Health Financial Systems SHORES AT WESLEY MANOR In Lieu of Form CMS-2540-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expires: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315394 Worksheet S Parts I, II & III Peri od. From 07/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 06/30/2024 Date/Time Prepared: То 11/26/2024 3: 32 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/26/2024 Time: 3:32 pm use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 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 Code 12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received: 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 OF 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 07/01/2023 and ending 06/30/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Robe	ert Peterson	ř	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Robert Peterson			2
3	Signatory Title	VICE PRESIDENT OF FINANCE			3
4	Date	(Dated when report is electronical			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	298	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
1 <mark>00. 00</mark>	TOTAL	0	<mark>298</mark>	0	0	<mark>100. 0</mark> 0

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

Heal th	Financial Systems	SHORES	AT WESLEY	MANOR		L	n Lie	u of For	m CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACI	LITY HEALTH	I CARE	Provi der		Peri od:		Workshe		
COMPLE	X INDENTIFICATION DATA					From 07/01/ To 06/30/		Part I Date/Ti	me Pre	nared
						10 00/ 30/	2024	11/26/2		
	1.00		2.00		3.00					
1 00	Skilled Nursing Facility and Skilled Nursi Street: 2201 BAY AVENUE	PO Box:	Complex Ad	dress:						1.00
	City: OCEAN CITY	State: N	1	Zip Code	08226					2.00
	County: CAPE MAY	CBSA Code		Urban/Ru						3.00
3.01		CBSA Code								3.01
			Compor	ent Name	Provi der	Date	Paym	ent Syst		
					CCN	Certified		0, or N	í	-
			1	. 00	2.00	3.00	V 4.00	XVIII 5.00	XI X 6.00	
	SNF and SNF-Based Component Identification	:	1	. 00	2.00	5.00	4.00	5 5.00	0.00	
	SNF		SHORES AT N	VESLEY MAN	IOR 315394	02/16/1998	N	Р	0	4.00
	Nursing Facility									5.00
	ICF/IID									6.00
	SNF-Based HHA									7.00
	SNF-Based RHC SNF-Based FQHC									8.00 9.00
	SNF-Based CMHC									10.00
11.00	SNF-Based OLTC									11.00
	SNF-Based HOSPICE									12.00
13.00	SNF-Based CORF									13.00
						From: 1.00		To 2. (-
14.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2		06/30/		14.00
	Type of Control (See Instructions)						1			15.00
								Y/		
		· .						1. (00	
	Type of Freestanding Skilled Nursing Facil Is this a distinct part skilled nursing fac		monte the	roqui romo	ate est forth	in 42 CED /	conti	on N		16.00
	483. 5?	chilly that	meets the	r equi r eillei	its set for th	TH 42 CFR	Secti			10.00
	Is this a composite distinct part skilled r	nursing faci	ility that	meets the	requirements	set forth i	in 42	N		17.00
	CFR section 483.5?									
	Are there any costs included in Worksheet					ed organi za	ti ons	Y		18.00
	as defined in CMS Pub. 15-1, chapter 10? Miscellaneous Cost Reporting Information	IT yes, com	plete works	neet A-8-	1.					
	If this is a low Medicare utilization cost	report, in	dicate with	a "Y", f	or ves. or "N"	' for no.		N		19.00
	If line 19 is yes, does this cost report me						e	N		19.01
	utilization cost report, indicate with a "									
	Depreciation - Enter the amount of deprecia	ation repor	ted in this	SNF for	the method in	dicated on	Li nes			
	Straight Line Declining Balance							2,0	782, 367 0	20.00 21.00
	Sum of the Year's Digits								C	22.00
	Sum of line 20 through 22							2,0	085, 369	23.00
	If depreciation is funded, enter the bala								C	
	Were there any disposal of capital assets of	5		51	• •			Y		25.00
26.00	Was accelerated depreciation claimed on any	y assets in	the curren	t or any	orior cost rep	porting peri	i od?	N		26.00
27 00	(Y/N) Did you cease to participate in the Medica	re program a	at end of t	he period	to which this	s cost repo	rt	N		27.00
	applies? (Y/N)	o program i		no por ou		5 000 t 1 0p0.				27.00
28.00	Was there a substantial decrease in health	insurance	proportion	of allowa	ole cost from	prior cost		N		28.00
	reports? (Y/N)						Dorst	A Dowt D	Othors	
							1. 00	APart B 0 2.00	3.00	-
	If this facility contains a public or non-	public prov	ider that o	ual i fi es	for an exempti	ion from th				
	of the lower of the costs or charges enter									
	exemption.									
	Skilled Nursing Facility						N	N	N	29.00
	Nursing Facility ICF/IID								N	30.00
	SNF-Based HHA						N	N		32.00
	SNF-Based RHC									33.00
	SNF-Based FQHC									34.00
	SNF-Based CMHC							N		35.00
36.00	SNF-Based OLTC					V/N				36.00
						Y/N 1.00		2.0	00	
37.00	Is the skilled nursing facility located in	a state th	at certifie	s the pro	vider as a SNF			2.0		37.00
	regardless of the level of care given for	Titles V & 2	XIX patient							
	Are you legally-required to carry malpracti					N				38.00
39.00	Is the malpractice a "claims-made" or "occu enter 1. If the policy is "occurrence", en		iicy?lf th	e policy	s "claims-mac	de" 1				39.00
	penter i. II the policy is occurrence, en	ισι <u>Ζ</u> .			Premi ums	Paid Los	ses	Self Ins	urance	
					1.00	2.00		3.0		
41.00	List malpractice premiums and paid losses:				211, 316	0		0		41.00

Health Financial Systems	SHORES AT WE	SLEY MANOR		In Lieu	」of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3		i od:	Worksheet S-2	2
COMPLEX INDENTIFICATION DATA				m 07/01/2023	Part I	
			То	06/30/2024	Date/Time Pre	
					<u>11/26/2024 3:</u> Y/N	32 pm
						-
					1.00	
42.00 Are malpractice premiums and paid loss					N	42.00
center? Enter Y or N. If yes, check bo	ox, and submit supporti	ing schedule listing	g cost cent	ers and		
amounts.						
43.00 Are there any home office costs as def					Y	43.00
44.00 If line 43 is yes, enter the home offi	ce chain number and er	nter the name and a	ddress of t	ne home office	¥153010	44.00
on lines 45, 46 and 47.						
1.00	2.0	00		3.00		
If this facility is part of a chain or	ganization, enter the	name and address o	of the home	office on the	lines	
bel ow.						
45.00 Name: UNITED METHODIST HOMES OF NJ	Contractor's Name: UN	II TED METHODI ST	Contractor's	s Number: 1200	1	45.00
	НО	MES OF NJ				
46.00 Street: 3311 HIGHWAY 33	PO Box:					46.00
47.00 City: NEPTUNE	State: NJ		Zip Code:	0775	3	47.00

	ED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH C	ARE Provi der	No.: 315394	Peri od:	Worksheet S-2	2
MPL	EX REIMBURSEMENT QUESTIONNAIRE			From 07/01/2023 To 06/30/2024		
			-	Y/N	Date	<u>32 pi</u>
				1.00	2.00	
	General Instruction: For all column 1 responses enter in responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	n column 1, "Y" fo	r Yes or "N"	for No. For all	the date	_
00	Provider Organization and Operation Has the provider changed ownership immediately prior to	the beginning of	the cost	N		1.
00	reporting period? If column 1 is "Y", enter the date of instructions)			Ň		
			Y/N	Date	V/I	_
00	Has the provider terminated participation in the Medicar	re Program? If	1.00 N	2.00	3.00	2.
	column 1 is yes, enter in column 2 the date of terminati					
00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, incluc contracts, with individuals or entities (e.g., chain hor medical supply companies) that are related to the provid officers, medical staff, management personnel, or member directors through ownership, control, or family and other relationships? (see instructions)	me offices, drug o der or its rs of the board of				3.
			Y/N	Туре	Date	
	Financial Data and Danasta		1.00	2.00	3.00	-
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Ce Accountant? (Y/N) Column 2: If yes, enter "A" for Audite	ed, "C" for	Y	A	10/24/2024	4.
	Compiled, or "R" for Reviewed. Submit complete copy or e available in column 3. (see instructions) If no, see ins					
00	Are the cost report total expenses and total revenues di on the filed financial statements? If column 1 is "Y", s reconciliation.	fferent from thos	e Y			5.
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
)()		°olumn 2 ls the	nrovider the	N	N	٦ ٦
00	Column 1: Were costs claimed for Nursing School? (Y/N) (legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs? (Y/N) see	e instructions.		N	N	7.
00	legal operator of the program? (Y/N)	e instructions. reporting period			N	7.
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs? (Y/N) see Were approvals and/or renewals obtained during the cost	e instructions. reporting period		Ν	Y/N	7.
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs? (Y/N) see Were approvals and/or renewals obtained during the cost School and/or Allied Health Program? (Y/N) see instructi	e instructions. reporting period		Ν		7.
00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs? (Y/N) see Were approvals and/or renewals obtained during the cost School and/or Allied Health Program? (Y/N) see instructi Bad Debts Is the provider seeking reimbursement for bad debts? (Y/ If line 9 is "Y", did the provider's bad debt collection	e instructions. reporting period ions. /N) see instructio	for Nursing	NN	Y/N	7. 8. 9.
00 00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs? (Y/N) see Were approvals and/or renewals obtained during the cost School and/or Allied Health Program? (Y/N) see instructi Bad Debts Is the provider seeking reimbursement for bad debts? (Y/N) If line 9 is "Y", did the provider's bad debt collection period? If "Y", submit copy.	e instructions. reporting period ons. /N) see instructio n policy change du	for Nursing ns. ring this co	N N st reporting	Y/N 1.00 Y	7. 8. 9. 10.
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	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs? (Y/N) see Were approvals and/or renewals obtained during the cost School and/or Allied Health Program? (Y/N) see instructi Bad Debts Is the provider seeking reimbursement for bad debts? (Y, If line 9 is "Y", did the provider's bad debt collection period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsur Bed Complement Have total beds available changed from prior cost report Dee PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	e instructions. reporting period ions. /N) see instruction n policy change du rance waived? If " ting period? If "Y scription	for Nursing ns. ring this co: Y", see instr ", see instr P Y/N 1.00 Y	N N St reporting ructions. art A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 N	7, 8, 9, 10, 11, 12, 13, 14,
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00 00 00 . 00 . 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs? (Y/N) see Were approvals and/or renewals obtained during the cost School and/or Allied Health Program? (Y/N) see instructi Bad Debts Is the provider seeking reimbursement for bad debts? (Y/If line 9 is "Y", did the provider's bad debt collection period? If "Y", submit copy. If line 9 is "Y", did the provider's bad debt collection period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsure Bed Complement Have total beds available changed from prior cost report Dee PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions.	e instructions. reporting period ions. /N) see instruction n policy change du rance waived? If " ting period? If "Y scription	for Nursing ns. ring this co: Y", see instr ", see instr ", see instr P Y/N 1.00 Y N N	N N St reporting ructions. art A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 N N	7. 8. 9. 10. 11.

Heal th	Financial Systems	SHORES AT WE	ESLEY	MANOR	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY	/ HEALTH CARE		Provider No.: 315394	Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				From 07/01/2023 To 06/30/2024	Part II Date/Time Pre	nared
						11/26/2024 3:	
				1.00	2.	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/	position held	DEAND	RA	FALLON		19.00
	by the cost report preparer in columns 1, 2, a	ind 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost re	port prepare	BAKER	TILLY ADVISORY GROUP,			20.00
			LP				
21.00	Enter the telephone number and email address c	of the cost	570-8	20-0301	DEANDRA. FALLON	BAKERTILLY. CO	21.00
	report preparer in columns 1 and 2, respective	el y.					

Heal th	Financial Systems	SHORES AT WES	LEY MANOR		In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provi der	No.: 315394	Period: From 07/01/2023 To 06/30/2024	Worksheet S-2 Part II Date/Time Pre 11/26/2024 3:	pared:
		Part B Date 4.00					
	PS&R Data			-			
	Was the cost report prepared using the PS&R						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 4.						14.00
15.00	". 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.						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 information? If yes, see instructions.						16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:						17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.						18.00
		-	2	00	-		
	Cost Report Preparer Contact Information			00			
	Enter the first name, last name and the title by the cost report preparer in columns 1, 2, respectively.		I RECTOR				19.00
	Enter the employer/company name of the cost in Enter the telephone number and email address report preparer in columns 1 and 2, respective	of the cost					20. 00 21. 00

COMPLE	Financial Systems D NURSING FACILITY AND SKILLED NURSIN X STATISTICAL DATA	SHORES AT WES G FACILITY HEALTH CARE		F	eriod: rom 07/01/2023 o 06/30/2024	u of Form CMS-2 Worksheet S-3 Part I Date/Time Prep 11/26/2024 3:3	bared:
				l np	atient Days/Vis		·
	Component	Number of Beds	Bed Days Avai LabLe	Title V	Title XVIII	Title XIX	
	1	1.00	2.00	3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	60	21, 960		5, 492	6, 565	1.00
. 00 . 00	NURSING FACILITY	0	0	-		0	2.00 3.00
00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
00	Other Long Term Care	255	93, 330				5.00
00	SNF-Based CMHC						6.00
00	HOSPICE	0 315	115 200	0	0 E 402	0	7.00
00	Total (Sum of lines 1-7)	Inpatient D	<u>115, 290</u> avs/Vi si ts	0	5, 492 Di scharges	6, 565	8.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
00	SKILLED NURSING FACILITY	6.00	7.00	8.00	9.00	10.00	1.00
00	NURSING FACILITY	7,820	19,8//		1/6	23	2.00
00	ICF/IID	0	0			0	3.00
00	HOME HEALTH AGENCY COST	0	0				4.00
00	Other Long Term Care	47, 841	47, 841				5.00
00 00	SNF-Based CMHC HOSPI CE	0	0	0	0	0	6.00 7.00
00	Total (Sum of Lines 1-7)	55, 661	67, 718		176	23	8.00
		Di scha			age Length of		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	oomporterre	11.00	12.00	13.00	14.00	15.00	
00	SKILLED NURSING FACILITY	233	432			285.43	1.00
00	NURSING FACILITY	0	0			0.00	2.00
00 00	ICF/IID HOME HEALTH AGENCY COST	0	0			0.00	3.00 4.00
00	Other Long Term Care	86	86				4. 00 5. 00
00	SNF-Based CMHC						6.00
00	HOSPI CE	0	0			0.00	7.00
00	Total (Sum of lines 1-7)	319	518			285.43	8.00
		Average Length of Stay		Admi s	sions		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
. 00	SKILLED NURSING FACILITY	46.01	0		10	200	1.00
00 00	NURSING FACILITY	0. 00 0. 00	0		0	0	2.00 3.00
00	HOME HEALTH AGENCY COST	0.00			0	0	4.00
00	Other Long Term Care	556. 29				85	5.00
	SNF-Based CMHC			_		_	6.00
		0.00	0			0 285	7.00 8.00
00	HOSPICE	120 721	0		10	205	0.00
00	Total (Sum of Lines 1-7)	130.73 Admi ssi ons	Full Time	Equivalent			
00	Total (Sum of lines 1-7)	Admissions					
00			Full Time Employees on Payroll	Equi vai ent Nonpai d Workers			
00	Total (Sum of Lines 1-7) Component	Admi ssi ons Total 21.00	Employees on Payroll 22.00	Nonpaid Workers 23.00			
00 00	Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY	Admi ssi ons Total 21.00 409	Employees on Payroll 22.00 40.11	Nonpaid Workers 23.00 0.00			
00 00	Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY	Admi ssi ons Total 21.00 409 0	Employees on Payroll 22.00 40.11 0.00	Nonpai d Workers 23.00 0.00 0.00			2.00
00 00 00 00 00 00	Total (Sum of lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID	Admi ssi ons Total 21.00 409	Employees on Payroll 22.00 40.11 0.00 0.00	Nonpai d Workers 23.00 0.00 0.00 0.00			2.00 3.00
00	Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY	Admi ssi ons Total 21.00 409 0	Employees on Payroll 22.00 40.11 0.00	Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00			1.00 2.00 3.00 4.00 5.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	Admi ssi ons Total 21.00 409 0 0	Employees on Payrol1 22.00 40.11 0.00 0.00 0.00 44.87 0.00	Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			2.00 3.00 4.00 5.00 6.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	Admi ssi ons Total 21.00 409 0 0	Employees on Payroll 22.00 40.11 0.00 0.00 0.00 44.87	Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			2.0 3.0 4.0 5.0

	Financial Systems	SHORES AT WE				u of Form CMS-2	
SNF W	IGE INDEX INFORMATION		Provi der	1	Period: From 07/01/2023 Fo 06/30/2024		pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
			Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	10, 864, 317	0	10, 864, 31			
2.00	Physician salaries-Part A	0	0	(0.00		
3.00	Physician salaries-Part B	0	C	(0.00		3.00
4.00	Home office personnel	0	C	(0.00		4.00
5.00	Sum of lines 2 through 4	0	C	(0.00		5.00
6.00	Revised wages (line 1 minus line 5)	10, 864, 317		10, 864, 31			
7.00	Other Long Term Care	3, 312, 708	0	3, 312, 708			7.00
8.00	HOME HEALTH AGENCY COST	0	0		0.00		
9.00	CMHC	0	0		0.00		
10.00	HOSPI CE	0	0		0.00		
11.00	Other excluded areas	50, 976		50, 97			
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	3, 363, 684		3, 363, 684			
13.00	Total Adjusted Salaries (line 6 minus line 12)	7, 500, 633	C	7, 500, 633	3 252, 634. 00	29.69	13.00
	OTHER WAGES & RELATED COSTS		_				
14.00	Contract Labor: Patient Related & Mgmt	546, 778	C	546, 778			14.00
15.00	Contract Labor: Physician services-Part A	28, 008		28, 008			15.00
16.00	Home office salaries & wage related costs	998, 592	0	998, 592	2 15, 779. 00	63.29	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	2, 603, 623		2,000,02.			17.00
18.00	Wage-related costs other (See Part IV)	4,003		4, 003			18.00
19.00	Wage related costs (excluded units)	806, 104	0	806, 104	1		19.0
20.00	Physician Part A - WRC	0	0	(ו		20.00
21.00	Physician Part B - WRC	0	0	(ו		21.00
22.00	Total Adjusted Wage Related cost (see instructions)	1, 801, 522	C	1, 801, 522	2		22.00

Heal th	Financial Systems	SHORES AT WE	SLEY MANOR		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 07/01/2023		narod
					10 00/ 30/ 2024	11/26/2024 3:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from		Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	1	1	1	1		
1.00	Employee Benefits	0	0		0.00		
2.00	Administrative & General	1, 412, 401		1, 412, 401			2.00
3.00	Plant Operation, Maintenance & Repairs	464, 402	0	464, 402	2 19, 461. 00	23.86	3.00
4.00	Laundry & Linen Service	79, 025	0	79, 02	5 3, 761. 00	21.01	4.00
5.00	Housekeepi ng	393, 435	0	393, 43	5 19, 436. 00	20. 24	5.00
6.00	Dietary	1, 205, 184	0	1, 205, 184	4 61, 501. 00	19.60	6.00
7.00	Nursing Administration	0	0	(0.00	0.00	7.00
8.00	Central Services and Supply	0	0	(0.00	0.00	8.00
9.00	Pharmacy	0	0	(0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	(0.00	0.00	10.00
11.00	Social Service	75, 994	0	75, 994	4 2, 038. 00	37.29	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	330, 266	0	330, 260	5 15, 006. 00	22.01	13.00
14.00	Total (sum lines 1 thru 13)	3, 960, 707	0	3, 960, 70	7 151, 595. 00	26.13	14.00

Heal th	Financial Systems	SHORES AT WESLE	Y MANOR	In Lie	u of Form CMS-2	2540-10
	GE RELATED COSTS		Provi der No. : 315394	Period: From 07/01/2023 To 06/30/2024	Worksheet S-3 Part IV	pared:
					Amount Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					1
	RETIREMENT COST					1
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	ution			0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost				191, 486	3.00
4.00	Prior Year Pension Service Cost				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External C)rgani zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	ı			0	6.00
7.00	Employee Managed Care Program Administration	Fees			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)				1, 181, 009	8.00
9.00	Prescription Drug Plan				0	
10.00	Dental, Hearing and Vision Plan				10, 613	10.00
11.00	Life Insurance (If employee is owner or benef	fi ci ary)			0	
12.00	Accident Insurance (If employee is owner or k				0	12.00
13.00	Disability Insurance (If employee is owner or				4, 140	13.00
14.00	Long-Term Care Insurance (If employee is owned	er or beneficiary)			0	14.00
15.00	Workers' Compensation Insurance	5,			286, 830	15.00
16.00	Retirement Health Care Cost (Only current yea	ar, not the extrao	rdinary accrual require	ed by FASB 106. No		
	cumulative portion)		5	5		
	TAXES					
17.00	FICA-Employers Portion Only				647, 452	17.00
18.00	Medicare Taxes - Employers Portion Only				151, 871	18.00
19.00	Unemployment Insurance				130, 222	19.00
20.00	State or Federal Unemployment Taxes				0	20.00
	OTHER					
21.00	Executive Deferred Compensation				0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23))			2, 603, 623	24.00
	· · · · · · · · · · · · · · · · · · ·				Amount	
					Reported	
					1.00	
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COST				4, 003	25.00

Heal th	Financial Systems	SHORES AT WES	SLEY MANOR		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES		Provi der		Period: From 07/01/2023 To 06/30/2024	Worksheet S-3 Part V Date/Time Pre 11/26/2024 3:	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)		Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	703, 645	168, 593				1.00
2.00	Licensed Practical Nurses (LPNs)	621, 716	148, 963				2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1, 120, 885	268, 564	1, 389, 44	9 39, 363.00	35.30	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2, 446, 246	586, 120				4.00
5.00	Physical Therapists	404,071	96, 815	500, 88	6 8, 453. 00	59.26	5.00
6.00	Physical Therapy Assistants	0	0		0 0.00		6.00
7.00	Physical Therapy Aides	68, 301	16, 365	84, 66	6 1, 613. 00	52.49	7.00
8.00	Occupational Therapists	170, 676	40, 894	211, 57			8.00
9.00	Occupational Therapy Assistants	0	0		0 0.00		9.00
10.00	Occupational Therapy Aides	63, 975	15, 328				10.00
11.00	Speech Therapists	49, 539	11, 870				11.00
12.00	Respiratory Therapists	62,082	14, 875				12.00
13.00	Other Medical Staff	275, 036	65, 899	340, 93	5 8, 591. 00	39.69	13.00
	Contract Labor						
	Nursing Occupations	ii		1	-		
	Registered Nurses (RNs)	154, 565		154, 56			14.00
15.00	Licensed Practical Nurses (LPNs)	105, 108		105, 10			15.00
16.00	Certified Nursing Assistant/Nursing	287, 105		287, 10	5 7, 362.00	39.00	16.00
17.00	Assistants/Aides Total Nursing (sum of lines 14 through 16)	546, 778		546, 77	8 11, 617. 00	47.07	17.00
17.00	Physical Therapists	540,778		540,77	0 0.00		17.00
	Physical Therapy Assistants	0			0 0.00		
20.00	Physical Therapy Aides	0			0 0.00		
20.00	Occupational Therapists	0			0.00		20.00
21.00	Occupational Therapy Assistants	0			0.00		21.00
22.00	Occupational Therapy Assistants	0			0.00		
23.00	Speech Therapi sts	0			0.00		
24.00	Respiratory Therapists	0			0 0.00		
	Other Medical Staff	0			0 0.00		26.00
20.00		9		I	0.00	0.00	20.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	SHORES AT WESL	EY MANOR Provider No.: 3	15394	In Lie Period:	u of Form CMS Worksheet S-	
				From 07/01/2023 To 06/30/2024	Date/Time Pr	repared:
				Group	11/26/2024 3 Days	5. 52 pili
				1.00	2.00	
1.00 2.00				RUX RUL		1.00 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 9.00				RML RLX		8.00 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 16. 00				RVA RHC		15.00 16.00
17.00				RHB		17.00
18.00				RHA		18.00
19.00				RMC		19.00
20.00				RMB		20.00
21.00				RMA		21.00
22. 00 23. 00				RLB RLA		22.00 23.00
24.00				ES3		23.00
25.00				ES2		25.00
26.00				ES1		26.00
27.00				HE2		27.00
28.00				HE1		28.00
29. 00 30. 00				HD2 HD1		29.00 30.00
31.00				HC2		31.00
32.00				HC1		32.00
33. 00				HB2		33.00
34.00				HB1		34.00
35. 00				LE2		35.00
36. 00 37. 00				LE1 LD2		36.00 37.00
38.00				LD2 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 44.00				CE2 CE1		43.00 44.00
45.00				CD2		45.00
46. 00				CD1		46.00
47.00				CC2		47.00
48.00				CC1		48.00
49. 00 50. 00				CB2 CB1		49.00 50.00
51.00				CA2		50.00
52.00				CA1		52.00
53.00				SE3		53.00
54.00				SE2		54.00
55. 00 56. 00				SE1 SSC		55.00 56.00
57.00				SSC		56.00
58.00				SSA		58.00
59.00				I B2		59.00
60. 00				I B1		60.00
61.00				I A2		61.00
62. 00 63. 00				I A1 BB2		62.00 63.00
64. 00				BB2 BB1		64.00
65.00				BA2		65.00
66. 00				BA1		66.00
67. 00				PE2		67.00
68.00				PE1		68.00
69. 00 70. 00				PD2 PD1		69.00 70.00
71.00				PD1 PC2		70.00
72.00				PC1		72.00
73.00				PB2		73.00
74.00				PB1		74.00
75.00				PA2		75.00

Health Financial Systems	SHORES AT WESLEY	MANOR		In Lie	u of Form CM	S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315394	Period:	Worksheet S	-7
				From 07/01/2023 To 06/30/2024	Date/Time P 11/26/2024	
				Group	Days	
				1.00	2.00	
76.00				PA1		76.00
99.00				AAA		99.00
100. 00 TOTAL						100.00
			Expenses	Percentage	Y/N	
			1.00	2.00	3.00	
A notice published in the Federal Register Vo payments beginning 10/01/2003. Congress exper expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fo with direct patient care and related expenses (See instructions)	cted this increase n column 1 the amou r each category to or yes or "N" for n	to be used nt of the total SNF p if the s	l for direct expense for revenue from pending refl	batient care and each category. Er Worksheet G-2, F ects increases as	related iterin Partl, sociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, II	ne 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

	Financial Systems	SHORES AT WES				u of Form CMS-	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315394	Period: From 07/01/2023	Worksheet A	
					To 06/30/2024	Date/Time Pre 11/26/2024 3:	
	Cost Center Description	Sal ari es	Other		1 Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons I ncrease/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)		
	1	1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1	0.005.170	0.005.45		0.005.470	
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		3, 305, 172	3, 305, 17	2 0 0 0	3, 305, 172	1.00
2.00	00300 EMPLOYEE BENEFITS	0	2, 607, 626	2, 607, 62	-	0 2, 607, 626	3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	1, 412, 401	3, 059, 076			4, 471, 477	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	464, 402	1, 370, 947			1, 835, 349	
6.00	00600 LAUNDRY & LINEN SERVICE	79, 025	32, 530			111, 555	•
7.00	00700 HOUSEKEEPI NG	393, 435	131, 294	524, 72	9 0	524, 729	7.00
8.00	00800 DI ETARY	1, 205, 184	1, 508, 907	2, 714, 09	0 0	2, 714, 091	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	10.00
11.00 12.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	11.00 12.00
13.00	01300 SOCIAL SERVICE	75, 994	0	75, 99	0 0	75, 994	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	,0, ,,	0 0	0	14.00
15.00	01500 ACTI VI TI ES	266, 137	38, 468	304, 60	05 0	304, 605	•
15.01	01501 CHAPLAI N	64, 129	110	64, 23	9 0	64, 239	15.01
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					
30.00	03000 SKI LLED NURSI NG FACI LI TY	2, 721, 282	867, 473				1
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D	0	0		0 0	0	31.00
33.00	03300 OTHER LONG TERM CARE	3, 312, 708	252, 143	3, 564, 85			32.00 33.00
55.00	ANCI LLARY SERVICE COST CENTERS	3, 312, 700	202, 140	3, 304, 00	0	3, 304, 031	33.00
40.00	04000 RADI OLOGY	0	15, 474	15, 47	4 0	15, 474	40.00
41.00	04100 LABORATORY	0	16, 487	16, 48	37 0	16, 487	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	62, 082	21, 622			83, 704	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	472, 372 234, 651	143, 284 0				•
46.00	04600 SPEECH PATHOLOGY	49, 539	0				
47.00	04700 ELECTROCARDI OLOGY	47,337	0	47, 50	0 0	01,049	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15, 107	15, 10	07 0	15, 107	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	232, 893	232, 89	03 0	232, 893	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
60.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC		0		0		62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0		0 0		70.00
	07100 AMBULANCE	0	0		0 0		
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80.00
81.00	08100 I NTEREST EXPENSE		0		0 0	0	1
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	82.00
83.00	08300 HOSPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	10, 813, 341	13, 618, 613	24, 431, 95	04	24, 431, 954	89.00
00.00	NONREI MBURSABLE COST CENTERS	E0 07/	29, 052	00.07	8 0	00,000	00.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	50, 976	29, U52 N	80, 02		80, 028	
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	•
		o	0		0 0	0	1
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
100.00	TOTAL	10, 864, 317	13, 647, 665	24, 511, 98	0	24, 511, 982	100. 00

	nancial Systems FICATION AND ADJUSTMENT OF TRIAL BALANCE O	SHORES AT WE		No.: 315394	Peri od:	u of Form CMS- Worksheet A	2040-1
LULAJJII	TEATION AND ADJUSTMENT OF TREAD ALANCE O	EXI ENSES	11001dei	10 515574	From 07/01/2023		
					To 06/30/2024	Date/Time Pre 11/26/2024 3:	
	Cost Center Description	Adjustments to	Net Expenses			11/20/2021 0.	
			For Allocation				
		Wkst A-8)	(col. 5 +-				
		(00	col. 6)	-			
GE	NERAL SERVICE COST CENTERS	6.00	7.00				-
	1100 CAP REL COSTS - BLDGS & FIXTURES	-274, 133	3, 031, 039				1.0
	200 CAP REL COSTS - MOVABLE EQUI PMENT	0	C	1			2.0
	300 EMPLOYEE BENEFITS	-72, 761	2, 534, 865				3.0
	400 ADMINISTRATIVE & GENERAL	-931, 237	3, 540, 240				4.0
. 00 00	500 PLANT OPERATION, MAINT. & REPAIRS	-26, 749	1, 808, 600				5.0
. 00 00	600 LAUNDRY & LINEN SERVICE	-4, 920	106, 635				6.0
. 00 00	1700 HOUSEKEEPI NG	-216	524, 513				7.0
. 00 00	800 DI ETARY	-12, 801	2, 701, 290				8.0
9.00 00	900 NURSING ADMINISTRATION	0	C				9.0
0. 00 01	000 CENTRAL SERVICES & SUPPLY	0	C				10.0
1.00 01	100 PHARMACY	0	C				11. C
2.00 01	200 MEDICAL RECORDS & LIBRARY	0	C				12.0
13.00 01	300 SOCIAL SERVICE	0	75, 994	Ļ			13.0
	400 NURSING AND ALLIED HEALTH EDUCATION	0	C				14. C
	500 ACTI VI TI ES	0	304, 605				15. C
	501 CHAPLAI N	0	64, 239				15.0
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 SKILLED NURSING FACILITY	0	3, 588, 755				30.0
	100 NURSING FACILITY	0	C				31.0
	200 CF/I D	0	C				32.0
	300 OTHER LONG TERM CARE	0	3, 564, 851				33.0
	CILLARY SERVICE COST CENTERS	-		1			1
1	000 RADI OLOGY	0	15, 474	1			40.0
	100 LABORATORY	0	16, 487	1			41.0
	200 I NTRAVENOUS THERAPY	0	0 70				42.0
	300 OXYGEN (INHALATION) THERAPY	0	83, 704	1			43.0
	400 PHYSI CAL THERAPY 500 OCCUPATI ONAL THERAPY	0	481, 819 336, 384	1			44.0
	600 SPEECH PATHOLOGY	0	81, 643	1			46.0
1	700 ELECTROCARDI OLOGY	0	01,043	1			40.0
	800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15, 107				47.0
	900 DRUGS CHARGED TO PATIENTS	0	232, 893	1			49.0
	0000 DENTAL CARE - TITLE XIX ONLY	0	202, 070				50.0
1.00 05	100 SUPPORT SURFACES	0		1			51.0
	TPATIENT SERVICE COST CENTERS		-	1			
	000 CLINIC	0	C)			60.0
1.00 06	100 RURAL HEALTH CLINIC	0	C				61.0
2.00 06	200 FQHC						62.0
OT	HER REIMBURSABLE COST CENTERS						
0. 00 07	OOO HOME HEALTH AGENCY COST	0	C				70.0
1.00 07	100 AMBULANCE	0	C				71.0
3.00 07	300 CMHC	0	0				73.0
SP	ECIAL PURPOSE COST CENTERS			_			
	000 MALPRACTICE PREMIUMS & PAID LOSSES	0	C				80.0
	100 INTEREST EXPENSE	0	C				81.0
	200 UTILIZATION REVIEW - SNF	0	C				82.0
	300 HOSPI CE	0	C				83.0
9.00	SUBTOTALS (sum of lines 1-84)	-1, 322, 817	23, 109, 137	1			89.0
	NREI MBURSABLE COST CENTERS	1		T			-
	0000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	80, 028	1			90.0
	100 BARBER AND BEAUTY SHOP	0	C	1			91.0
	200 PHYSICIANS PRIVATE OFFICES	0	C				92.0
	2300 NONPALD WORKERS	0	C				93.0
4.00 09 00.00	400 PATIENTS LAUNDRY	0		0			94.0
	TOTAL	-1, 322, 817	23, 189, 165	al de la constante de la consta			100. C

Health Financial Systems	SHORES AT WESLEY	MANOR		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 07/01/2023	Worksheet A-6	
				To 06/30/2024	Date/Time Pre 11/26/2024 3:	pared: 32 pm
			Increases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
(1) A - TO RECLASS OT AND ST						
1.00	OCCUPATI ONAL THERAF	γ	45.0	0 44, 706	57, 027	1.00
2.00	SPEECH PATHOLOGY		46.0	0 14, 108	17, 996	2.00
TOTALS						
	Total Reclassificat of columns 4 and 5 sum of columns 8 ar	must equal		58, 814	75, 023	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	SHORES AT WESLEY	MANOR		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Period:	Worksheet A-6	
				From 07/01/2023 To 06/30/2024	Date/Time Pre 11/26/2024 3::	pared: 32 pm
			Decreases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
(1) A - TO RECLASS OT AND ST						
1.00	PHYSI CAL THERAPY		44. (00 58, 814	75, 023	1.00
2.00			0. (0 0	0	2.00
TOTALS			_			
100.00				58, 814	75, 023	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.

RECONCILIATION OF CAPITAL COSTS CENTERS Provider No.: 315394 Period: period: Tom 07/01/2023 To 06/30/2024 Worksheet A-7 Description Beginning Balances Purchases Donation Total Disposal s and Retirements 1.00 Land Doscription 0 0 0 0 2.00 Land Improvements 0 0 0 0 0 3.00 Building Improvements 0 <t< th=""><th>Heal th</th><th>Financial Systems</th><th>SHORES AT WE</th><th>SLEY MANOR</th><th></th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2540-10</th></t<>	Heal th	Financial Systems	SHORES AT WE	SLEY MANOR			In Lie	u of Form CMS-2	2540-10
Description Beginning Balances Acquisitions Disposals and Retirements 1.00 2.00 3.00 4.00 5.00 AMALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00 1.00 Land mprovements 0 0 0 0 1.00 2.00 Bilding improvements 0 0 0 0 0 2.00 3.00 Fixed Equipment 463,497 0 0 0 0 0 2.00 4.00 Building improvements 0 0 0 0 0 0 2.00 5.00 Fixed Equipment 4,175,514 159,801 0 159,801 142,215 5.00 0.00 Reconciling Items 0 57,748,091 545,798 0 545,798 287,165 7.00 0 Daterrition Ending Balance Fully Pepreciated Assets 3.00 4.00 50,00 3.00 3.00 3.00 <td< td=""><td>RECON</td><td>CILIATION OF CAPITAL COSTS CENTERS</td><td></td><td>Provi der</td><td>No.: 315394</td><td></td><td></td><td>Worksheet A-7</td><td></td></td<>	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315394			Worksheet A-7	
Description Acquisitions Disposal s and Purchases Disposal s and Purchases ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 9 0 3.00 4.00 5.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 0 <								Date/Time Pre	nared
Description Beginning Balances Purchases Donation Total Disposal s and Retirements 1.00 2.00 3.00 4.00 5.00 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 463,497 0 0 0 0 2.00 1.00 Land inprovements 0 0 0 0 2.00 3.00 Buil ding Improvements 0 0 0 0 2.00 4.00 Buil ding Improvements 0 0 0 0 0 2.00 5.00 Fixed Equipment 4,175,514 159,801 0 159,801 142,215 5.00 6.00 Novable Equipment 4,175,514 159,801 0<							00/ 30/ 2024	11/26/2024 3:	32 pm
Balances Balances Retirements 1.00 2.00 3.00 4.00 5.00 1.00 Land 0<					Acqui si ti on	s			
I.00 2.00 3.00 4.00 5.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 463,497 0		Description		Purchases	Donati on		Total		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 463,497 0 <									
1.00 Land 463,497 0 <				2.00	3.00		4.00	5.00	
2.00 Land Improvements 0 0 0 0 0 2.00 3.00 Building sand Fixtures 53,013,293 385,997 0 385,997 71,484 3.00 4.00 Building Improvements 0 0 0 0 0 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 4,175,514 159,801 0 159,801 142,215 5.00 6.00 Movable Equipment 95,787 0 0 0 73,466 6.00 7.00 Subtotal (sum of lines 1-6) 57,748,091 545,798 0 545,798 287,165 7.00 8.00 Reconciling Items 0 0 0 0 0 8.00 9.00 Total (line 7 minus line 8) 57,748,091 545,798 0 545,798 287,165 9.00 9.00 Total (line 7 minus line 8) 57,748,091 545,798 287,165 9.00 8.00 2.00 Land Ending Balance Fully Depreciated Assets 6.00									
3.00 Buildings and Fixtures 53,013,293 385,997 0 385,997 71,484 3.00 4.00 Building Improvements 0 <td< td=""><td></td><td></td><td>463, 497</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td></td></td<>			463, 497	0		0	0	0	
4.00 Building Improvements 0 0 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 4,175,514 159,801 0 159,801 142,215 5.00 6.00 Movable Equipment 95,787 0 0 0 73,466 6.00 7.00 Subtotal (sum of lines 1-6) 57,748,091 545,798 0 545,798 287,165 7.00 8.00 Reconciling Items 0			50.010.000	0		0	0	71 101	
5.00 Fixed Equipment 4, 175, 514 159, 801 0 159, 801 142, 215 5.00 6.00 Movable Equipment 95, 787 0 0 73, 466 6.00 7.00 Subtotal (sum of lines 1-6) 57, 748, 091 545, 798 0 545, 798 287, 165 7.00 8.00 Reconciling Items 0 0 0 0 0 8.00 9.00 Total (line 7 minus line 8) 57, 748, 091 545, 798 0 545, 798 287, 165 7.00 Description Ending Balance Fully Pepreciated Assets 6.00 7.00 0 0 287, 165 7.00 AnALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 0 0 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 3.00 4.00 4.00 5.00 4.00 5.00 4.00 5.00 5.00 5.0			53, 013, 293	385, 997		0	385, 997		
6.00 Movable Equipment 95,787 0 0 0 73,466 6.00 7.00 Subtotal (sum of lines 1-6) 57,748,091 545,798 0 545,798 287,165 7.00 8.00 Reconciling Items 0 <				150.001		0	150.001	0	
7.00 Subtotal (sum of lines 1-6) 57,748,091 545,798 0 545,798 287,165 7.00 8.00 Reconciling ltems 0 <				159, 801		0	159, 801		
8.00 Reconciling Items 0 0 0 0 0 0 8.00 8.00 9.00 Total (line 7 minus line 8) 57,748,091 545,798 0 545,798 287,165 9.00 Description Ending Bal ance Assets Fully Depreciated Assets 6.00 7.00 7.00 7.00 1.00 2.00 1.00 2.00 3.00 8.01 7.00 1.00 2.00 3.00 8.01 7.00 1.00 2.00 3.00 8.01 7.00 3.00 4.03,497 0 2.00 3.00 4.01 1.00 2.00 3.00 3.00 8.01 4.03,100 0 4.00 4.00 4.00 4.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 6.00 0 0 0 0 0 0.00 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <				U		0			
9.00 Total (line 7 minus line 8) 57,748,091 545,798 0 545,798 287,165 9.00 Description Ending Balance Fully Depreciated Assets Fully Depreciated 287,165 9.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 1.00 2.00 Land 0 0 2.00 3.00 Buildings and Fixtures 53,327,806 0 3.00 3.00 4.00 5.00 Fixed Equipment 4.00 5.00 4.00 5.00 5.00 5.00 58,006,724 0 5.00 5.00 58,006,724 0 6.00 0			57, 748, 091	545, 798		0	545, 798		
DescriptionEnding BalanceFully Depreciated AssetsANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES6.007.001.00Land002.00Land Improvements003.00Buildings and Fixtures53, 327, 80604.00Building Improvements005.00Fixed Equipment4, 193, 10006.0022, 32105.006.00Stotal (sum of Lines 1-6)58, 006, 72408.00Reconciling Items008.00Reconciling Items00			57 740 001	U		0		0	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Depreciated Assets 1.00 1.00 Land 0 0 1.00 2.00 Solution 1.00 2.00 Solution 1.00 2.00 3.00 Buildings and Fixtures 53, 327, 806 0 0 0 3.00 4.00 5.00 Fixed Equipment 4.193, 100 0 4.00 5.00 Fixed Equipment 5.00 6.00 7.00 4.00 5.00 6.00 0	9.00					0	545, 798	287, 165	9.00
ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 Land 463,497 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 53,327,806 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 4,193,100 0 4.00 6.00 Movable Equipment 22,321 0 5.00 7.00 Subtotal (sum of Lines 1-6) 58,006,724 0 7.00 8.00 Reconciling Items 0 0 8.00		Description	Ending Bai ance						
ANALYSI S 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 53,327,806 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 4,193,100 0 5.00 6.00 Movable Equipment 22,321 0 6.00 7.00 Subtotal (sum of Lines 1-6) 58,006,724 0 7.00 8.00 Reconciling Items 0 0 8.00									
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 53,327,806 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 4,193,100 0 4.00 5.00 Movable Equipment 22,321 0 6.00 8.00 Reconciling Items 0 0 7.00			6.00						
1.00 Land 463,497 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 53,327,806 0 3.00 4.00 Building Improvements 0 0 0 5.00 Fixed Equipment 4,193,100 0 5.00 6.00 Movable Equipment 22,321 0 6.00 7.00 Subtotal (sum of Lines 1-6) 58,006,724 0 7.00 8.00 Reconciling Items 0 0 8.00		ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		7.00					
2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 53, 327, 806 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 4, 193, 100 0 5.00 6.00 Movable Equipment 22, 321 0 6.00 7.00 Subtotal (sum of Lines 1-6) 58, 006, 724 0 7.00 8.00 Reconciling Items 0 0 8.00	1.00			0					1.00
3.00 Buildings and Fixtures 53,327,806 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 4,193,100 0 5.00 6.00 Movable Equipment 22,321 0 6.00 7.00 Subtotal (sum of lines 1-6) 58,006,724 0 7.00 8.00 Reconciling Items 0 0 8.00			0	0					
4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 4,193,100 0 5.00 6.00 Movable Equipment 22,321 0 6.00 7.00 Subtotal (sum of lines 1-6) 58,006,724 0 7.00 8.00 Reconciling Items 0 0 8.00			53, 327, 806	0					
5.00 Fixed Equipment 4, 193, 100 0 5.00 6.00 Movable Equipment 22, 321 0 6.00 7.00 Subtotal (sum of lines 1-6) 58, 006, 724 0 7.00 8.00 Reconciling Items 0 0 8.00			0	0					
6.00 Movable Equipment 22,321 0 6.00 7.00 Subtotal (sum of lines 1-6) 58,006,724 0 7.00 8.00 Reconciling Items 0 0 8.00			4, 193, 100	0					
7.00 Subtotal (sum of lines 1-6) 58,006,724 0 7.00 8.00	6.00			0					6.00
8.00 Reconciling Items 0 0 0 8.00				0					
	8.00	Reconciling Items	0	0					8.00
	9.00	Total (line 7 minus line 8)	58, 006, 724	0					9.00

	Financial Systems MENTS TO EXPENSES	SHORES AT WESL		No.: 315394	Peri od:	u of Form CMS-2 Worksheet A-8	
5051	MENTS TO EXTENSES		TTOVIGET	NO 313374	From 07/01/2023		
					To 06/30/2024	Date/Time Pre 11/26/2024 3:	
					lassification on	Worksheet A	
				To/From Whice	ch the Amount is	to be Adjusted	
			A		t Cantan	Line Ne	
	Description (1)	(2) Basis For Adjustment	Amount	Cos	t Center	Line No.	
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds	В	-274, 133	CAP REL COST	S - BLDGS &	1.00	1
00	(chapter 2) Trade, quantity, and time discounts (chapter		C	FIXTURES		0.00	2
	8)		C C	,		0.00	
00	Refunds and rebates of expenses (chapter 8)		C			0.00	3
00	Rental of provider space by suppliers		C			0.00	4
00	(chapter 8) Telephone services (pay stations excluded)		C			0.00	5
	(chapter 21)		-				
00	Television and radio service (chapter 21)	В	-25, 089		ION, MAINT. &	5.00	6
00	Parking lot (chapter 21)		C	REPAIRS		0.00	7
00	Remuneration applicable to provider-based	A-8-2	C	þ		0.00	8
	physician adjustment						
)0 00	Home office cost (chapter 21) Sale of scrap, waste, etc. (chapter 23)		(0.00	
00	Nonallowable costs related to certain Capital		(0.00	
00	expendi tures (chapter 24)					0.00	
00	Adjustment resulting from transactions with	A-8-1	-100, 595	5			12
00	related organizations (chapter 10) Laundry and linen service	В	4 020	LAUNDRY & LI		6.00	13
00	Revenue - Employee meals	B		IDI ETARY	NEN SERVICE	8.00	
00	Cost of meals - Guests		C	þ		0.00	15
00	Sale of medical supplies to other than		C	D I I I I I I I I I I I I I I I I I I I		0.00	16
00	patients Sale of drugs to other than patients		C			0.00	17
00	Sale of medical records and abstracts		C			0.00	
00	Vending machines		C			0.00	
00	Income from imposition of interest, finance		C	D		0.00	20
00	or penalty charges (chapter 21) Interest expense on Medicare overpayments and	4	C			0.00	21
00	borrowings to repay Medicare overpayments					0100	
00	Utilization reviewphysicians' compensation		C	UTILIZATION	REVIEW - SNF	82.00	22
00	(chapter 21) Depreciationbuildings and fixtures		C	CAP REL COST	S - BLDGS &	1.00	23
				FI XTURES			
00	Depreciationmovable equipment		C	CAP REL COST	S - MOVABLE	2.00	24
00	MARKETING SALARIES AND OTHER	A	-605 517	EQUI PMENT ADMI NI STRATI	VE & GENERAL	4.00	25
	MARKETING SALAKTES AND OTHER	A		EMPLOYEE BEN		3.00	
02	NON-ALLOWABLE EXPENSES	A		ADMI NI STRATI		4.00	25
03	BED TAX ASSESSMENT	A		ADMI NI STRATI		4.00	
04	ELECTRI C REVENUE	В	-595	SPLANT OPERAT REPAI RS	ION, MAINT. &	5.00	25
05	HOUSEKEEPING	В	-216	HOUSEKEEPING		7.00	25
06	LATE CHARGES	В		ADMI NI STRATI		4.00	
07	MAINTENANCE SERVICE	В	-1, 065		ION, MAINT. &	5.00	25
08	MI SCELLANEOUS I NCOME	В	-20	REPAI RS ADMI NI STRATI	VE & GENFRAL	4.00	25
00		-	0			0.00	
D. 00	Total (sum of lines 1 through 99) (Transfer		-1, 322, 817	7			100

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

Health Financial Systems	SHORES AT WE	SLEY MANOR		In Lie	u of Form CMS	-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS				Period: From 07/01/2023 To 06/30/2024	Worksheet A- Parts I-II Date/Time Pr 11/26/2024 3	8-1 epared:
	Line No.	Cost (Expense		
	1.00	2.		3.		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANIZATIONS	S OR	
1.00	4.00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE COS	ST	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 TOTALS (sum of lines 1-9). Transfer column	0.00					10.00
6, line 100 to Worksheet A-8, column 3, line						10.00
12.						
12.	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu			
	Cost	Wkst. A, col.	col. 5)	3		
	0031	5				
	4.00	5.00	6,00	_		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN				ED ORGANIZATIONS	S OR	
CLAIMED HOME OFFICE COSTS:						
1.00	1, 314, 027	1, 414, 622	-100, 59	95		1.00
2.00	0	0		0		2.00
3.00	0	0		0		3.00
4.00	0	0		0		4.00
5.00	0	0		0		5.00
6.00	0	0		0		6.00
7.00	0	0		0		7.00
8.00	0	0		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	1, 314, 027	1, 414, 622	-100, 59	95		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						
			-			-

Health Financial Systems	SHORES AT WE	SLEY MANOR	In Lie	u of Form CMS-2	540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ. OFFICE COSTS	ATIONS AND HOME	E Provider No.: 31539	From 07/01/2023	Worksheet A-8- Parts I-II Date/Time Prep 11/26/2024 3:3	ared:
	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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

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

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

1.00		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
	specify:				

(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 organizati on.

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	Related Organization(s) and/or Home Office				
	Name	Percentage of	Type of Business			
		Ownershi p				
	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. 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

rerinbur					
1.00		UNITED METHODIST HOMES OF NJ	100.00 SI	UPPORT 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.

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

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.

2:00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 0 2:00 0200 PUIVOTE ENERTITS 0 2:00 0200 PUIVOTE ENERTITS 0 2:53, 865 0 0 2:54, 865 3:00 3:00 0:00 00400 ADMINISTRATIVE & GENERAL 3:540, 240 93, 752 0 2:564, 865 3:00 111, 470 1, 944, 535 5:0 5:0 0:00 0:00 PLAIT OPERATION, MAINT & REPAIRS 1:06, 635 29, 991 0 111, 470 1, 944, 366 3:2, 37 7:0 0:00 00600 PLETARY 2, 701, 290 57, 067 0 290, 279 3:047, 36 8:0 0 <t< th=""><th>Heal th</th><th>Financial Systems</th><th>SHORES AT WES</th><th>LEY MANOR</th><th></th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2540-10</th></t<>	Heal th	Financial Systems	SHORES AT WES	LEY MANOR			In Lie	u of Form CMS-2	2540-10
Cost Center Description Net Expenses For Cost (rec) BURS & FITURES MOVABLE EQUIPMENT EWPLOYFE BENET IS Subtotal 0 0 0 1.00 2.00 3.00 3.4 1.00 000000 (AP REL COST - BLIDS & FIXTURES 0.000000 (AP REL COST - BLIDS & FIXTURES 0.0000000 (AD RES ICOST - BLIDS & FIXTURES 0.0000000 (AR RES ICOST - BLIDS & FIXTURES 0.0000000 (AD RES ICOST - BLIDS & FIXTURES 0.0000000 (AR RES ICOST - BLIDS & FIXTURES 0.0000000 (AD RES ICOST - BLIDS & FIXTURES 0.0000000 (AR RES ICOST - BLIDS & FIXTURES 0.000000000 (AR RES ICOST - BLIDS & FIXTURES 0.00000000000000000000000000000000000	COST AL	LOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315394	Fro	om 07/01/2023	Part I Date/Time Pre	
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NONREI MBURSABLE COST CENTERS 90. 00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 80, 028 0 0 12, 236 92, 264 90. 00			23 109 137	3 028 324			2 522 629	-	
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 80, 028 0 0 12, 236 92, 264 90. 0			20,107,107	5, 020, 324	1	<u> </u>	2, 022, 027	20,074,100	0,00
91.00 01001 BARBER AND BEAUTY SHOP 0 2,715 0 0 2.715 91.00	90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	80, 028			0	12, 236	92, 264	90.00
			0	2, 715		0	0		
			0	0		0	0	-	
	93.00 0		0	0		0	0		
			0	0	1		01		1 74.00
99.00 Negative Cost Centers 0 0 0 0 99.00	94.00		0	0		0	0	-	98.00
100. 00 TOTAL 23, 189, 165 3, 031, 039 0 2, 534, 865 23, 189, 165 100. 0	94.00 98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0	0		-	0	0	99.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 07/01/2023 o 06/30/2024	Worksheet B Part I Date/Time Pre 11/26/2024 3:	pared: 32 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDCS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	3, 900, 118 393, 171 31, 440 127, 895 616, 211 0 0 0 0 0 20, 427 0 81, 098	2, 337, 702 23, 989 10, 905 45, 799 0 0 0 0 5, 453 0 26, 168	210, 923 0 0 0 0 0 0 0 0 0 0 0 0 0	771, 337	3, 724, 987 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
	01501 CHAPLAI N	16, 101	20, 108		0, 703	0	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		-	-	-	-	
31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	949, 800 0 0 1, 347, 820	365, 604 0 0 1, 850, 674	0	0 0	1, 205, 117 0 0 2, 519, 870	30.00 31.00 32.00 33.00
40.00	04000 RADI OLOGY	3, 129	0			0	40.00
45.00 46.00 47.00 48.00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDIOLOGY 04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 0UTPATIENT SERVICE COST CENTERS	3, 334 0 19, 937 119, 238 81, 572 19, 597 0 3, 055 47, 089 0 0	0 0 6, 931 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	0 0 2, 322 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0			0	60.00 61.00
	06200 FQHC	0	0		0	0	62.00
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0 0			0 0	70.00
	07300 CMHC	0	0	0	0	0	73.00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 3, 880, 914	0 2, 335, 523	0 210, 923	0 770, 607	0 <u>3, 724, 987</u>	83.00 89.00
91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	18, 655 549 0 0 0	0 2, 179 0 0 0	0 0 0 0 0	0 730 0 0 0	0 0 0 0 0	90.00 91.00 92.00 93.00 94.00
94.00 98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	98.00 99.00

	Financial Systems	SHORES AT WES				eu of Form CMS-2	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315394	Period: From 07/01/2023 To 06/30/2024		pared: 32 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	1 1				_	
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 5.00	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 HOUSEKEEPING						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0				10.00
11.00	01100 PHARMACY	0	0		0		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	12.00
13.00	01300 SOCIAL SERVICE	0	0		0	0 128, 735	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0 0	14.00
15.00	01500 ACTI VI TI ES	0	0		0	0 0	15.00
15.01	01501 CHAPLAI N	0	0		0	0 0	15.01
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 1		1			
30.00	03000 SKI LLED NURSI NG FACI LI TY	0	0			0 128, 735	30.00
31.00	03100 NURSING FACILITY	0	0			0 0	31.00
32.00	03200 I CF/I I D	0	0			0 0	32.00
33.00	O3300 OTHER LONG TERM CARE	0	0		0	0 0	33.00
40, 00	ANCI LLARY SERVI CE COST CENTERS	0	0		0	0 0	40.00
40.00	04100 LABORATORY	0	0		-	0 0	40.00
41.00	04200 I NTRAVENOUS THERAPY	0	0		0	0 0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0		0		43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0	0 0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0	0 0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0	o o	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0 0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	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
(0.00	OUTPATIENT SERVICE COST CENTERS						1 / 0 . 00
60.00	06000 CLINIC	0	0			0 0	60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0	0 0	61.00 62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0 0	70.00
	07100 AMBULANCE	0	0			0 0	
	07300 CMHC	0	0		0	-	73.00
	SPECIAL PURPOSE COST CENTERS			1			
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
	08300 HOSPI CE	0	0			0 0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	0		0	0 128, 735	89.00
~~ ~~	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0 0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0	0 0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0				92.00
93.00 94.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0			0 0 0 0	93.00 94.00
94.00 98.00	Cross Foot Adjustments	0	0				94.00 98.00
98.00 99.00	Negative Cost Centers	0	0		0	o o	
100.00		0	0			0 128, 735	
	1 1	, oj	0	1	- 1	.20,.00	

Heal th	Financial Systems	SHORES AT WE	SLEY MANOR		In Lie	u of Form CMS-2	2540-10
	LLOCATION - GENERAL SERVICE COSTS			No.: 315394	Peri od: From 07/01/2023 To 06/30/2024	Worksheet B Part I Date/Time Pre	pared:
			OTHER GENER	RAL SERVICE		11/26/2024 3:	32 pm
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Stepdown Adjustments	
		14.00	15.00	15. 01	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS	1					1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00 2.00
2.00 3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY						10.00 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 ACTIVITIES	0	517, 123				15.00
15.01	01501 CHAPLAI N	0	0	95, 73	33		15.01
	INPATIENT ROUTINE SERVICE COST CENTERS	·					
30.00	03000 SKILLED NURSING FACILITY	0	517, 123			0	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00 33.00	03200 I CF/IID 03300 OTHER LONG TERM CARE	0	0	67, 6	0 0	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	07, 0,	33 13, 114, 052	0	33.00
40.00	04000 RADI OLOGY	0	0		0 18, 603	0	40.00
41.00	04100 LABORATORY	0	0		0 19, 821	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 118, 542	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0 718, 213	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0		0 485, 010	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0		0 116, 517 0 0	0	46.00 47.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 18, 162	0	47.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 279, 982	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 CLINIC	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	0		0 0	0	
73.00	07300 CMHC	0	0		0 0		
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPICE	0	() E17 100	05.7		0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	517, 123	95, 73	33 23, 072, 073	0	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 110, 919	0	90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 6, 173	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	
98.00	Cross Foot Adjustments	0	0		0 0	0	
99.00 100.00	Negative Cost Centers TOTAL	0	() E17 100	05 7	U 0	0	99.00 100.00
100.00	I ITTAL	I U	517, 123	95, 7	33 23, 189, 165	0	1.00.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315394 Period: From 07/01/2023 To 06/30/2024 Worksheet Part I Date/Time 11/26/2024 Cost Center Description Total 18.00 GENERAL SERVICE COST CENTERS Service COST CENTERS 1.00 00100 CAP REL COSTS - BLOGS & FIXTURES 0.02000 CAP REL COSTS - BLOGS & FIXTURES	Prepared:
Cost Center Description Total 11/26/2024 6ENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	3: 32 pm 1.00 2.00 3.00 4.00 5.00
Cost Center Description Total 11/26/2024 Is. 00 Is. 00 Is. 00 Is. 00	3: 32 pm 1.00 2.00 3.00 4.00 5.00
18.00 GENERAL SERVI CE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FI XTURES	2.00 3.00 4.00 5.00
GENERAL SERVI CE COST CENTERS 1. 00 00100 CAP REL COSTS - BLDGS & FI XTURES	2.00 3.00 4.00 5.00
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES	2.00 3.00 4.00 5.00
	2.00 3.00 4.00 5.00
2. 00 00200 CAP REL COSTS - MOVABLE EQUI PMENT	4.00 5.00
3.00 00300 EMPLOYEE BENEFITS	5.00
4. 00 00400 ADMINI STRATI VE & GENERAL	
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	6.00
6.00 00600 LAUNDRY & LINEN SERVICE	
7. 00 00700 HOUSEKEEPING	7.00
8. 00 00800 DI ETARY	8.00
9.00 00900 NURSI NG ADMI NI STRATI ON	9.00
10.00 O1000 CENTRAL SERVICES & SUPPLY	10.00
	11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 13. 00 01300 SOCI AL SERVI CE	12.00 13.00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	14.00
15. 00 01500 ACTIVITIES	15.00
15. 01 01501 CHAPLAI N	15.00
INPATIENT ROUTINE SERVICE COST CENTERS	10.01
30. 00 03000 SKI LLED NURSI NG FACI LI TY 8, 183, 171	30.00
31.00 03100 NURSING FACILITY 0	31.00
32.00 03200 I CF/I I D 0	32.00
33. 00 03300 OTHER LONG TERM CARE 13, 114, 052	33.00
ANCILLARY SERVICE COST CENTERS	
40. 00 04000 RADI OLOGY 18, 603	40.00
41. 00 04100 LABORATORY 19, 821	41.00
42.00 04200 I NTRAVENOUS THERAPY 0	42.00
43. 00 04300 DXYGEN (INHALATION) THERAPY 118,542	43.00
44. 00 04400 PHYSI CAL THERAPY 718, 213	44.00
45. 00 04500 OCCUPATI ONAL THERAPY 485, 010 46. 00 04600 SPEECH PATHOLOGY 116, 517	45.00 46.00
40. 00 04000 SPEECH PATHOLOGY 110, 517 47. 00 04700 ELECTROCARDI OLOGY 0	47.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 18, 162	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS 279, 982	49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0	50.00
51.00 05100 SUPPORT SURFACES 0	51.00
OUTPATIENT SERVICE COST CENTERS	
60. 00 06000 CLINIC 0	60.00
61. 00 06100 RURAL HEALTH CLINIC 0	61.00
62. 00 06200 FOHC	62.00
OTHER REI MBURSABLE COST CENTERS	70.00
70. 00 07000 HOME HEALTH AGENCY COST 0	70.00
71.00 07100 AMBULANCE 0 73.00 07300 CMHC 0	71.00
SPECIAL PURPOSE COST CENTERS	73.00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES	80.00
81.00 08100/INTEREST EXPENSE	81.00
82.00 08200 UTILIZATION REVIEW - SNF	82.00
83. 00 08300 HOSPI CE 0	83.00
89.00 SUBTOTALS (sum of lines 1-84) 23,072,073	89.00
NONREI MBURSABLE COST CENTERS	
90. 00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 110, 919	90.00
91.00 09100 BARBER AND BEAUTY SHOP 6, 173	91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0	92.00
93. 00 09300 NONPAID WORKERS 0	93.00
94. 00 09400 PATIENTS LAUNDRY 0	94.00
98.00 Cross Foot Adjustments 0 99.00 Negative Cost Centers 0	98.00
99.00 Negative Cost Centers 0 100.00 TOTAL 23, 189, 165	99.00 100.00
	1100.00

Heal th	Financial Systems	SHORES AT WES	SLEY MANOR		In Lie	eu of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315394	Period: From 07/01/2023 To 06/30/2024		pared: 32 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		0	1.00	2.00	2A	3.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00 2.00
3.00	00300 EMPLOYEE BENEFITS	0	0		0 0	0	3.00
4.00	00400 ADMINI STRATI VE & GENERAL	0	93, 752		0 93, 752	0	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	24, 461		0 24, 461	0	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	29, 891		0 29, 891		6.00
7.00	00700 HOUSEKEEPI NG	0	13, 588		0 13, 588		7.00
8.00	00800 DI ETARY	0	57, 067		0 57,067		8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0		0 0	0	10.00 11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	12.00
13.00	01300 SOCIAL SERVICE	0	6, 794		0 6, 794		13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15.00	01500 ACTI VI TI ES	0	32, 606		0 32,606	0	15.00
15.01	01501 CHAPLAI N	0	0		0 0	0	15.01
	INPATIENT ROUTINE SERVICE COST CENTERS	i					
30.00	03000 SKILLED NURSING FACILITY	0	455, 550		0 455, 550		30.00
31.00	03100 NURSING FACILITY	0	0		0 0		31.00
32.00 33.00	03200 I CF/IID 03300 OTHER LONG TERM CARE	0	0 2, 305, 978		0 0 0 2, 305, 978	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS	0	2, 303, 970		2, 303, 478	0	33.00
40.00	04000 RADI OLOGY	0	0		0 0	0	40.00
41.00	04100 LABORATORY	0	0		0 0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	8, 637		0 8, 637		44.00
45.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0 0	-	45.00
46.00 47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	46.00 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS					1	
60.00	06000 CLINIC	0	0		0 0		60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FOHC 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	1 1				1	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF	0	0		0	0	82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	3, 028, 324		0 0 0 3, 028, 324	0	83.00 89.00
07.00	NONREI MBURSABLE COST CENTERS	0	5,020, 524		0 3, 020, 324	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	0	2, 715		0 2, 715	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
93.00	09300 NONPAI D 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	-	98.00
99.00 100.00	Negative Cost Centers TOTAL	0	0 3, 031, 039		0 3, 031, 039	0	99.00 100.00
100.00		I U	3, 031, 039	l	J 3, US 1, US 9	1 0	100.00

2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2 4.00 00400 ADMINISTRATIVE & GENERAL 93, 752 4 5.00 00500 PLAT OPERTITION, MAINT, & REPARS 9, 575 348 30, 995 6.00 00600 LANIN PERTITION, MAINT, & REPARS 9, 575 348 30, 995 6.00 00600 LANINGEN AGAININISTRATION 16, 820 0 6 0.00 00900 DETAKY 14, 812 6, 644 0 33 10.00 000000 DETAKY 0 0 0 0 0 0 0 11.00 01400 DHIRAN AGAININISTRATION 0	Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	SHORES AT WES			Peri od:	u of Form CMS- Worksheet B	2040-10
Like Struct Description AVXIII NSTRATIVE 6 GRHEAL OPLANT OPLANT LIKENSIVE 0 Description DESCRIPTION 1 A GRHEAL SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.000 5.00 7.00 8.000 5.00 7.00 8.000 5.00 7.00 8.000 5.00 7.00 8.000 5.00 <t< th=""><th></th><th></th><th></th><th></th><th></th><th>Date/Time Pre</th><th></th></t<>						Date/Time Pre	
EXERCISE EXERCISES 0.0 00000 CAP REL COSTS - BLOGS & FIXURES 2.0 0.0000 CAP REL COSTS - BLOGS & FIXURES 93.752 0.0000 CAP REL COSTS - BLOGS & FIXURES 93.752 0.0000 CAPINE COSTS - BLOGS & FIXURES 93.752 0.0000 CAPINE TOT VE & LIAINT & REPAIRS 93.752 0.0000 CAPINE STRV CE 756 0.0000 CAPINES STRV CE 0 0.0000 CAPINES STRV CE <th>Cost Center Description</th> <th></th> <th>OPERATION, MAINT. &</th> <th></th> <th></th> <th></th> <th></th>	Cost Center Description		OPERATION, MAINT. &				
1.00 OOTOOLGAP REL COSTS - BLOS A FLXTURES 1 2.00 OOZOOLGAP REL COSTS - MONABLE EDUPMENT 3 3.00 OOZOOLGAP REL COSTS - MONABLE EDUPMENT 3 5.00 OOZOOLGAP REL COSTS - MONABLE EDUPMENT 1 5.00 OOZOOLGAP REL COSTS - MONABLE EDUPMENT 1 6.00 OOZOOLGAP REL COSTS - MURSING ADMINISTRATION 0 0 0 6.00 OOZOOLCHISTRA LIBERARY 0 0 0 0 0 10.00 OITOO CHISTRA LIBERARY 0		4.00	5.00	6.00	7.00	8.00	
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2 3.00 00300 CMPTOVEE BENERAL 93, 752 3.00 00300 CMAIN OFERTATIVE & GENERAL 93, 752 3.00 00300 CMAIN OFERTATIVE & GENERAL 93, 752 3.00 00300 CMAIN OFERTATIVE 750 348 30, 995 3.00 00300 CMAIN OFERTATION 16, 820 0 0 0 0.00 00000 LIESING AMINI STRATION 16, 820 0				1			1.00
INPATI ENT FOUTINE SERVICE COST CENTERS Impati entities 11 00 00 000000000 SKILLED NURSING FACILLITY 22,830 5,303 24,796 2,677 23,578 30 310 00 03100 NURSING FACILLITY 22,830 5,303 24,796 2,677 30 00 330 00 330 00 330 00 330 00 330 00 0 0 33 00 330 00 0 0 0 33 00 03300 OTHER LONG TERM CARE 32,405 26,846 6,199 13,517 49,300 33 40.00 04000 RADIOLOGY 75 0 </td <td>2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 3.00 00300 EMPLOYEE BENEFITS 4.00 00400 ADMINISTRATIVE & GENERAL 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE 7.00 00700 HOUSEKEEPING 8.00 00800 DI ETARY 9.00 00900 NURSING ADMINISTRATION 10.00 01000 CENTRAL SERVICES & SUPPLY 11.00 01100 PHARMACY 12.00 01200 MEDICAL RECORDS & LIBRARY 13.00 01300 SOCIAL SERVICE 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 15.00 01500 ACTIVITIES</td> <td>9, 450 756 3, 074 14, 812 0 0 0 0 0 491 0 1, 949</td> <td>348 158 664 0 0 0 79 0 380</td> <td></td> <td>16, 820 335 0 191</td> <td>0 0 0 0 0 0 0 0 0</td> <td>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</td>	2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 3.00 00300 EMPLOYEE BENEFITS 4.00 00400 ADMINISTRATIVE & GENERAL 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE 7.00 00700 HOUSEKEEPING 8.00 00800 DI ETARY 9.00 00900 NURSING ADMINISTRATION 10.00 01000 CENTRAL SERVICES & SUPPLY 11.00 01100 PHARMACY 12.00 01200 MEDICAL RECORDS & LIBRARY 13.00 01300 SOCIAL SERVICE 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 15.00 01500 ACTIVITIES	9, 450 756 3, 074 14, 812 0 0 0 0 0 491 0 1, 949	348 158 664 0 0 0 79 0 380		16, 820 335 0 191	0 0 0 0 0 0 0 0 0	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
30:00 03000 (SKILLED NURSING FACILITY 22,830 5,303 24,796 2,670 23,578 30 30:00 03200 (CF/II 0 0 0 0 0 31 32:00 03200 (TFUR LONC TEM CARE 32,405 26,846 6,199 13,517 49,300 33 40:00 04000 (FABC LONC TEM CARE 32,405 26,846 6,199 13,517 49,300 34 40:00 04000 (FABC LONC TEM CARE 32,405 26,846 6,199 13,517 49,300 34 40:00 04200 (FARCHONC TEM CARE 75 0 0 0 40 41:00 04200 (FARCHONC THERAPY 80 0 0 0 43 42:00 04200 (CLARCHONC THERAPY 1,961 0 0 0 44 04400 PHYSICAL THERAPY 1,961 0 0 0 44 0 0 0 45 46:00 04600 SPEECH PATHOLOGY 471 0 0 0 0 0 47 49:00 04000 MEDICAL SUPPLICE COST CENTERS 0 0 <		387	0) (0 0	0	15.01
40.00 Q4000 RADIOLOGY 75 0 0 0 0 41.00 Q4100 LABORATORY 80 0	30. 00 03000 SKI LLED NURSING FACILITY 31. 00 03100 NURSING FACILITY 32. 00 03200 I CF/I I D 33. 00 03300 OTHER LONG TERM CARE	0 0	0		0 0 0 0	0	31.00 32.00
41.00 04100 LABORATORY 80 0 0 0 0 1 42.00 04200 INTRAVENOUS THERAPY 0 0 0 42 43.00 04300 OXYGEN (INHALATION) THERAPY 479 0 0 0 43 44.00 04400 PHYSI CAL THERAPY 2,866 101 0 51 0 44 50.00 04600 OCUPATIONAL THERAPY 1,961 0 0 0 45 64.00 04600 SPEECH PATHOLOGY 471 0 0 0 47 70.00 0400 ELECTROCARDIOLOGY 471 0 0 0 47 70.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 7.3 0 0 0 47 70.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 50 70.00 05000 OLING CALINIC 0 0 0 0 0 0 60 70.00 07000 (HOME HEALTH ACENY COST 0 0 0 0 0 70		75				0	1 40 00
42.00 04200 INTRAVENOUS THERAPY 0							40.00
49.00 04900 DRUGS CHARGED TO PATIENTS 1,132 00	43.00 04300 0XYGEN (I NHALATI ON) THERAPY 44.00 04400 PHYSI CAL THERAPY 45.00 04500 OCCUPATI ONAL THERAPY 46.00 04600 SPEECH PATHOLOGY	479 2, 866 1, 961 471	0 101		0 0 0 51	0 0 0 0	43.00 44.00 45.00 46.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0			0) (0 0	•	48.00
51.00 005100 SUPPORT SURFACES 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td>49.00</td>			0			-	49.00
60.00 06000 CLINIC 0	51.00 05100 SUPPORT SURFACES		-		-		1
62.00 OG200 FOHC 62 0THER REIMBURSABLE COST CENTERS 62 70.00 O7000 HMALTH AGENCY COST 0		0	0) (0 0	0	60.00
70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 70 71.00 07100 AMBULANCE 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>61.00 62.00</td>		0	0		0 0	0	61.00 62.00
71.00 07100 AMBULANCE 0 0 0 0 0 0 71 73.00 07300 CMHC 0 0 0 0 0 0 0 73 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 80.00 08000 INTEREST EXPENSE 81 81 82.00 08200 UTILIZATI ON REVIEW - SNF 81 81 83.00 08300 HOSPI CE 0 0 0 83 89.00 SUBTOTALS (sum of lines 1-84) 93, 291 33, 879 30, 995 16, 804 72, 878 89 90.00 O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 448 0 0 0 0 90 91.00 09100 BARBER AND BEAUTY SHOP 13 322 0 16 0 91 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92 93.00 09300 NONPAI D WORKERS 0 0 0 93 93 0 0			0	J		0	70.00
73.00 07300 CMHC 0 0 0 0 0 0 73 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 81.00 08100 INTEREST EXPENSE 81 82.00 08200 UTILIZATION REVIEW - SNF 82 82.00 08300 HOSPICE 0 0 0 83 81.00 08300 HOSPICE 0 0 0 82 81.00 08300 HOSPICE 0 0 0 83 83.00 08300 HOSPICE 0 0 0 0 0 0 0 89 NONREL MBURSABLE COST CENTERS 93, 291 33, 879 30, 995 16, 804 72, 878 89 90.00 09000 GI		0					70.00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 81.00 08100 INTEREST EXPENSE 81 82.00 08200 UTILIZATION REVIEW - SNF 82 83.00 08300 HOSPICE 0 0 0 82 89.00 SUBTOTALS (sum of lines 1-84) 93,291 33,879 30,995 16,804 72,878 89 NONREL MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 448 0 0 0 90 91.00 09100 BARBER AND BEAUTY SHOP 13 32 0 16 91 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92 93.00 09300 NONPAID WORKERS 0 0 0 92 94.00 09400 PATI ENTS LAUNDRY 0 0 0 94 99.00 Negative Cost Centers 0 0 0 99	73. 00 07300 CMHC	0	0		0 0		
81.00 08100 INTEREST EXPENSE 81 82.00 08200 UTI LI ZATI ON REVIEW - SNF 82 83.00 08300 HOSPI CE 0 0 0 83 89.00 SUBTOTALS (sum of lines 1-84) 93,291 33,879 30,995 16,804 72,878 89 NONREL MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 448 0 0 0 90 91 0 91.00 09100 BARBER AND BEAUTY SHOP 13 322 0 16 0 91 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92.00 9300 NONPAI D WORKERS 0 0 0 93.00 9300 NONPAI D WORKERS 0 0 0 93.00 94.00 0 0 0 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>80.00</td>							80.00
83.00 08300 HOSPICE 0 0 0 0 83 89.00 SUBTOTALS (sum of lines 1-84) 93,291 33,879 30,995 16,804 72,878 89 NONREL MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 448 0 0 0 90 91.00 09100 BARBER AND BEAUTY SHOP 13 322 0 16 0 91 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92 93.00 00300 NONPAID WORKERS 93.00 0 0 93.00 00300 NONPAID WORKERS 0 0 0 93.00 93.00 0 0 0 93.00 94.00 0 0 0 94.00 94.00 0 0 0 94.90 94.00 94.00 90.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00							81.00
89.00 SUBTOTALS (sum of lines 1-84) 93,291 33,879 30,995 16,804 72,878 89 NONREL MBURSABLE COST CENTERS 90.00 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 448 0 0 0 90 90 90 91.00 09100 BARBER AND BEAUTY SHOP 13 322 0 166 0 91 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92 93.00 09300 NONPAID WORKERS 0 0 93 93.00 09300 NONPAID WORKERS 0 0 0 93 94.00 0 0 0 94.00 94.00 0 0 0 94.00 94.00 90.00 0 0 0 94.00 94.00 90.00 0 0 0 94.00 94.00 90.00 0 0 0 94.00 98.00 0 0 0 0 0 99.90 99.00 Negative Cost Centers 0 0 0 0 99.							82.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 448 0 0 0 90 91.00 09100 BARBER AND BEAUTY SHOP 13 32 0 16 91 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92 93.00 09300 NONPAI D WORKERS 0 0 0 94 94.00 09400 PATI ENTS LAUNDRY 0 0 0 94 98.00 Cross Foot Adjustments 0 0 0 0 99 99.00 Negative Cost Centers 0 0 0 0 99	89.00 SUBTOTALS (sum of lines 1-84)	0 93, 291	0 33, 879	30, 99	5 16, 804		
91.00 09100 BARBER AND BEAUTY SHOP 13 32 0 16 91 92.00 09200 PHYSI CLANS PRI VATE OFFICES 0 0 0 92 93.00 09300 NONPAI D WORKERS 0 0 0 93 94.00 09400 PATI ENTS LAUNDRY 0 0 0 94 98.00 Cross Foot Adjustments 0 0 0 98 99.00 Negative Cost Centers 0 0 0 99		148	0			0	90.00
93.00 09300 NONPAID WORKERS 0 0 0 93 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94 98.00 Cross Foot Adjustments 0 0 0 0 98 99.00 Negative Cost Centers 0 0 0 0 99							1
94.00 09400 PATIENTS LAUNDRY 0 0 0 94 98.00 Cross Foot Adjustments 0 0 0 98 99.00 Negative Cost Centers 0 0 0 99		0	0				
98.00 Cross Foot Adjustments 0 0 98 99.00 0 0 0 98 99.00 0 0 0 0 98 99.00 0 0 0 0 98 99.00 0 0 0 0 98 99.00 0 0 0 0 99.00 99.00 0 0 0 0 0 99.00 0 0 0 0 99.00 0 0 0 0 99.00 0		0	0				
99.00 Negative Cost Centers 0 0 0 0 0 99			0				1
TUU. UU TUTAL 93, 752 33, 911 30, 995 16, 820 72, 878 100	99.00 Negative Cost Centers	0	0				99.00
	100.00 101AL	93, 752	33, 911	30, 99!	bj 16, 820	72, 878	100.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315394	Period: From 07/01	/2023	Vorksheet B Part II	
					To 06/30.	/2024 [Date/Time Pre 11/26/2024 3:	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CA RECORDS	L SC	DCIAL SERVICE	<u>32 pm</u>
		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 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS							2.00 3.00
4.00	00400 ADMINI STRATI VE & GENERAL							4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS							5.00
6.00	00600 LAUNDRY & LINEN SERVICE							6.00
7.00	00700 HOUSEKEEPI NG							7.00
8.00	00800 DI ETARY							8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0					10.00
11.00	01100 PHARMACY	0	0		0			11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0	0		12.00
13.00	01300 SOCI AL SERVI CE	0	0		0	0	7,404	•
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	
15.00 15.01	01500 ACTI VI TI ES 01501 CHAPLAI N	0	0		0	0	0	
15.01	INPATIENT ROUTINE SERVICE COST CENTERS	0	U		U	U	0	15.01
30.00	03000 SKI LLED NURSI NG FACI LI TY	0	0		0	0	7,404	30.00
31.00	03100 NURSING FACILITY	0	0		0	o	0	
32.00	03200 CF/I D	0	0		0	o	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	0	
	ANCILLARY SERVICE COST CENTERS	•						
40.00	04000 RADI OLOGY	0	0		0	0	0	40.00
41.00	04100 LABORATORY	0	0		0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0	0	0	44.00
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0	0	0	45.00 46.00
40.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	48.00
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	o		0	Ö	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	0	61.00
62.00								62.00
70.00	OTHER REIMBURSABLE COST CENTERS		0		0	0	0	
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0	0 0	0	
	07300 CMHC	0	0		0	0		73.00
/ 5. 00	SPECIAL PURPOSE COST CENTERS	0	9		0	<u> </u>	0	/ 5. 00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES							80.00
81.00	08100 INTEREST EXPENSE							81.00
82.00	08200 UTILIZATION REVIEW - SNF							82.00
83.00	08300 HOSPI CE	0	0		0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	0		0	0	7,404	89.00
00.5-	NONREI MBURSABLE COST CENTERS	I						00.77
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		0	0	0	
02 00	UTJUUNPALD WURKERS	0	0		0	0	-	
93.00							· · · · · · · · · · · · · · · · · · ·	
94.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0		0	0	0	
	09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers	0 0 0	0 0 0		0	0		94.00 98.00 99.00

Heal th	Financial Systems	SHORES AT WES	SLEY MANOR		In Lie	u of Form CMS-2	2540-10
	TION OF CAPITAL RELATED COSTS			No.: 315394	Period: From 07/01/2023 To 06/30/2024	Worksheet B Part II Date/Time Prep 11/26/2024 3:3	pared:
			OTHER GENER	RAL SERVICE			
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Step-Down Adjustments	
		14.00	15.00	15. 01	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS	1 1					1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00 2.00
2.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY						11. 00 12. 00
12.00	01300 SOCIAL SERVICE						12.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTI VI TI ES	0	35, 126				15.00
	01501 CHAPLAI N	0	0	3	87		15.01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	35, 126	1	14 577, 371	0	30.00
	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200 CF/I D	0	0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	2	73 2, 434, 518	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS		0		0 75	0	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0		0 75 0 80	0	40.00 41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 479	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0 11, 655	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 1, 961	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 471	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 73	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 1, 132	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	51.00
60.00	06000 CLINIC	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						
	07000 HOME HEALTH AGENCY COST	0	0		0 0	Ŭ	70.00
	07100 AMBULANCE	0	0		0 0	0	
73.00	07300 CMHC	0	0		0 0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS	1 1					00.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
81.00	08200 UTILIZATION REVIEW - SNF						81.00
	08300 HOSPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	35, 126	3	87 3, 027, 815	0	89.00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 448	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0 2, 776	0	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
	09400 PATIENTS LAUNDRY	0	0		U 0	0	94.00
98.00 99.00	Cross Foot Adjustments	0	0		0 0	0	98.00 99.00
99.00 100.00	Negative Cost Centers TOTAL	0	0 35, 126	2	87 3, 031, 039	-	99.00 100.00
100.00		ı V	55, 120	ı ک	5, 051, 059	0	1.00.00

LLOCATI	inancial Systems ON OF CAPITAL RELATED COSTS	SHORES AT WESLE	Provi der No.: 315394	Peri od:	u of Form CMS-2540 Worksheet B
2200/11				From 07/01/2023 To 06/30/2024	Part II
	Cost Center Description	Total 18.00			
G	ENERAL SERVICE COST CENTERS	10.00		· · · · · · · · · · · · · · · · · · ·	
00 0	0100 CAP REL COSTS - BLDGS & FIXTURES				1
00 0	0200 CAP REL COSTS - MOVABLE EQUIPMENT				2
00 0	0300 EMPLOYEE BENEFITS				3
00 0	0400 ADMINISTRATIVE & GENERAL				4
00 0	0500 PLANT OPERATION, MAINT. & REPAIRS				5
	0600 LAUNDRY & LINEN SERVICE				6
00 0	0700 HOUSEKEEPI NG				7
	0800 DI ETARY				8
1	0900 NURSI NG ADMI NI STRATI ON				9
	1000 CENTRAL SERVICES & SUPPLY				10
	1100 PHARMACY				11
	1200 MEDICAL RECORDS & LIBRARY				12
1	1300 SOCIAL SERVICE				13
	1400 NURSING AND ALLIED HEALTH EDUCATION				14
	1500 ACTI VI TI ES				15
	1501 CHAPLAI N				15
	NPATIENT ROUTINE SERVICE COST CENTERS	,			
	3000 SKILLED NURSING FACILITY	577, 371			30
	3100 NURSING FACILITY	0			31
	3200 I CF/I I D	0			32
	3300 OTHER LONG TERM CARE	2, 434, 518			33
_	NCI LLARY SERVICE COST CENTERS				
	4000 RADI OLOGY	75			40
	4100 LABORATORY	80			41
	4200 I NTRAVENOUS THERAPY	0			42
1	4300 OXYGEN (INHALATION) THERAPY	479			43
	4400 PHYSI CAL THERAPY	11,655			44
	4500 OCCUPATIONAL THERAPY	1,961			45
		471			46
1	4700 ELECTROCARDI OLOGY 4800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 73			47
	4900 DRUGS CHARGED TO PATTENTS	1, 132			49
	5000 DENTAL CARE - TITLE XIX ONLY	0			50
	5100 SUPPORT SURFACES	0			51
	UTPATIENT SERVICE COST CENTERS	0			
	6000 CLINIC	0			60
	6100 RURAL HEALTH CLINIC	0			61
	6200 FQHC	0			62
-	THER REIMBURSABLE COST CENTERS	<u> </u>			
	7000 HOME HEALTH AGENCY COST	0			70
	7100 AMBULANCE	0			71
	7300 CMHC	0			73
	PECIAL PURPOSE COST CENTERS				
	8000 MALPRACTICE PREMIUMS & PAID LOSSES				80
	8100 I NTEREST EXPENSE				81
	8200 UTILIZATION REVIEW - SNF				82
	8300 HOSPI CE	0			83
. 00	SUBTOTALS (sum of lines 1-84)	3, 027, 815			89
	ONREI MBURSABLE COST CENTERS	· · · · ·			
	9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	448			90
	9100 BARBER AND BEAUTY SHOP	2, 776			91
	9200 PHYSICIANS PRIVATE OFFICES	0			92
	9300 NONPALD WORKERS	0			93
	9400 PATIENTS LAUNDRY	0			94
3.00	Cross Foot Adjustments	0			98
9.00	Negative Cost Centers	0			99
	TOTAL	3, 031, 039			100

JJI AL	Financial Systems LOCATION - STATISTICAL BASIS	SHORES AT WE		No.: 315394 P	In Lie Period:	u of Form CMS-: Worksheet B-1	
	LUCATION - STATISTICAL BASIS		Provider		rom 07/01/2023		
				T	o 06/30/2024	Date/Time Pre 11/26/2024 3:	pared:
		CAPI TAL RE	LATED COSTS			1172072024 3.	
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation		
		FIXTURES	EQUI PMENT (\$ VALUE OR SQ	BENEFITS (GROSS		& GENERAL (ACCUM COST)	
		(SQUARE FEET)	(\$ VALUE OK SU FT)	SALARI ES)		(ACCOM COST)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS - BLDGS & FIXTURES	215, 483					1.00
	00200 CAP REL COSTS - MOVABLE EQUI PMENT		0				2.00
	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	6, 665	-			19, 289, 047	3.00
	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 739		464, 402			
	00600 LAUNDRY & LINEN SERVICE	2, 125					
	00700 HOUSEKEEPI NG	966		393, 435	0	632, 537	7.00
	00800 DI ETARY	4, 057	0	1, 205, 184	0	3, 047, 636	8.00
	00900 NURSI NG ADMI NI STRATI ON	C	-	C	0 0	0	
	01000 CENTRAL SERVICES & SUPPLY	C	-	C	-	0	
		C	-	C	-	0	
	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	483	-	C 75, 994	-	0 101, 029	
	01400 NURSING AND ALLIED HEALTH EDUCATION	403		, 75, 994		01,029	1
	01500 ACTI VI TI ES	2, 318	-	-	-		
	01501 CHAPLAI N	2,010					
7	INPATIENT ROUTINE SERVICE COST CENTERS	4	•		-	· · · ·	1
	03000 SKILLED NURSING FACILITY	32, 386	0	2, 721, 282	2 0	4, 697, 492	30.00
	03100 NURSING FACILITY	C	-			-	
	03200 CF/I D	C	-				
	03300 OTHER LONG TERM CARE	163, 937	0	3, 312, 708	8 0	6, 665, 979	33.00
	ANCI LLARY SERVI CE COST CENTERS	C) 0	C	0	15, 474	40.00
	04100 LABORATORY		-	-			
	04200 I NTRAVENOUS THERAPY					0	1
	04300 OXYGEN (INHALATION) THERAPY	C	0	62, 082	0	98, 605	
4.00	04400 PHYSI CAL THERAPY	614	0	413, 558	8 0	589, 722	44.00
	04500 OCCUPATI ONAL THERAPY	C	0 0	279, 357		403, 438	
	04600 SPEECH PATHOLOGY	C	0			96, 920	
		C	0	C	-	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS				-		
	05000 DENTAL CARE - TITLE XIX ONLY			-	-	,	
	05100 SUPPORT SURFACES						
	DUTPATIENT SERVICE COST CENTERS		,		,ŭ	ŭ	1 0 1. 0
	06000 CLINIC	C	0 0	C	0 0	0	60.00
	06100 RURAL HEALTH CLINIC	C	0	C	0	0	61.00
	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	1					
	07000 HOME HEALTH AGENCY COST	C					
	07100 AMBULANCE 07300 CMHC						
	SPECIAL PURPOSE COST CENTERS				0	0	1 / 3. 0
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 0
	08100 INTEREST EXPENSE						81.0
	08200 UTILIZATION REVIEW - SNF						82.0
3.00	08300 HOSPI CE	C		C	0 0	0	83.00
9.00	SUBTOTALS (sum of lines 1-84)	215, 290	00	10, 509, 664	-3, 900, 118	19, 194, 068	89.00
	NONREI MBURSABLE COST CENTERS			50.07/		00.077	
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0					
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	193 0			0	2, 715 0	
	09300 NONPAID WORKERS				-	0	
00 h	09400 PATI ENTS LAUNDRY				-	0	
	Cross Foot Adjustments					0	98.0
4.00		1			1		99.0
1.00 3.00	Negative Cost Centers						
4.00 3.00 9.00		t 3, 031, 039	0	2, 534, 865	5	3, 900, 118	102.0
4.00 8.00 9.00 02.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)						
4.00 8.00 9.00 02.00 03.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	14. 066256		0. 240029		0. 202193	103.00
4.00 8.00 9.00 02.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	14. 066256					103.00

Heal th	Financial Systems	SHORES AT WE	SLEY MANOR		In Lie	u of Form CMS-	2540-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2023	Worksheet B-1	
				Τ		Date/Time Pre	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	11/26/2024 3: NURSI NG	32 pm
	cost center bescription	OPERATION,	LINEN SERVICE		(MEALS SERVED)		
		MAINT. &	(POUNDS OF			(DI RECT	
		REPAI RS	LAUNDRY)			NURSI NG)	
		(SQUARE FEET) 5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	9.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	007 070					4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	207, 079 2, 125					5.00 6.00
7.00	00700 HOUSEKEEPING	966					7.00
8.00	00800 DI ETARY	4,057	0		184, 219		8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9.00
	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
		0	0	0	0	0	
	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	483		0 483	0	0	
	01400 NURSING AND ALLIED HEALTH EDUCATION	403		403	0	0	
	01500 ACTI VI TI ES	2, 318	C	2, 318	0	0	1
15.01	01501 CHAPLAI N	0	C	0	0	0	15.01
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 SKI LLED NURSI NG FACI LI TY	32, 386			59, 599	0	
	03100 NURSING FACILITY 03200 ICF/IID	0		0	0	0	
	03300 OTHER LONG TERM CARE	163, 937	54,655	-	124, 620	0	1
00.00	ANCI LLARY SERVICE COST CENTERS	100,707	01,000	100,707	121,020		00.00
40.00	04000 RADI OLOGY	0	C	0	0	0	40.00
	04100 LABORATORY	0	0		-	0	
	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	
	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	614		0 614	0	0	
	04400 PHISICAL THERAPY	014		014	-	0	1
	04600 SPEECH PATHOLOGY	0	0	0	0	0	1
47.00	04700 ELECTROCARDI OLOGY	0	C	0	0	0	47.00
	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	04900 DRUGS CHARGED TO PATIENTS	0		0	0	0	
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	, s	0	-	0	
51.00	OUTPATIENT SERVICE COST CENTERS	0			0	0	01.00
60.00	06000 CLI NI C	0	C	0		0	60.00
	06100 RURAL HEALTH CLINIC	0	0	0	0	0	
62.00							62.00
70 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	0		0	5	0	
	07300 CMHC	0	0			0	
	SPECIAL PURPOSE COST CENTERS	1		1			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	_		0	0	0	82.00 83.00
89.00	SUBTOTALS (sum of lines 1-84)	206, 886	273, 276		184, 219		1
	NONREI MBURSABLE COST CENTERS			1		-	
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0				0	
	09100 BARBER AND BEAUTY SHOP	193	0			0	
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0		0	0	0	1
	09400 PATIENTS LAUNDRY				0	0	
98.00	Cross Foot Adjustments			l	0	0	98.00
99.00	Negative Cost Centers						99.00
102.00		2, 337, 702	210, 923	771, 337	3, 724, 987	0	102.00
100.00)	11 000000	0 774003	0.704004	00,000,000	0.000000	102.00
103.00 104.00		11. 288938 33, 911				0.00000	103.00
104.00	(11)	. 33, 711	30, 995	10, 020	12,018	0	104.00
105.00		0. 163759	0. 113420	0. 082456	0. 395605	0. 000000	105.00
		•					

Heal th F	inancial Systems	SHORES AT WE	SLEY MANOR		In Lie	u of Form CMS-	2540-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2023	Worksheet B-1	
					To 06/30/2024	Date/Time Pre	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		32 pm
		SERVICES & SUPPLY	(COSTED REQUIS)	RECORDS & LI BRARY	(PATI ENT DAYS)	ALLI ED HEALTH EDUCATI ON	
		(COSTED	KLQUI 3)	(TIME SPENT)		(ASSI GNED	
		REQUI S)		10.00	10.00	TIME)	
GI	ENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
	0100 CAP REL COSTS - BLDGS & FIXTURES						1.00
	0200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
	0300 EMPLOYEE BENEFITS 0400 ADMINISTRATIVE & GENERAL						3.00
	0500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 0	0600 LAUNDRY & LINEN SERVICE						6.00
	0700 HOUSEKEEPING						7.00
	0800 DI ETARY 0900 NURSI NG ADMI NI STRATI ON						8.00 9.00
	1000 CENTRAL SERVICES & SUPPLY	0					10.00
	1100 PHARMACY	0	C				11.00
	1200 MEDI CAL RECORDS & LI BRARY 1300 SOCI AL SERVI CE	0	C		0 0 19, 877		12.00
	1400 NURSING AND ALLIED HEALTH EDUCATION	0	C		0 19, 377	0	14.00
	1500 ACTI VI TI ES	0	C		0 0	0	15.00
		0	C)	0 0	0	15.01
	NPATIENT ROUTINE SERVICE COST CENTERS 3000 SKILLED NURSING FACILITY	0	C		0 19, 877	0	30.00
	3100 NURSI NG FACI LI TY	0	C		0 0	0	31.00
	3200 I CF/I I D	0	C		0 0	0	32.00
	3300 OTHER LONG TERM CARE	0	C)	0 0	0	33.00
	NCI LLARY SERVI CE COST CENTERS 4000 RADI OLOGY	0	С		0 0	0	40.00
-	4100 LABORATORY	0	C		0 0	0	41.00
	4200 I NTRAVENOUS THERAPY	0	C	D	0 0	0	42.00
1	4300 OXYGEN (I NHALATI ON) THERAPY 4400 PHYSI CAL THERAPY	0	C		0 0 0 0	0	43.00
	4500 OCCUPATIONAL THERAPY	0	C		0 0	0	45.00
46.00 04	4600 SPEECH PATHOLOGY	0	C		0 0	0	46.00
	4700 ELECTROCARDI OLOGY	0	C		0 0	0	47.00
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS 4900 DRUGS CHARGED TO PATIENTS	0			0 0	0	48.00 49.00
	5000 DENTAL CARE - TITLE XIX ONLY	0	C		0 0	0	50.00
	5100 SUPPORT SURFACES	0	C)	0 0	0	51.00
	JTPATIENT SERVICE COST CENTERS	0			0 0	0	60.00
	6100 RURAL HEALTH CLINIC	0	C		0 0	0	61.00
	6200 FQHC						62.00
	THER REIMBURSABLE COST CENTERS	0	C			0	1 70 00
	7000 HOME HEALTH AGENCY COST 7100 AMBULANCE	0	C	2 1	0 0	0	
	7300 CMHC	0	C		0 0	0	
	PECIAL PURPOSE COST CENTERS			1			
	8000 MALPRACTICE PREMIUMS & PAID LOSSES 8100 INTEREST EXPENSE						80.00 81.00
	8200 UTILIZATION REVIEW - SNF						82.00
	8300 HOSPI CE	0	C		0 0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	0	C		0 19, 877	0	89.00
	9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0 0	0	90.00
	9100 BARBER AND BEAUTY SHOP	0	C		0 0	0	91.00
	9200 PHYSI CLANS PRI VATE OFFI CES	0	C		0 0	0	1
	9300 NONPAI D WORKERS 9400 PATI ENTS LAUNDRY	0				0	93.00 94.00
98.00	Cross Foot Adjustments	0	C			0	98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part	0	C		0 128, 735	0	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 00000	0 6. 476581	0.00000	103.00
104.00	Cost to be allocated (per Wkst. B, Part	0	C)	0 7, 404		104.00
105.00) Unit cost multiplier (Wkst. B, Part)	0. 000000	0. 000000	0. 00000	0 0. 372491	0. 000000	105 00
105.00	John Cost multipiter (WKSL B, Part II)	0.000000	0.00000	η 0.00000	0.372491	0.00000	105.00

	Financial Systems NLLOCATION - STATISTICAL BASIS	SHORES AT WES		No.: 315394	Period: From 07/01/2023	u of Form CMS-2540- Worksheet B-1
					To 06/30/2024	Date/Time Prepared 11/26/2024 3:32 pm
		OTHER GENER	AL SERVICE			
	Cost Center Description	ACTI VI TI ES (PATI ENT DAYS) (CHAPLAIN (PATIENT DAYS)			
		15.00	15.01			
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES					1.0
. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT					2.0
. 00	00300 EMPLOYEE BENEFITS					3.0
. 00	00400 ADMINISTRATIVE & GENERAL					4.0
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS					5.0
. 00	00600 LAUNDRY & LINEN SERVICE					6.
. 00	00700 HOUSEKEEPI NG					7.0
. 00	00800 DI ETARY					8.0
. 00	00900 NURSI NG ADMI NI STRATI ON					9.0
0.00	01000 CENTRAL SERVICES & SUPPLY					10.
1.00						11.0
	01200 MEDI CAL RECORDS & LI BRARY					12.
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION					13.0
	01500 ACTI VI TI ES	19, 877				14.
	01501 CHAPLAI N	0	67, 718			15.0
0.0.	INPATIENT ROUTINE SERVICE COST CENTERS		011110			
0. 00	03000 SKILLED NURSING FACILITY	19, 877	19, 877			30.
1.00	03100 NURSING FACILITY	0	0			31.0
2.00	03200 CF/I D	0	0			32.
3.00	03300 OTHER LONG TERM CARE	0	47, 841			33.
	ANCI LLARY SERVI CE COST CENTERS		ō			
	04000 RADI OLOGY	0	0			40.
1.00 2.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0			41.
2.00 3.00	04300 OXYGEN (INHALATION) THERAPY	0	0			42.
4.00	04400 PHYSI CAL THERAPY	0	0			44.
5.00	04500 OCCUPATI ONAL THERAPY	0	0			45.
6.00	04600 SPEECH PATHOLOGY	0	0			46.
7.00	04700 ELECTROCARDI OLOGY	0	0			47.
8.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			48.
9.00	04900 DRUGS CHARGED TO PATIENTS	0	0			49. (
0.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			50.
1.00	05100 SUPPORT SURFACES	0	0			51.
0. 00	OUTPATIENT SERVICE COST CENTERS	0	0			60.
	06100 RURAL HEALTH CLINIC	0	0			61.
	06200 FQHC		-			62.0
	OTHER REIMBURSABLE COST CENTERS					
	07000 HOME HEALTH AGENCY COST	0	0			70.
	07100 AMBULANCE	0	0			71.
3.00	07300 CMHC	0	0			73.
0. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	I				80.
1.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES					80.
2.00	08200 UTILIZATION REVIEW - SNF					82.
3.00	08300 H0SPI CE	o	0			83.
9.00	SUBTOTALS (sum of lines 1-84)	19, 877	67, 718			89.
	NONREIMBURSABLE COST CENTERS					
0. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			90.
1.00	09100 BARBER AND BEAUTY SHOP	0	0			91.
2.00	09200 PHYSICIANS PRIVATE OFFICES	0	0			92.
3.00	09300 NONPALD WORKERS	0	0			93.
1 00	09400 PATIENTS LAUNDRY	0	0			94. 98.
	Cross Foot Adjustments					98. 99.
3.00			05 700			
4.00 8.00 9.00 02.00	Negative Cost Centers Cost to be allocated (per Wkst B Part	517 122	95 / 22			11117
8.00	0	517, 123	95, 733			102.
8. 00 9. 00	Cost to be allocated (per Wkst. B, Part I)	517, 123 26. 016149	95, 733 1. 413701			
8. 00 9. 00 02. 00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	26. 016149				102. 103. 104.

Health Financial Systems	SHORES AT WESLEY	MANOR		In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT	COST CENTERS	Provi der	No.: 315394	Peri od:	Worksheet C	
				From 07/01/2023 To 06/30/2024	Date/Time Pre 11/26/2024 3:	pared: 32 pm
Cost Center Description			Total (from		Ratio (col. 1	
			Wkst. B, Pt I	1	di vi ded by	
			<u>col. 18)</u>		col . 2	
			1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS			10.4	10.044	4 745544	40.00
40. 00 04000 RADI OLOGY			18, 60			•
41.00 04100 LABORATORY			19, 82	16, 004		•
42.00 04200 I NTRAVENOUS THERAPY			110 5	0 0	0.00000	
43. 00 04300 OXYGEN (INHALATION) THERAPY			118, 54			
44. 00 04400 PHYSI CAL THERAPY			718, 2			•
45. 00 04500 OCCUPATI ONAL THERAPY			485, 01			•
46.00 04600 SPEECH PATHOLOGY			116, 51	7 194, 082		•
47. 00 04700 ELECTROCARDI OLOGY				0 0	0.00000	•
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			18, 10			•
49.00 04900 DRUGS CHARGED TO PATIENTS			279, 98	32 234, 500		•
50. 00 05000 DENTAL CARE - TITLE XIX ONLY				0 0	0.00000	•
51.00 05100 SUPPORT SURFACES				0 0	0.00000	51.00
OUTPATIENT SERVICE COST CENTERS			1			
60. 00 06000 CLINIC				0 0	0.00000	
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC				_		62.00
71.00 07100 AMBULANCE				0 0	0.00000	•
100. 00 Total			1, 774, 8	1, 905, 956		100.00

Health Financial Systems	SHORES AT WE	SLEY MANOR		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 07/01/2023 To 06/30/2024		
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care Pr	rogram Charges	s Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	IENT COST					
ANCI LLARY SERVI CE COST CENTERS				- F		
40. 00 04000 RADI OLOGY	1. 715511	8, 805		0 15, 105		101.00
41. 00 04100 LABORATORY	1. 238503	14, 038		0 17, 386	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 000000			0 0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 416205			0 0	0	101.00
44. 00 04400 PHYSI CAL THERAPY	0. 975141	393, 289		0 383, 512	0	1 11 00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 788387	416, 810		0 328, 608	0	45.00
46.00 04600 SPEECH PATHOLOGY	0. 600349	131, 434		0 78, 906	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 202224	0		0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 193953	194, 754		0 232, 527	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						1
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)		1, 159, 130		0 1, 056, 044	0	100. 00

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

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

Health Financial Systems	SHORES AT WES	SLEY MANOR		In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 07/01/2023 To 06/30/2024		
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		·			1.00	
PART II - APPORTIONMENT OF VACCINE COST						
1.00 Drugs charged to patients - ratio of co	st to charges (From Workshee	t C, column 3,	line 49)	1. 193953	1.00
2.00 Program vacci ne charges (From your reco				,	0	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	, iders, transf	er this amoun [.]	t to Worksheet E	, 0	3.00
Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
	(From Wkst. B,			Cost (From	& Allied	
		(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	1)	4.00	F 00	
PART III - CALCULATION OF PASS THROUGH COSTS	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	FUR NURSING &	ALLIED HEALIH				
40. 00 04000 RADI OLOGY	18, 603	0	0.00000	0 15, 105	0	40.00
40. 00 04000 KADI 02001 41. 00 04100 LABORATORY	19, 821	0	0.00000		0	101.00
42. 00 04200 INTRAVENOUS THERAPY	17, 021	0	0.00000		0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	118, 542	0	0.00000		0	43.00
44. 00 04400 PHYSI CAL THERAPY	718, 213	0	0.00000		0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	485,010	0	0.00000		0	45.00
46. 00 04600 SPEECH PATHOLOGY	116, 517	0	0. 00000		0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0, 00000		0	47.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 162	0	0.00000		0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	279, 982	0	0.00000		0	49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000		0	50.00
51.00 05100 SUPPORT SURFACES	0	0	0.00000		0	51.00
100.00 Total (Sum of Lines 40 - 52)	1, 774, 850	0		1, 056, 044	0	100.00

Health Financial Systems	SHORES AT WESLEY MANOR	In Lie	u of Form CMS-2	2540-10
COMPUTATION OF INPATIENT ROUTINE COSTS	Provi der No. : 315394	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Parts I-II Date/Time Pre 11/26/2024 3:	pared:
	Title XVIII	Skilled Nursing Facility	PPS	
			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COS	TS			
I NPATI ENT DAYS				1
1.00 Inpatient days including private room days			19, 877	1.00
2.00 Private room days			0	2.00
3.00 Inpatient days including private room days			5, 492	3.00
4.00 Medically necessary private room days appli			0	4.00
5.00 Total general inpatient routine service cos	t		8, 183, 171	5.00
PRIVATE ROOM DI FFERENTI AL ADJUSTMENT				
6.00 General inpatient routine service charges			9, 659, 623	6.00
7.00 General inpatient routine service cost/char			0.847152	
8.00 Enter private room charges from your record			0	8.00
9.00 Average private room per diem charge (Priva 10.00 Enter semi-private room charges from your r		room days, line z	2) 0.00 9,659,623	
11.00 Average semi-private room per diem charge		d by semi_private		11.00
room days)	(Semi-private room charges rifle ro, divide	u by sein -private	405.97	11.00
12.00 Average per diem private room charge differ	ential (Line 9 minus Line 11)		0.00	12.00
13.00 Average per diem private room cost differen				13.00
14.00 Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00 General inpatient routine service cost net	of private room cost differential (Line 5	minus line 14)	8, 183, 171	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00 Adjusted general inpatient service cost per			411.69	16.00
17.00 Program routine service cost (Line 3 times			2, 261, 001	
18.00 Medically necessary private room cost appli			0	
19.00 Total program general inpatient routine ser			2, 261, 001	
20.00 Capital related cost allocated to inpatient line 30 for SNF; line 31 for NF, or line 32		t II column 18,	577, 371	20.00
21.00 Per diem capital related costs (Line 20 di	vided by line 1)		29.05	21.00
22.00 Program capital related cost (Line 3 times			159, 543	
23.00 Inpatient routine service cost (Line 19 mi	,		2, 101, 458	
24.00 Aggregate charges to beneficiaries for exce			0	24.00
25.00 Total program routine service costs for com	parison to the cost limitation (Line 23 mi	nus line 24)	2, 101, 458	
26.00 Enter the per diem limitation (1)		2() (1)		26.00
27.00 Inpatient routine service cost limitation (27.00
28.00 Reimbursable inpatient routine service cost to Worksheet E, Part II, line 4) (See instr		iine 27) (Iranste	er.	28.00
(1) Lines 26 and 27 are not applicable for title X	WIII, but may be used for title V and or t	itle XIX		

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	19, 877	1.00
2.00	Program inpatient days (see instructions)	5, 492	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 276299	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	SHORES AT WESLEY MANOR	In Lie	u of Form CMS-2	2540-10
COMPUTATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315394	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Parts I-II Date/Time Pre 11/26/2024 3:	pared:
	Title XIX	Skilled Nursing Facility	Cost	
			1.00	
PART I CALCULATION OF INPATIENT ROUTIN	e costs		1.00	
I NPATI ENT DAYS				1
1.00 Inpatient days including private room	days		19, 877	1.00
2.00 Private room days	5		0	2.00
3.00 Inpatient days including private room	days applicable to the Program		6, 565	3.00
4.00 Medically necessary private room days	applicable to the Program		0	4.00
5.00 Total general inpatient routine servic	e cost		8, 183, 171	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00 General inpatient routine service char	5		9, 659, 623	6.00
	/charge ratio (Line 5 divided by line 6)		0.847152	
8.00 Enter private room charges from your r			0	8.0
	Private room charges line 8 divided by private	room days, line 2		
10.00 Enter semi-private room charges from y			9, 659, 623	
11.00 Average semi-private room per diem cha room days)	rge (Semi-private room charges line 10, divide	ed by semi-private	485.97	11.00
12.00 Average per diem private room charge d				12.0
13.00 Average per diem private room cost dif			0.00	13.0
14.00 Private room cost differential adjustm			0	14.0
15.00 General inpatient routine service cost PROGRAM INPATIENT ROUTINE SERVICE COST	<u>net of private room cost differential (Line 5</u> S	minus line 14)	8, 183, 171	15.0
16.00 Adjusted general inpatient service cos	t per diem (Line 15 divided by line 1)		411.69	16.0
17.00 Program routine service cost (Line 3	times line 16)		2, 702, 745	17.0
18.00 Medically necessary private room cost	applicable to program (line 4 times line 13)		0	18.0
19.00 Total program general inpatient routin	e service cost (Line 17 plus line 18)		2, 702, 745	19.0
20.00 Capital related cost allocated to inpa line 30 for SNF; line 31 for NF, or li	tient routine service costs (From Wkst. B, Panne 32 for ICF/IID)	rt II column 18,	577, 371	20. 0
21.00 Per diem capital related costs (Line			29.05	21.0
22.00 Program capital related cost (Line 3	times line 21)		190, 713	22.0
23.00 Inpatient routine service cost (Line	19 minus line 22)		2, 512, 032	23.0
24.00 Aggregate charges to beneficiaries for			0	
	r comparison to the cost limitation (Line 23 mi	nus line 24)	2, 512, 032	
26.00 Enter the per diem limitation (1)			0.00	
	ion (Line 3 times the per diem limitation line		0	
28.00 Reimbursable inpatient routine service to Worksheet E, Part II, line 4) (See	costs (Line 22 plus the lesser of line 25 or instructions)	line 27) (Transfe	er 2, 702, 745	28.00
(1) Lines 26 and 27 are not applicable for ti	tle XVIII, but may be used for title V and or	title XIX		

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	19, 877	1.00
2.00	Program inpatient days (see instructions)	6, 565	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 330281	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

	Financial Systems SHORES AT WES ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provi der No. : 315394	Peri od:	u of Form CMS-2 Worksheet E	
			From 07/01/2023 To 06/30/2024	Part I Date/Time Prep 11/26/2024 3:3	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIME	BURSEMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)			3, 886, 234	1.00
2.00	Nursing and Allied Health Education Activities (pass through	h payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			3, 886, 234	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			527, 052	5.00
6.00	Allowable bad debts (From your records)			32, 600	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See ins	structions)		32, 600	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			21, 190	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			3, 380, 372	11.00
12.00	Interim payments (See instructions)			3, 312, 466	12.00
13.00	Tentati ve adjustment			0	13.0
14.00	OTHER adjustment (See instructions)			0	14.0
14.50	Demonstration payment adjustment amount before sequestration	n		0	14.5
14.55	Demonstration payment adjustment amount after sequestration			0	14.5
14.75	Sequestration for non-claims based amounts (see instructions	s)		424	14.7
14.99	Sequestration amount (see instructions)			67, 184	14.99
15.00	Balance due provider/program (see Instructions)			298	15.00
16.00	Protested amounts (Nonallowable cost report items in accorda			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESS	SER OF COST OR CHARGES - T	TTLE 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
22.00 23.00	Primary payor amounts Coinsurance and deductibles			0	22.00
23.00	Allowable bad debts (From your records)			0	23.00
24.00	Allowable Bad debts for dual eligible beneficiaries (see ins	structions)		0	24.0
24.01	Adjusted reimbursable bad debts (see instructions)	structrons)		0	24.0
24.02	Subtotal (Sum of Lines 21 and 24, minus Lines 22 and 23)			0	24.02
26.00	Interim payments (See instructions)			0	26.00
20.00	Tentati ve adjustment			0	20.00
28.00	Other Adjustments (See instructions) Specify			0	27.00
28.50	Demonstration payment adjustment amount before sequestration	n		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
				0	

	Financial Systems	SHORES AT WESLE			of Form CMS-2	2540-
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT TITLE V and	TITLE XIX UNLY	Provider No.: 315394	Period: From 07/01/2023	Worksheet E Part II	
				To 06/30/2024	Date/Time Pre	pared
					11/26/2024 3:	
			Title XIX	Skilled Nursing	Cost	
				Facility		
				-	1 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1.00	
. 00	Inpatient ancillary services (see Instruction	nc)			0	1 1.
. 00	Nursing & Allied Health Cost (From Workshee		E)		0	
. 00	Outpatient services	t D-1, Pt. 11, 111	le 5)		0	
. 00	Inpatient routine services (see instructions)	`			2, 702, 745	
. 00	Utilization reviewphysicians' compensation		corde)		2, 702, 745	
5.00 5.00	Cost of covered services (Sum of Lines 1 - 5)	· · ·	corus)		-	
. 00			Lace then comingivete	accommodations	2, 702, 745 0	
. 00	Differential in charges between semiprivate a	accommodations and	riess than semi private	accommodations	-	
. 00	SUBTOTAL (Line 6 minus line 7)				2, 702, 745	
	Primary payor amounts				0	
0. 00	Total Reasonable Cost (Line 8 minus line 9)				2, 702, 745	10.
1 00	REASONABLE CHARGES				0	1 1 1
	Inpatient ancillary service charges				0	
	Outpatient service charges				0	
	Inpatient routine service charges				0	
	Differential in charges between semiprivate a	accommodations and	i less than semiprivate	accommodations	0	1
5.00	Total reasonable charges CUSTOMARY CHARGES				0	15.
6 00	Aggregate amount actually collected from pati	ionte lighto for r	avmont for sorvices on	a chargo hacis	0	16.
	Amounts that would have been realized from part				0	
7.00	had such payment been made in accordance with			n a charge basis	0	17.
8.00	Ratio of line 16 to line 17 (not to exceed 1.				0.000000	18.
	Total customary charges (see instructions)	. 000000)			0.000000	
7.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				0	17.
00 0	Cost of covered services (see Instructions)				0	20.
	Deducti bl es				0	
2.00	Subtotal (Line 20 minus line 21)				0	
	Coinsurance				0	
4.00	Subtotal (Line 22 minus line 23)				0	
	Allowable bad debts (from your records)				0	
5.00	Subtotal (sum of lines 24 and 25)				0	
7.00	Unrefunded charges to beneficiaries for exces	ss costs erroneous	ly collected based on c	orrection of cost	0	
	limit				0	2.
3. 00	Recovery of excess depreciation resulting fro	om provider termir	ation or a decrease in	program utilizati	on O	28.
7.00	Other Adjustments (see instructions) Specify				0	
0.00	Amounts applicable to prior cost reporting p		rom disposition of depr	eciable assets (-	
	minus, enter amount in parentheses)				. 0	30.
1.00	Subtotal (Line 26 plus or minus lines 29, a	nd 30. minus lines	27 and 28)		0	31.
	Interim payments				0	
3.00	Balance due provider/program (Line 31 minus)	line 32) (indicate	overpayments in parent	heses) (see	0	
2.00			a star payments in parent		0	1 00.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provi der	No.: 315394	Period: From 07/01/2023 To 06/30/2024	Worksheet E-1 Date/Time Prep 11/26/2024 3:3	pared: 32 pm
		Title XVIII		Skilled Nursing Facility	PPS	<u>52 piii</u>
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		3, 291, 9	98 0	0 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider			I		
3.01	ADJUSTMENTS TO PROVIDER	12/11/2023	20, 4	68	0	3.01
3.02				0	0	3.02
3.03 3.04				0	0	3.03 3.04
3.04 3.05				0	0	3.02
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.5
3.53 3.54				0	0	3.53 3.54
3. 54 3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		20, 4		0	3. 54
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		3, 312, 4	66	0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write					5.00
	"NONE" or enter a zero. (1) Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. Oʻ
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.5
5.52				0	0	5.5
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 -			0	0	5.9
6.00	5.98) Determined net settlement amount (balance due) based on the					6.00
(01	cost report. (1)		_	00		1.0
6. 01 6. 02	PROGRAM TO PROVIDER PROVIDER TO PROGRAM		2	98	0	6.0° 6.02
6.02 7.00	Total Medicare program liability (see instructions)		3, 312, 7	U U	0	0.02 7.00
				actor Name	Contractor	,
					Number	
				1.00	2.00	

(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.

	HEET (If you are nonproprietary and do not maintain fund- g records, complete the "General Fund" column only)	type Provi der	No.: 315394	Period: From 07/01/2023	Worksheet G	
Journing				To 06/30/2024	Date/Time Pre 11/26/2024 3:	
		General Fund	Specific Purpose Func	Endowment Fund		
0		1.00	2.00	3.00	4.00	
Asse	ets RENT ASSETS					-
	h on hand and in banks	59, 320		0 0	0	1
0 Tem	porary investments	0		0 0	0	2
	es recei vabl e	0		0 0	0	
	ounts receivable	2, 114, 180		0 0	0	
	er receivables s: allowances for uncollectible notes and accounts	-647, 300		0 0	0	-
	ei vabl e	-047, 300		0 0	0	1
	entory	96, 326		0 0	0	1 7
	pai d'expenses	177, 949		0 0	0	8
	er current assets	228		0 0	0	
	e from other funds	24,079,730		0 0	0	
	AL CURRENT ASSETS (Sum of lines 1 - 10)	25, 880, 433		0 0	0	11
00 Lan		463, 497		0 0	0	12
	d improvements	000, 177		0 0	0	
	s: Accumulated depreciation	0		0 0	0	14
00 Bui	l di ngs	53, 327, 806		0 0	0	15
	s Accumulated depreciation	-26, 592, 831		0 0	0	
	sehold improvements	0		0 0	0	
	s: Accumulated Amortization	0 4, 193, 100		0 0	0	
	s: Accumulated depreciation	-2, 759, 201			0	
	omobiles and trucks	22, 737, 201		0 0	0	
	s: Accumulated depreciation	-22, 321		0 0	0	
	or movable equipment	0		0 0	0	23
00 Les	s: Accumulated depreciation	0		0 0	0	24
	or equipment - Depreciable	0		0 0	0	
	or equipment nondepreciable	0		0 0	0	
	er fixed assets	416, 193		0 0	0	
	AL FIXED ASSETS (Sum of lines 12 - 27) ER ASSETS	29, 048, 564		0 0	0	28
	restments	0		0 0	0	29
	osits on leases	0		0 0	0	
00 Due	from owners/officers	0		0 0	0	31
	er assets	3, 479, 853		0 0	0	
1	AL OTHER ASSETS (Sum of Lines 29 - 32)	3, 479, 853		0 0	0	
	AL ASSETS (Sum of lines 11, 28, and 33) bilities and Fund Balances	58, 408, 850		0 0	0	34
	RENT LIABILITIES					-
	ounts payable	1, 152, 544		0 0	0	35
	aries, wages, and fees payable	1, 463, 692		0 0	0	36
	roll taxes payable	0		0 0	0	
	es & loans payable (Short term)	442, 117		0 0	0	
	Ferred income	0		0 0	0	
	elerated payments to other funds	0		0 0	0	40
	er current liabilities	8, 773, 737		0 0	0	
	AL CURRENT LIABILITIES (Sum of lines 35 - 42)	11, 832, 090		0 0	0	
	G TERM LI ABI LI TI ES					
	tgage payable	0		0 0	0	
	es payable	27, 718, 852		0 0	0	
	ecured Loans ns from owners:	0		0	0	
	ns from owners: mer long term liabilities	0 12, 500			0	
	IER (SPECIFY)	12, 300 N		0 0	0	
	AL LONG TERM LIABILITIES (Sum of lines 44 - 49	27, 731, 352		0 0	0	
	AL LIABILITIES (Sum of lines 43 and 50)	39, 563, 442		0 0	0	
	I TAL ACCOUNTS					
	eral fund balance	18, 845, 408				52
	cific purpose fund			0		53
	or created - endowment fund balance - restricted or created - endowment fund balance - unrestricted			0		54
	erning body created - endowment fund barance - unrestricted			0		56
	int fund balance - invested in plant			0	0	
	nt fund balance - reserve for plant improvement,				0	
rep	lacement, and expansion					
00 TOT	AL FUND BALANCES (Sum of lines 52 thru 58)	18, 845, 408		0 0	0	
	AL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59) 58, 408, 850		0 0		60

Heal th	Financial Systems	SHORES AT WES	SLEY MANOR		In Lie	eu of Form CMS-2	2540-10
	ENT OF CHANGES IN FUND BALANCES			No.: 315394	Period: From 07/01/2023 To 06/30/2024	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00	3.00	4.00	5.00	1.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY RECONCILIATION	0	-1, 338, 239 18, 845, 409		0	0	2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00 10.00	ROUNDING Total additions (sum of line 5 - 9)	0 0 0 0	C		0 0 0 0	0 0 0 0	6.00 7.00 8.00 9.00 10.00
11.00 12.00 13.00 14.00 15.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING	1 0 0	18, 845, 409		0	0 0 0	11.00 12.00 13.00 14.00 15.00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0	1 18, 845, 408		0 0 0 0	0	16.00 17.00 18.00 19.00
		Endowment Fund	PI ant	: Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY RECONCILIATION ROUNDING	0	C		0		1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING	0 0			0 0		7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0			0 0		16. 00 16. 00 17. 00 18. 00 19. 00

Heal th	Financial Systems	SHORES AT WESLEY	MANOR		_	In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315394		i od: m 07/01/2023 06/30/2024	Worksheet G-2 Parts I-II Date/Time Pre 11/26/2024 3:	pared: 32 pm
	Cost Center Description			I npati ent		Outpati ent	Total	
				1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Care Services							
1.00	SKILLED NURSING FACILITY			9, 659, 62	23		9, 659, 623	1.00
2.00	NURSING FACILITY				0		0	2.00
3.00	ICF/IID				0		0	3.00
4.00	OTHER LONG TERM CARE			13, 610, 32			13, 610, 324	4.00
5.00	Total general inpatient care services (Sum of	lines 1 - 4)		23, 269, 9	47		23, 269, 947	5.00
	All Other Care Services							
6.00	ANCI LLARY SERVI CES			1, 836, 6	62	0	1, 836, 662	6.00
7.00	CLINIC					0	0	7.00
8.00	HOME HEALTH AGENCY COST					0	0	8.00
9.00	AMBULANCE					0	0	9.00
10.00	RURAL HEALTH CLINIC					0	0	10.00
10. 10	FQHC					0	0	10. 10
11.00	СМНС					0	0	11.00
12.00	HOSPI CE				0	0	0	12.00
13.00	OTHER (SPECIFY)				0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Worksheet G-3, Line 1)	Transfer column 3	to	25, 106, 60	09	0	25, 106, 609	14.00
	Cost Center Description							
	·					1.00	2.00	
	PART II - OPERATING EXPENSES							
1.00	Operating Expenses (Per Worksheet A, Col. 3, L	ine 100)					24, 511, 982	1.00
2.00	Add (Specify)					0		2.00
3.00						0		3.00
4.00						0		4.00
5.00						0		5.00
6.00						0		6.00
7.00						0		7.00
8.00	Total Additions (Sum of lines 2 - 7)						0	8.00
9.00	Deduct (Specify)					0		9.00
10.00						0		10.00
11.00						0		11.00
12.00						0		12.00
13.00						0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)						0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8	8, minus line 14)					24, 511, 982	15.00

Heal th	Financial Systems SHORES AT WESLE'	Y MANOR	In Lie	eu of Form CMS-2	2540-10
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315394	Peri od:	Worksheet G-3	
			From 07/01/2023		
			To 06/30/2024		
				11/26/2024 3:	32 pm
				1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		25, 106, 609	1.00
2.00	Less: contractual allowances and discounts on patients account			2, 587, 037	2.00
3.00	Net patient revenues (Line 1 minus line 2)			22, 519, 572	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, I	ine 15)		24, 511, 982	4.00
5.00	Net income from service to patients (Line 3 minus 4)			-1, 992, 410	5.00
	Other income:				
6.00	Contributions, donations, bequests, etc			282, 460	6.00
7.00	Income from investments			274, 133	7.00
8.00	Revenues from communications (Telephone and Internet service)			0	8.00
9.00	Revenue from television and radio service			25, 089	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			4, 920	13.00
14.00	Revenue from meals sold to employees and guests			12, 801	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 the	an patients		0	16.00
	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
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20.00
21.00	5			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			51, 424	
24.02	TRANS - RESIDENTIAL			8, 552	
24.03	I NSURANCE REVENUE			0	24.03
24.04	ELECTRI C REVENUE			595	
24.05	BANK FEE RETURN			20	
	MI SCELLANEOUS I NCOME			2, 324	
24.07	HOUSEKEEPING REVENUE			216	24.07
	INVESTMENT SETTLEMENT			38	
	COVID-19 PHE Funding			0	24.50
	Total other income (Sum of lines 6 - 24)			662, 572	
	Total (Line 5 plus line 25)			-1, 329, 838	
	LOSS ON DI SPOSAL OF ASSET			8, 401	
28.00	INVESTMENT LOSS			0	28.00
29.00 30.00	Total other expenses (Sum of Lines 27 - 29)			8, 401	29.00 30.00
	Net income (or loss) for the period (Line 26 minus line 30)			-1, 338, 239	
31.00	Iner meanine (or ross) for the period (Line 20 millius Tille 30)			-1, 550, 259	51.00