 00
28.00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)			0	29. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2,	section 115.2	0	30. 00
			·	,	

Health Financial Systems	SHORES AT WESLEY	MANOR	In Lie	u of Form CMS-2	540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and	H TITLE XIX ONLY	Provi der No.: 315394	From 07/01/2022	Worksheet E Part II Date/Time Prep 11/30/2023 1:5	
		Title XIX	Skilled Nursing Facility	Cost	

		litte xix	Facility	COST	
			1 40		
				1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	1. 00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpati ent servi ces			0	3. 00
4.00	Inpatient routine services (see instructions)			3, 535, 200	4. 00
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			3, 535, 200	6. 00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7. 00
8.00	SUBTOTAL (Line 6 minus line 7)			3, 535, 200	
9.00	Primary payor amounts			0	
10.00	Total Reasonable Cost (Line 8 minus line 9)			3, 535, 200	10. 00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges				11. 00
12. 00	Outpati ent servi ce charges			0	12.00
13. 00	Inpatient routine service charges			0	
14. 00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES			_	
16.00	Aggregate amount actually collected from patients liable for pa				16. 00
17. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR 413.13(e)	payment for services o	on a charge basis	0	17. 00
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	10 00
19. 00	Total customary charges (see instructions)			0.000000	
19.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			U	19.00
20. 00	Cost of covered services (see Instructions)			0	20. 00
21. 00	Deductibles			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coi nsurance			0	23. 00
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)			0	
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl	v collected based on o	correction of	0	
27.00	cost limit	<i>y</i> 20.1.2010a 2000a 0.1. 0		Ĭ,	27.00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	program	0	28. 00
	utilization				
29.00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depr	reciable assets (0	30. 00
	if minus, enter amount in parentheses)				
	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	
32. 00	Interim payments			0	
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	theses) (see	0	33. 00
	Instructions)				

From 07/01/2022 To 06/30/2023

Date/Time Prepared: 11/30/2023 1:57 pm Title XVIII Skilled Nursing PPS

Inpatient Part A			ΠΤΙ	e XVIII S	Killed Nursing Facility	PPS	
1.00			Innation	t Dart A		+ R	
1.00			<u> </u>				
Total interim payments paid to provider 2,560,703 0 1.00 0 2.00 0 0 0 0 0 0 0 0 0							
Interrim payments payable on individual bills, either submitted or to be submitted for the cost reporting period. If none, enter zero 1.			1. 00				
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero 3.00 1.00							
Services rendered in the cost reporting period. If none, enter zero 1	2. 00			0		0	2. 00
enter zero anount based on subsequent revision of the interim rate for the cost reporting period at last of each payment. If none, write "NONE" or enter a zero. (1)							
3.00 List separately each retroactive lump sum adjustment amount based on subsequent revel sion of the Interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01							
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)	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider DJUSTMENTS TO PROVIDER 0 0 0 3.01							
ADJUSTMENTS TO PROVIDER					L		
3.03	3. 01			0		0	3. 01
3. 04 0	3.02			0		0	3. 02
ADJUSTMENTS TO PROGRAM	3.03			0		0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.50 0 0 3.51 3.52 0 0 0 3.53 3.51 3.52 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 3.59	3.04			0		0	3. 04
ADJUSTMENTS TO PROGRAM	3.05			0		0	3. 05
3.51 3.52 3.53 0							
3.52 3.53 3.54 3.99 3.52 3.53 3.54 3.99 3.53 3.54 3.99 3.53 3.54 3.99 3.53 3.54 3.99 3.53 3.99		ADJUSTMENTS TO PROGRAM		-		- 1	
3.53				-		-	
3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.54				_		- 1	
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50				_		-	
- 3.98 Total interim payments (sum of lines 1, 2, and 3.99)				_		_	
A.00 Total Interim payments (sum of lines 1, 2, and 3.99) 2,560,703 0 4.00	3. 99	· ·		0		0	3. 99
Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR	4 00			2 560 702			4 00
26 For Part B) TO BE COMPLETED BY CONTRACTOR	4.00			2, 300, 703		U	4.00
TO BE COMPLETED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Frogram to Provider	5.00						5.00
Program to Provider							
S. 01 TENTATIVE TO PROVIDER		write "NONE" or enter a zero. (1)					
Description							
5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 0 5.51 5.52 0 0 0 5.52 5.59 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.59 - 5.98 0 0 0 5.99 - 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 6.01 PROGRAM TO PROVIDER 20,468 0 6.01 6.02 PROVIDER TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 2,581,171 0 7.00 Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00		TENTATI VE TO PROVI DER					
Provider to Program							
TENTATI VE TO PROGRAM	5. 03			0		0	5. 03
5.51 5.52 5.52 5.52 5.52 5.52 5.52 5.52 5.52 5.53 5.52 5.54 5.552 5.59 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 5.52 5.98 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.59 0 5.50 0 5.5					l .	_	
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		TENTATIVE TO PROGRAM					
5. 99 Subtotal (Sum of lines 5. 01 - 5. 49 minus sum of lines 5. 50 - 5. 98) 0 0 5. 99 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 20, 468 0 6. 01 6. 01 PROGRAM TO PROVIDER 20, 468 0 6. 01 6. 02 PROVIDER TO PROGRAM 0 0 6. 02 7. 00 Total Medicare program liability (see instructions) 2, 581, 171 0 7. 00 Contractor Name Contractor Number 8. 00 Name of Contractor 8. 00				-			
- 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) - 5.98) 20,468 0 6.01 0 7.00		Subtatal (Sum of Lines E O1		-			
6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 PROGRAM TO PROVIDER 6. 02 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Name Contractor Number	5. 99			0		U	5. 99
the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) 20,468 0 0 6.01 0 6.02 7.00 Contractor Name Contractor Name Contractor Name 1.00 2.00 8.00 Name of Contractor 8.00 Name of Contractor 8.00 Name of Contractor	6 00						6.00
6. 01 PROGRAM TO PROVIDER OF ROVIDER OF ROVIDER OF ROVIDER OF ROVIDER TO PROGRAM OF ROVIDER OF ROVI	0.00						0.00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00 Name of Contractor	6. 01			20. 468		n	6, 01
7.00 Total Medicare program liability (see instructions) 2,581,171 0 7.00 Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00						-	
Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00				2, 581, 171			
8.00 Name of Contractor 8.00							
8.00 Name of Contractor 8.00						Number	
				1.	00	2. 00	
		!					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 SHORES AT WESLEY MANOR In Lieu of Form CMS-2540-10

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

Provider No.: 315394 | Period: From 07/01/202 To 06/30/202

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/30/2023 1:57 pm

iii y <i>)</i>					11/30/2023 1:	57 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4. 00	
Ass	RENT ASSETS					1
	sh on hand and in banks	59, 320	C	0	0	1.0
	mporary investments	0	C	_	_	
	tes recei vabl e	0	C	0	0	
	counts receivable	2, 502, 034	0	0	0	1
- 1	ner receivables ss: allowances for uncollectible notes and accounts	-641, 000		0	0	
	cei vabl e	-641,000		0	0	0.
1	ventory	141, 545	d	0	0	7.
	epai d'expenses	201, 218	1	0	0	8.
.00 Oth	ner current assets	5, 000		0	0	
- 1	e from other funds	24, 079, 730		_	0	
	FAL CURRENT ASSETS (Sum of lines 1 - 10)	26, 347, 847	[0	0	11.
2. 00 Lan	KED ASSETS	463, 497		0	0	12.
	nd improvements	0	ď	_		
1	ss: Accumulated depreciation	0	C	0	1	
	I di ngs	53, 013, 293		0	0	
	ss Accumulated depreciation	-24, 867, 846		_	0	
	asehold improvements	0	C	0	0	1
	ss: Accumulated Amortization ked equipment	4, 175, 514		0	0	
	ss: Accumulated depreciation	-2, 604, 115	l .	0	0	
1	tomobiles and trucks	95, 787	1	0	0	
	ss: Accumulated depreciation	-95, 787	1	0	0	
	or movable equipment	0	C	0	0	
1	ss: Accumulated depreciation	0	O C	0	0	
	nor equipment - Depreciable	0	0	0	0	
	nor equipment nondepreciable ner fixed assets	29, 086		0	0	1
- 1	TAL FIXED ASSETS (Sum of lines 12 - 27)	30, 209, 429	1	_	1	
	IER ASSETS	00/20// 12/	1			
4	vestments	0	C	0		
1 .	posits on leases	0	O C	_		1
	e from owners/officers	0	C	_	0	1 .
	ner assets FAL OTHER ASSETS (Sum of Lines 29 - 32)	2, 949, 664 2, 949, 664	1	_	0	
4	FAL ASSETS (Sum of Lines 11, 28, and 33)	59, 506, 940		_	1	1
	bilities and Fund Balances	, , , , , , , , , , , ,				
	RENT LIABILITIES			T.		
	counts payable	1, 299, 891	C	_		1
	aries, wages, and fees payable	1, 480, 594	0	_	0	
	yroll taxes payable tes & loans payable (Short term)			0		
	ferred income	0	Ö	0	0	1
- 1	cel erated payments	0				40.
1. 00 Due	e to other funds	0	C	0	0	41.
	ner current liabilities	8, 394, 663	l .			1
	FAL CURRENT LIABILITIES (Sum of lines 35 - 42)	11, 175, 148	<u>C</u>	0	0	43.
	IG TERM LIABILITIES tqage payable	1 0	C	0	0	44.
	tes payable	28, 135, 644				
4	secured Loans	0	ď	_	Ö	
7. 00 Loa	ans from owners:	0	C	0	0	47.
	ner long term liabilities	12, 500	0	0	0	1
	HER (SPECIFY)	0	9	0	0	
	FAL LONG TERM LIABILITIES (Sum of lines 44 - 49 FAL LIABILITIES (Sum of lines 43 and 50)	28, 148, 144 39, 323, 292	1		0	
	TAL ACCOUNTS	1 37, 323, 292		1 0	1 0	31.
	neral fund balance	20, 183, 648				52.
1	ecific purpose fund		C			53.
1	nor created - endowment fund balance - restricted			0		54.
1	nor created - endowment fund balance - unrestricted			0		55.
1	verning body created - endowment fund balance			0	_	56.
1	ant fund balance - invested in plant ant fund balance - reserve for plant improvement,				0 0	
	olacement, and expansion					30.
	TAL FUND BALANCES (Sum of lines 52 thru 58)	20, 183, 648	l c	0	0	59.
	TAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	59, 506, 940	1	0	0	
59)		1	1		I	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES SHORES AT WESLEY MANOR

Provi der No.: 315394

					To 06/30/202		
		Genera	l Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		22, 959, 486			0	1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)		-2, 775, 834 20, 183, 652	1		0	2. 00 3. 00
4. 00	Additions (credit adjustments)		20, 163, 632			٩	4. 00
5. 00	INTERCOMPANY RECONCILIATION	0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	
8.00		0			0	0	8. 00
9. 00 10. 00	Total additions (sum of line 5 - 9)	0	0		٥	ol	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		20, 183, 652			0	11.00
12. 00	Deductions (debit adjustments)		20, 100, 002			٦	12.00
13.00	ROUNDI NG	4			0	0	13. 00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00 17. 00		0			0	0	16. 00 17. 00
18. 00	Total deductions (sum of lines 13 - 17)		4			ol	18.00
19. 00	Fund balance at end of period per balance		20, 183, 648			ō	19. 00
	sheet (Line 11 - line 18)		51 .	L			
		Endowment Fund	Pi ant	: Fund T	_		
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	0			0		2. 00 3. 00
4. 00	Additions (credit adjustments)	0		•	O .		4. 00
5. 00	INTERCOMPANY RECONCILIATION		0	i			5. 00
6.00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9. 00 10. 00	Total additions (sum of line 5 - 9)	0	0	1	0		9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				Ö		11. 00
12. 00	Deductions (debit adjustments)		•				12.00
13. 00	ROUNDI NG		0				13. 00
14.00			0	1			14. 00
15. 00 16. 00			0				15. 00 16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 13 - 17)	0			0		18. 00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0			0		19. 00

Health Financial Systems SHORES AT WESLEY MANOR In Lieu of Form CMS-2540-10 Provider No.: 315394 Period: From 07/01/2022 To 06/30/2023 Cost Center Description PART I - PATIENT REVENUES General Inpatient Routine Care Services
PART I - PATIENT REVENUES 1.00 2.00 3.00
PART I - PATIENT REVENUES
1. 00 SKILLED NURSING FACILITY 8, 257, 606 8, 257, 606 1. 00
2.00 NURSING FACILITY 8,257,000 8,257,000 1.00
3.00 ICF/IID
4. 00 OTHER LONG TERM CARE 12, 350, 905 12, 350, 905 4. 00
5.00 Total general inpatient care services (Sum of lines 1 - 4) 20,608,511 20,608,511 5.00
All Other Care Services
6. 00 ANCI LLARY SERVICES 1, 586, 732 0 1, 586, 732 6. 00
7. 00 CLINIC 0 0 7. 00
8.00 HOME HEALTH AGENCY COST
9. 00 AMBULANCE 0 0 9. 00
10.00 RURAL HEALTH CLINIC 0 0 10.00
10. 10 FQHC 0 10. 10
11. 00 CMHC 0 0 11. 00
12. 00 HOSPI CE 0 0 0 12. 00
13. 00 OTHER (SPECI FY) 0 0 13. 00
14.00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 22,195,243 0 22,195,243 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) 23, 228, 097 1.00
2.00 Add (Specify) 2.00
3.00 4.00
5.00
6.00
7.00

8. 00

9. 00

10. 00

11. 00 12. 00 13. 00 14. 00

23, 228, 097 15. 00

8. 00 9. 00

10.00

11.00

12.00

Total Additions (Sum of lines 2 - 7)

15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

13.00 14.00 Total Deductions (Sum of lines 9 - 13)

Deduct (Specify)

	ealth Financial Systems SHORES AT WESLEY MANOR In TATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315394 Period:			u of Form CMS-2 Worksheet G-3	
SIMIL	LENT OF TATTENT REVENUES AND OF ENVITTING EXPENSES	11001461 No. : 010071	From 07/01/2022	Worksheet 6 6	
			To 06/30/2023	Date/Time Pre 11/30/2023 1:	
				11/30/2023 1.	37 pili
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	e 14)	,	22, 195, 243	1.00
2.00	Less: contractual allowances and discounts on patients accou			2, 475, 195	
3.00	Net patient revenues (Line 1 minus line 2)			19, 720, 048	
4.00	Less: total operating expenses (From Worksheet G-2, Part II,	line 15)		23, 228, 097	4.00
5.00	Net income from service to patients (Line 3 minus 4)	•		-3, 508, 049	5. 00
	Other income:				
6.00	Contributions, donations, bequests, etc			253, 060	6.00
7.00	Income from investments			1, 106, 260	7.00
8.00	Revenues from communications (Telephone and Internet service	e)		0	8.00
9.00	Revenue from television and radio service			20, 001	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			5, 827	13. 00
14.00	Revenue from meals sold to employees and guests			11, 013	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of skilled nursing space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	GAIN ON SALE OF ASSET			0	24. 00
24. 01	CATERING / COUNTRY STORE			45, 354	24. 01
24. 02	TRANS - RESIDENTIAL			7, 111	24. 02
24. 03	I NSURANCE REVENUE			0	24. 03
24. 04	ELECTRI C REVENUE			2, 065	24. 04
24. 05	GRANT REVENUE			0	
24. 06	MI SCELLANEOUS I NCOME			158	1
24. 07	HOUSEKEEPI NG REVENUE			0	24. 07
24. 08	INVESTMENT SETTLEMENT			226	
24. 50	COVI D-19 PHE Fundi ng			0	
25. 00	Total other income (Sum of lines 6 - 24)			1, 451, 075	
	Total (Line 5 plus line 25)			-2, 056, 974	
27 00	LIOSS ON DISPOSAL OF ASSET			Λ.	27 00

1, 451, 075 -2, 056, 974 26. 00 0 27. 00

718, 860

718, 860 30. 00 -2, 775, 834 31. 00

0 27.00 60 28.00 0 29.00

27. 00 LOSS ON DISPOSAL OF ASSET

30.00 Total other expenses (Sum of lines 27 - 29)
31.00 Net income (or loss) for the period (Line 26 minus line 30)

28.00 | I NVESTMENT LOSS

29. 00