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).

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315347

Period:
From 01/01/2022
To 12/31/2022

					8/2/2023 11:24 am	
PART I - COST I	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	ort		Date:	Ti me:	
use only	2. [] Manually prepared cost report] Manually prepared cost report				
	3. [0] If this is an amended report ent	ter the numbe	r of times the provi	ider resubmitted	this cost report	
	3.01 [] No Medicare Utilization. Enter '	'Y" for yes o	r Leave blank for no	0.		
Contractor	4. [2]Cost Report Status	6. Contractor	No	12001		
use only	(6) 6	7.[N] First	Cost Report for th	nis Provider CCN		
		8. [N] Last	Cost Report for thi	s Provider CCN		
	(3) Settled with audit	9. NPR Date:	08/07	/2023		
	(4) Reopened	10.[0][f [i	ne 4, column 1 is "	 '4": Enter number	of times reopened	
	(5) Amended		Vendor Code	4		
	5. Date Received: 05/30/2023	12.[F] Medi	care Utilization. E	nter "F" for full	, "L" for low, or "N"	
		for	no utilization.			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KESWICK PINES, INC. (315347) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR 1		CHECKBOX	ELECTRONI C		
			2	SI GNATURE STATEMENT		
1				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				2	
3	Signatory Title				3	
4	Date				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	0	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3. 00 I CF/I I D				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
7. 10 SNF - BASED CORF I	0		0		7. 10
100. 00 TOTAL	0	0	0	0	100.00

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

Health Financial Systems KESWICK PINES, In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315347 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 8/2/2023 11:24 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 509 ROUTE 530 PO Box: 1.00 2.00 City: WHITING State: NJ Zi p Code: 08759 2.00 3.00 County: OCEAN CBSA Code: 35154 Urban/Rural: U 3.00 3.01 CBSA Code: 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1. 00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF KESWICK PINES, INC. 315347 08/08/1995 N Р Ν 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 SNF-Based HHA 7.00 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10.00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To: 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 17.00 17.00 N 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 Ν 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no 19.00 N If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 19.01 20.00 Straight Line 1, 808, 802 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 23.00 Sum of line 20 through 22 1, 808, 802 23.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 N 26.00 (Y/N)Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 reports? (Y/N) Part A Part B Other If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility 30.00 31.00 ICF/IID 31.00 SNF-Based HHA Ν 32 00 Ν 32 00 33.00 SNF-Based RHC 33.00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC 36.00 Y/N 1. 00 2.00 37.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Υ regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Ν 38.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2. Paid Losses Self Insurance Premi ums 1.00 2.00 3.00 41.00 41.00 List malpractice premiums and paid losses: 77.479 0

Heal th	Financial Systems	KESWICK PINES,	I NC.		In Lieu	of Form CMS-2	2540-10
SKI LLE					Worksheet S-2		
COMPLE	COMPLEX INDENTIFICATION DATA From 01/01/2022						
							pared: 4 am
						1.00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administra	ative and	General cost	N	42.00
	center? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listir	na cost d	centers and		
	amounts.			3			
43 00	Are there any home office costs as def	ined in CMS Pub 15-1 Ch	apter 102			N	43.00
	If line 43 is yes, enter the home offi			address o	of the home	.,	44. 00
	office on lines 45. 46 and 47.	ce charif hamber and cirter	the name and c	addi C33 C	or the nome		44.00
		2.00			2 00		
	1. 00	2.00			3. 00		
	If this facility is part of a chain or	ganization, enter the nam	ne and address (of the h	ome office on the	e lines	
	bel ow.						
45.00	00 Name: Contractor's Name: Contractor's Number:						45.00
46.00	0 Street:						46.00
47.00	Ci ty:	State:	İz	Zip Code:			47.00
	I						

KI LLE	D NURSING FACILITY AND SKILLED NURSING FACIL	KESWICK PINES, TY HEALTH CARE		No.: 315347 P	eri od:	worksheet S-2	
	X REIMBURSEMENT QUESTIONNAIRE				rom 01/01/2022	Part II	
				1	Y/N	8/2/2023 11: 2	
					1.00	2. 00	
	General Instruction: For all column 1 respon responses the format will be (mm/dd/yyyy)	ses enter in column	1, "Y" fo	or Yes or "N" f	or No. For all	the date	
	Completed by All Skilled Nursing Facilites						
. 00	Provider Organization and Operation Has the provider changed ownership immediate	ly prior to the bea	ninning of	the cost	N	I	1.0
. 00	reporting period? If column 1 is "Y", enter	the date of the cha	ange in col	umn 2. (see			1.0
	instructions)			Y/N	Date	V/I	
			0.1.6	1. 00	2.00	3. 00	
. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date			N			2.0
00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac	etions including m	nogomont	N			3.0
00	contracts, with individuals or entities (e.g.	j., chain home offic	ces, drug	IV			3.0
	or medical supply companies) that are related officers, medical staff, management personned						
	of directors through ownership, control, or						
	relationships? (see instructions)			Y/N	Туре	Date	
				1. 00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prep	ared by a Certified	d Public	Y	A	04/30/2023	4.00
00	Accountant? (Y/N) Column 2: If yes, enter "A	" for Audited, "C"	for	·		0 17 007 2020	
	Compiled, or "R" for Reviewed. Submit compleavailable in column 3. (see instructions) If						
00	Are the cost report total expenses and total	revenues differen	t from	N			5.0
	those on the filed financial statements? If reconciliation.	COLUMN I IS "Y", SI	J IMOL				
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1.00	2.00	
00	Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column :). Is the	nrovider the	N	N	6.0
	Hedal operator of the program? (Y/N)		2. 13 1110	provider the			
	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program	ns? (Y/N) see instru	ucti ons.		N		
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00 00 00 00 00 00 00 00 00 00 00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for bat If line 9 is "Y", did the provider's bad deby period? If "Y", submit copy. If line 9 is "Y", are patient deductibles are Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",	ns? (Y/N) see instructions the cost reportions. Indicate instructions. Indic	instructions instruction y change du aived? If "	for Nursing ons. Iring this cost Y", see instruct Par Y/N 1.00 Y	N N N N N N N N N N N N N N N N N N N	1.00 Y N N N Part B Y/N 3.00 Y	9, 00 10, 00 11, 00 12, 00 13, 00
00 00 00 00 00 00 00 00 00 00 00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for bat If line 9 is "Y", did the provider's bad deby period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	ns? (Y/N) see instructions the cost reportions. Indicate instructions. Indic	instructions instruction y change du aived? If "	for Nursing ons. uring this cost Y", see instruct Par Y/N 1.00 Y	N N N N N N N N N N N N N N N N N N N	1.00 Y N N N Part B Y/N 3.00 Y	9, 00 10, 00 11, 00 12, 00 13, 00
00 00 00 00 00 00 00 00 00 00 00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for bat If line 9 is "Y", did the provider's bad deby period? If "Y", submit copy. If line 9 is "Y", are patient deductibles are Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	ns? (Y/N) see instructions the cost reportions. Indicate instructions. Indic	instructions instruction y change du aived? If "	for Nursing ons. uring this cost Y", see instruct Par Y/N 1.00 Y	N N N N N N N N N N N N N N N N N N N	1.00 Y N N N Part B Y/N 3.00 Y	9, 00 10, 00 11, 00 12, 00 13, 00 14, 00
00 00 00 00 00 00 00 00 00 00 00 00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for bat I line 9 is "Y", did the provider's bad deby period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior or the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Corrections of other PS&R Report information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?	ns? (Y/N) see instructions the cost reportions. Indicate instructions. Indic	instructions instruction y change du aived? If "	for Nursing ons. uring this cost 'Y", see instruc Par Y/N 1.00 Y	N N N N N N N N N N N N N N N N N N N	1.00 Y N N N Part B Y/N 3.00 Y N N	9, 00 10, 00 11, 00 12, 00 13, 00 14, 00
3. 00 4. 00 5. 00 7. 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for bat If line 9 is "Y", did the provider's bad deby period? If "Y", submit copy. If line 9 is "Y", are patient deductibles are Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. If line 13 or 14 is "Y", then were	d debts? (Y/N) see instructions. d debts? (Y/N) see to collection policy deformation to the cost reporting per percent of the cost reporting percent of the	instructions instruction y change du aived? If "	for Nursing ons. uring this cost 'Y", see instruc Par Y/N 1.00 Y	N N N N N N N N N N N N N N N N N N N	1.00 Y N N N Part B Y/N 3.00 Y N N	7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00

Heal th	Financial Systems KESWICK P	I NES,	I NC.	In Lie	of Form CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAI X REIMBURSEMENT QUESTIONNAIRE	RE	Provi der No.: 315347	Peri od: From 01/01/2022 To 12/31/2022		
					8/2/2023 11: 2	4 am
			1. 00	2.	00	
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title/position	DEAN	NDRA	FALLON		19. 00
	held by the cost report preparer in columns 1, 2, and 3,					
	respectively.					
20.00	Enter the employer/company name of the cost report	BAKE	ER TILLY US, LLP			20.00
	preparer.					
21.00	Enter the telephone number and email address of the cost	570.	820. 0301	DEANDRA. FALLON	®BAKERTI LLY. CO	21.00
	report preparer in columns 1 and 2, respectively.			M		

Heal th	Financial Systems	KESWICK PIN	ES,	I NC.	In Lieu	of Form CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACIL X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE		Provi der No.: 315347	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 8/2/2023 11:2	
	·	Part B		·			
		Date					
		4. 00					
	PS&R Data						
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter	02/23/2023					13.00

		Part B		
		Date		
		4. 00		
	PS&R Data			
13.00	Was the cost report prepared using the PS&R	02/23/2023		13.00
	only? If either col. 1 or 3 is "Y", enter			
	the paid through date of the PS&R used to			
	prepare this cost report in cols. 2 and			
	4. (see Instructions.)			
14. 00	Was the cost report prepared using the PS&R			14.00
	for total and the provider's records for			
	allocation? If either col. 1 or 3 is "Y"			
	enter the paid through date of the PS&R used			
	to prepare this cost report in columns 2 and 4.			
15. 00	4. If line 13 or 14 is "Y", were adjustments			15. 00
15.00	made to PS&R data for additional claims that			15.00
	have been billed but are not included on the			
	PS&R used to file this cost report? If "Y",			
	see Instructions.			
16. 00	If line 13 or 14 is "Y", then were			16.00
	adjustments made to PS&R data for			
	corrections of other PS&R Report			
	information? If yes, see instructions.			
17. 00	If line 13 or 14 is "Y", then were			17. 00
	adjustments made to PS&R data for Other?			
	Describe the other adjustments:			
18. 00	Was the cost report prepared only using the			18. 00
	provider's records? If "Y" see Instructions.			
			3.00	
	Cost Report Preparer Contact Information		3.00	
	Enter the first name, last name and the title	2/nosition	SENI OR MANAGER	19. 00
17.00	held by the cost report preparer in columns	•	SENT OR WANTED	17.00
	respectively.	., 2, 414 0,		
20. 00	Enter the employer/company name of the cost	report		20.00
	preparer.	- I		
21. 00	· · ·	of the cost		21.00
	report preparer in columns 1 and 2, respectiv			

Health Financial Systems	KESWICK PINES,	I NC.	In Lieu	u of Form CMS-2540-10
VOLUNTARY CONTACT INFORMATION		Provider No.: 315347		Worksheet S-2
			From 01/01/2022 To 12/31/2022	Part V Date/Time Prepared

		o 12/31/2022 Date/Time Pre	epared:
		8/2/2023 II: 2	24 am
		1.00	
	Cost Report Preparer Contact Information	1.00	
1.00	First Name		1.00
2. 00	Last Name		2.00
3. 00	Ti tle		3.00
4.00	Empl oyer		4.00
5.00	Phone Number		5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1		8. 00
9. 00	Mailing Address 2		9. 00
10.00	Ci ty		10.00
	State		11.00
12.00	Zip		12.00
40.00	Officer or Administrator of Provider Contact Information	live Till EEN	1 40 00
	First Name	KATHLEEN	13.00
	Last Name	MI LLER	14.00
	Title		15. 00 16. 00
	Employer Phone Number	7328492011	17.00
	E-mail Address	kmiller@thepinesatwhiting.or	11
16.00	E-liid i Addi ess	a control of the prines at will tring. or	10.00
19 00	Department	9	19.00
	Mailing Address 1	509 ROUTE 530	20.00
	Mailing Address 2	007 K0012 000	21.00
	Ci ty	WHI TI NG	22.00
23. 00		NJ	11
24. 00		08759	24. 00
	•	!	

KESWICK PINES, INC.

Health Financial Systems KESWICK PINI
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

				To	12/31/2022	Date/Time Prep 8/2/2023 11:24	
			<u> </u>	Inpa	atient Days/Vis		
	Component	Number of	Bed Days	Title V	Title XVIII	Title XIX	
	p	Beds	Avai I abl e				
1. 00	SKILLED NURSING FACILITY	1. 00	2. 00 24, 090	3.00	4. 00 1, 206	5. 00 5, 638	1. 00
2. 00	NURSING FACILITY	0	24, 090		1, 200	0,038	2.00
3.00	ICF/IID	o	0			0	3.00
4.00	HOME HEALTH AGENCY COST Other Long Term Care		0	0	0	0	4.00
5. 00 6. 00	SNF-Based CMHC	٩	U				5. 00 6. 00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0	0	0	0	0	7.00
8. 00	Total (Sum of lines 1-7)	66 Inpatient D	24, 090 avs/Vi si ts	0	1, 206 Di scharges	5, 638	8. 00
	Component	0ther 6.00	Total 7. 00	Title V 8.00	Title XVIII 9.00	Title XIX 10.00	
1. 00	SKILLED NURSING FACILITY	9, 604	16, 448		9.00	10.00	1. 00
2.00	NURSING FACILITY	o	0	0		0	2.00
3.00	I CF/IID	0	0			0	3.00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care		0				4. 00 5. 00
6. 00	SNF-Based CMHC		_				6.00
6. 10	SNF-Based CORF		0		0		6. 10
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	9, 604	16, 448	0	0 44	0 4	7. 00 8. 00
0.00	Total (cam or Trince 1 7)	Discha			age Length of		0.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	CYLLLED NUDCLING FACILLETY	11. 00	12. 00	13.00	14. 00	15.00	1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	0	117 0		27. 41	1, 409. 50 0. 00	1. 00 2. 00
3.00	I CF/II D	o	0			0. 00	3.00
4.00	HOME HEALTH AGENCY COST	0	0				4.00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	٩	U				5. 00 6. 00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0 69	0				7.00
8. 00	Total (Sum of lines 1-7)	Average	117	0.00 Admis	27. 41 si ons	1, 409. 50	8. 00
		Length of					
	Component	Stay Total	Title V	Title XVIII	Title XIX	Other	
	Component	16. 00	17. 00	18. 00	19. 00	20. 00	
1.00	SKILLED NURSING FACILITY	140. 58	0	64	4	42	1.00
2. 00 3. 00	NURSING FACILITY	0. 00 0. 00	0		0	0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			J	Ü	4. 00
5.00	Other Long Term Care	0.00				0	5.00
6. 00 6. 10	SNF-Based CMHC SNF-Based CORF						6. 00 6. 10
7. 00	HOSPI CE	0.00	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	140. 58	0		4	42	8. 00
		Admi ssi ons	Full lime	Equi val ent			
	Component	Total	Employees on	Nonpai d			
		21. 00	Payrol I 22. 00	Workers 23.00			
1. 00	SKILLED NURSING FACILITY	110	105. 01				1. 00
2.00	NURSING FACILITY	0	0.00				2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0	0. 00 0. 00				3. 00 4. 00
5. 00	Other Long Term Care	О	0.00				5. 00
6.00	SNF-Based CMHC		0.00	0.00			6.00
6. 10 7. 00	SNF-Based CORF HOSPI CE	0	0. 00 0. 00				6. 10 7. 00
7. 00 8. 00	Total (Sum of lines 1-7)	110	105. 01				8. 00
	•					'	

In Lieu of Form CMS-2540-10
Period: Worksheet S-3
From 01/01/2022 Part II
To 1/21/2022 Part III
To 1/21/2022 Part III Provi der No.: 315347

				Te	0 12/31/2022	Date/Time Pre 8/2/2023 11:2	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average	
		Reported	Salaries from	Sal ari es	Related to	Hourly Wage	
			Worksheet A-6	(col. 1 ±	Salary in	(col. 3 ÷	
				col. 2)	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)	7, 702, 960	0	7, 702, 960		24. 93	1. 00
2.00	Physician salaries-Part A	0	0	0	0. 00	0. 00	2.00
3.00	Physician salaries-Part B	0	0	0	0. 00	0. 00	3. 00
4.00	Home office personnel	0	0	0	0. 00	0. 00	4. 00
5.00	Sum of lines 2 through 4	0	0	0	0. 00	0. 00	5. 00
6.00	Revised wages (line 1 minus line 5)	7, 702, 960	0	7, 702, 960	308, 928. 00	24. 93	6. 00
7.00	Other Long Term Care	0	0	0	0. 00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0. 00	0.00	8. 00
9.00	CMHC	0	0	0	0. 00	0.00	9. 00
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0	0	0. 00		
11.00	Other excluded areas	2, 317, 725	-76, 627	2, 241, 098	92, 298. 00	24. 28	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	2, 317, 725	-76, 627	2, 241, 098	92, 298. 00	24. 28	12.00
	through 11)						
13.00		5, 385, 235	76, 627	5, 461, 862	216, 630. 00	25. 21	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
	Contract Labor: Patient Related & Mgmt	383, 221	l .	000,22.			
	Contract Labor: Physician services-Part A	12, 000	0	12, 000			
16. 00	Home office salaries & wage related costs	0	0	0	0. 00	0. 00	16.00
	WAGE-RELATED COSTS						
	Wage-related costs core (See Part IV)	2, 479, 817	0	2, 479, 817			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	721, 478	0	721, 478			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21. 00	Physician Part B - WRC	0	0	0			21.00
22. 00	Total Adjusted Wage Related cost (see	1, 758, 339	0	1, 758, 339			22. 00
	instructions)						

Heal th FinancialSystemsKESWICK PINES, INC.In Lieu of Form CMS-2540-10SNF WAGE INDEX INFORMATIONProvider No.: 315347Period:Worksheet S-3

From 01/01/2022 Part III Date/Time Prepared: 12/31/2022 8/2/2023 11:24 am Amount Reclass. of Adj usted Paid Hours Average Hourly Wage (col. 3 ÷ col. 4) Salaries from Sal ari es Related to Reported (col . 1 ± col . 2) Salary in col. 3 Worksheet A-6 4.00 5. 00 1. 00 2.00 3.00 PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0.00 0. 00 1.00 24, 956. 00 1, 039, 130 2.00 Administrative & General 794, 869 244, 261 41.64 2.00 309, 981 11, 097. 00 3.00 Plant Operation, Maintenance & Repairs 287, 233 22, 748 27.93 3.00 4.00 Laundry & Linen Service 43, 901 43, 901 3, 157. 00 13.91 4.00 Housekeepi ng 599, 432 -63, 777 5.00 535, 655 31, 457. 00 17.03 5.00 Di etary 1, 195, 187 75, 692. 00 6.00 37, 432 1, 232, 619 16.28 6.00 7.00 Nursing Administration 293, 285 293, 285 7, 256. 00 40.42 7.00 8.00 Central Services and Supply 0 0 0 0.00 0.00 8.00 0 0.00 0.00 9.00 9.00 Pharmacy 0 0 Medical Records & Medical Records Library 10.00 0 0 0.00 0.00 10.00

0

2, 876, 721

77,868

119, 332

775, 050

77, 868

119, 332

3, 651, 771

2, 030. 00

5, 539. 00

161, 184. 00

38.36

21. 54

22. 66 14. 00

11.00

12.00

13.00

11.00

13.00

Social Service

12.00 Nursing and Allied Health Ed. Act.

Other General Service

14.00 Total (sum lines 1 thru 13)

Health Financial Systems KESWICK PINES, INC.	In Lieu	of Form CMS-2540-10
SNF WAGE RELATED COSTS Provi de	From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 8/2/2023 11:24 am

	To 12/31/2022	Date/Time Pre	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
00	401K Employer Contributions	193, 474	1.
00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.
00	Qualified and Non-Qualified Pension Plan Cost	0	3.
00	Prior Year Pension Service Cost	0	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
00	401K/TSA Plan Administration fees	0	5.
00	Legal/Accounting/Management Fees-Pension Plan	0	6.
00	Employee Managed Care Program Administration Fees	0	7.
	HEALTH AND INSURANCE COST		
00	Health Insurance (Purchased or Self Funded)	1, 185, 478	8.
00	Prescription Drug Plan	0	9.
. 00	Dental, Hearing and Vision Plan	45, 027	10.
. 00	Life Insurance (If employee is owner or beneficiary)	9, 840	11.
	Accident Insurance (If employee is owner or beneficiary)	0	12.
. 00	Disability Insurance (If employee is owner or beneficiary)	0	13.
	Long-Term Care Insurance (If employee is owner or beneficiary)	ol	14.
	Workers' Compensation Insurance	325, 282	15.
	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.
	Non cumulative portion)		
	TAXES		
.00	FICA-Employers Portion Only	575, 590	17.
.00	Medicare Taxes - Employers Portion Only	0	18.
.00	Unempl oyment Insurance	0	19.
. 00	State or Federal Unemployment Taxes	134, 126	20.
	OTHER		
. 00	Executive Deferred Compensation	0	21.
. 00	Day Care Cost and Allowances	0	22.
	Tuition Reimbursement	11, 000	
. 00	Total Wage Related cost (Sum of lines 1 - 23)	2, 479, 817	24.
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.

				To	12/31/2022		pared:
	Occupational Catagory	Amount	Frings	Adi ustad	Paid Hours	8/2/2023 11: 2	4 am
	Occupational Category	Reported	Fringe Benefits	Adj usted Sal ari es	Related to	Average Hourly Wage	
		Reported	Delle I I LS	(col . 1 +	Salary in	(col. 3 ÷	
				col . 2)	col. 3	col . 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	Di rect Sal ari es	1.00	2.00	3.00	4.00	3.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	301, 079	96, 927	398, 006	7, 274. 00	54. 72	1.00
2.00	Licensed Practical Nurses (LPNs)	423, 080	136, 202	559, 282	11, 168. 00	50. 08	2.00
3.00	Certified Nursing Assistant/Nursing	737, 635	237, 467	975, 102	30, 301. 00	32. 18	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	1, 461, 794	470, 596	1, 932, 390	48, 743. 00	39. 64	4.00
5.00	Physi cal Therapi sts	230, 480	74, 199	304, 679	4, 284. 00	71. 12	5.00
6.00	Physical Therapy Assistants	893	287	1, 180	26. 00	45. 38	6.00
7.00	Physical Therapy Aides	0	0	0	0. 00	0. 00	7.00
8.00	Occupational Therapists	103, 133	33, 202	136, 335	2, 143. 00	63. 62	8.00
9.00	Occupational Therapy Assistants	0	0	0	0. 00	0. 00	9.00
10.00	Occupational Therapy Aides	0	0	0	0. 00	0. 00	10.00
11.00	Speech Therapists	13, 791	4, 440	18, 231	249. 00	73. 22	11.00
12.00	Respi ratory Therapi sts	0	0	0	0. 00	0. 00	12.00
13.00	Other Medical Staff	0	0	0	0. 00	0. 00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	38, 853		38, 853	621. 00	62. 57	14.00
15. 00	Licensed Practical Nurses (LPNs)	110, 817		110, 817	2, 015. 00	55. 00	15.00
16. 00	Certified Nursing Assistant/Nursing	233, 551		233, 551	6, 446. 00	36. 23	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	383, 221		383, 221	9, 082. 00	42. 20	
18. 00	Physi cal Therapi sts	0		0	0. 00	0. 00	18.00
19. 00	Physical Therapy Assistants	0		0	0. 00	0. 00	
20.00	Physi cal Therapy Ai des	0		0	0. 00	0. 00	
21. 00	Occupational Therapists	0		0	0. 00	0. 00	
22. 00	Occupational Therapy Assistants	0		0	0. 00		
23. 00	Occupational Therapy Aides	0		0	0. 00		
24. 00	Speech Therapists	0		0	0.00		24.00
25. 00	Respiratory Therapists	0		0	0.00	0.00	
26. 00	Other Medical Staff	0		0	0. 00	0.00	26.00

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 8/2/2023 11: 24 am

		8/2/2023 11: 2	4 am
	Group	Days	
1.00	1. 00 RUX	2. 00	1.00
2.00	RUL		2.00
3.00	RVX		3.00
4.00	RVL		4.00
5.00	RHX		5.00
6.00	RHL		6.00
7.00	RMX		7.00
8.00	RML		8.00
9.00	RLX		9. 00
10.00	RUC		10.00
11. 00	RUB		11.00
12. 00	RUA		12.00
13. 00	RVC		13.00
14. 00	RVB		14.00
15. 00	RVA		15.00
16. 00 17. 00	RHC RHB		16. 00 17. 00
18. 00	RHA		18.00
19. 00	RMC		19.00
20. 00	RMB		20.00
21. 00	RMA		21.00
22. 00	RLB		22.00
23.00	RLA		23. 00
24.00	ES3		24.00
25. 00	ES2		25.00
26. 00	ES1		26.00
27. 00	HE2		27.00
28. 00	HE1		28. 00
29. 00	HD2		29.00
30.00	HD1		30.00
31. 00 32. 00	HC2 HC1		31. 00 32. 00
33. 00	HB2		33.00
34. 00	HB1		34.00
35. 00	LE2		35.00
36.00	LE1		36.00
37.00	LD2		37.00
38.00	LD1		38.00
39.00	LC2		39.00
40.00	LC1		40.00
41.00	LB2		41.00
42. 00	LB1		42.00
43. 00	CE2		43.00
44.00	CE1		44.00
45. 00 46. 00	CD2 CD1		45. 00 46. 00
47. 00	CC2		47.00
48. 00	CC1		48.00
49. 00	CB2		49.00
50.00	CB1		50.00
51.00	CA2		51.00
52.00	CA1		52.00
53. 00	SE3		53.00
54. 00	SE2		54.00
55. 00	SE1		55.00
56.00	SSC		56.00
57. 00	SSB		57.00
58.00	SSA		58. 00 59. 00
59. 00 60. 00	I B2 I B1		60.00
61. 00	I A2		61.00
62.00	I A1		62.00
63. 00	BB2		63.00
64.00	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	PD2		69.00
70.00	PD1		70.00
71.00	PC2		71.00
72. 00 73. 00	PC1	I	72.00
73.00	כםם		1 72 00
74 00	PB2 PB1		73.00
74. 00 75. 00	PB2 PB1 PA2		73.00 74.00 75.00

Health Financial Systems	KESWICK PINES,	INC.		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der		Peri od:	Worksheet S-7	7
				From 01/01/2022 To 12/31/2022	Date/Time Pre 8/2/2023 11:2	
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL	-					100.00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)						
101.00 Staffing						101.00
102.00 Recrui tment						102.00
103.00 Retention of employees						103.00
104. 00 Trai ni ng						104. 00
105. 00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, li	ne 1, column 3)					106.00

KLCLAS	STITCATION AND ADJUSTMENT OF TRIAL BALANCE OF	LAFLINGLS	FIOVICE	F	rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	8/2/2023 11: 2 Recl assi fi ed	4 am
	oost denter bescription	our ur res	Other	+ col . 2)	i ons	Tri al Balance	
					Increase/Decr	(col. 3 +-	
					ease (Fr Wkst	col . 4)	
		1. 00	2. 00	3. 00	A-6) 4.00	5. 00	
	GENERAL SERVICE COST CENTERS		2.00	0.00		0.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		3, 006, 734			3, 006, 734	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0	0 470 704	_	0	2.00
3. 00 4. 00	OO3OO EMPLOYEE BENEFITS OO4OO ADMINISTRATIVE & GENERAL	794, 869	2, 479, 786 1, 444, 002			2, 479, 786 2, 483, 132	3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	287, 233	1, 114, 829			1, 424, 810	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	30, 903			74, 804	6.00
7. 00	00700 HOUSEKEEPI NG	599, 432	81, 849			617, 504	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	1, 195, 187	1, 753, 942	2, 949, 129		2, 986, 561	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY		0		293, 285 0	293, 285 0	10.00
11. 00	01100 PHARMACY	Ö	0	Ö	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	O	0	0	12.00
13.00	01300 SOCI AL SERVI CE	0	0	0	77, 868	77, 868	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01501 ACTIVITIES	0	14, 846	14, 846	119, 332	134, 178	14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	14, 040	14, 640	117, 332	134, 170	13.00
	03000 SKILLED NURSING FACILITY	2, 165, 653	504, 213	2, 669, 866	-702, 888	1, 966, 978	30. 00
	03100 NURSING FACILITY	0	0	1	_	0	31.00
32.00	03200 CF/IID	0	0	0		0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	l U	0	0	0	U	33. 00
40.00	04000 RADI OLOGY	0	7, 206	7, 206	0	7, 206	40. 00
41. 00	04100 LABORATORY	0	7, 597	7, 597	0	7, 597	41.00
	04200 I NTRAVENOUS THERAPY	0	0	1		0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	342, 861	971 63, 237			0 294, 610	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	03, 237	400, 070		103, 133	45. 00
46.00	04600 SPEECH PATHOLOGY	О	0	o		13, 791	46. 00
	04700 ELECTROCARDI OLOGY	0	0	0	· ·	0	47.00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	36, 274 49, 637			36, 274 49, 637	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		47,037	47,037		47,037	50.00
51.00	05100 SUPPORT SURFACES	O	0	O	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	O	0		0	0	60. 00
	06100 RURAL HEALTH CLINIC		0			0	61.00
62.00	06200 FQHC					_	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	C	0	0	63.00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
	07100 AMBULANCE		0				70.00
	07200 CORF	o o	Ō			Ö	
	07300 CMHC	0	0			-	
74. 00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
80 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0	0	80. 00
	08100 NTEREST EXPENSE		0	Ö		0	81. 00
82.00	08200 UTILIZATION REVIEW	0	0	C	0	0	82.00
83.00	08300 HOSPI CE	0	0	0	0	0	83.00
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	5, 385, 235	10, 596, 026	15, 981, 261	76, 627	0 16, 057, 888	84. 00 89. 00
67.00	NONREI MBURSABLE COST CENTERS	5, 365, 235	10, 340, 020	15, 701, 201	70,027	10, 037, 888	09.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	О	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	54, 718	834	55, 552	0	55, 552	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	0	92. 00 93. 00
	09300 NONPALD WORKERS 09400 PATLENTS LAUNDRY		0		0	0	93.00 94.00
	09500 OTHER NONREI MBURSABLE	2, 263, 007	791, 068	3, 054, 075	-76, 627	2, 977, 448	
100.00	TOTAL	7, 702, 960	11, 387, 928	19, 090, 888	0		

KESWICK PINES, INC. In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 KESWICE

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Peri od: Worksheet A From 01/01/2022 | Date/Time Pr Provi der No.: 315347

					To 12/31/2022	Date/Time Prepared:
	Cost Center Description	Adjustments	Net Expenses			8/2/2023 11: 24 am
	·	to Expenses	For			
		(Fr Wkst A-8)	Allocation (col. 5 +-			
			col. 6)			
		6. 00	7. 00			
1 00	GENERAL SERVICE COST CENTERS	2/0.040	2.745.00/	1		1.00
1. 00 2. 00	OO100 CAP REL COSTS - BLDGS & FIXTURES OO200 CAP REL COSTS - MOVABLE EQUIPMENT	-260, 848	2, 745, 886 0	1		1.00
3. 00	00300 EMPLOYEE BENEFITS	0	2, 479, 786			3.00
4.00	00400 ADMINISTRATIVE & GENERAL	-250, 735		1		4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	-102, 389		1		5.00
6. 00 7. 00	OO6OO LAUNDRY & LI NEN SERVI CE OO7OO HOUSEKEEPI NG	-19, 031 0	55, 773 617, 504	1		6. 00 7. 00
8. 00	00800 DI ETARY	-30, 934		1		8.00
9. 00	00900 NURSING ADMINISTRATION	0	293, 285	1		9.00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	0	0	1		10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0			12.00
	01300 SOCIAL SERVICE	0	77, 868			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1		14.00
15. 00	01501 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	134, 178			15. 00
30.00	03000 SKILLED NURSING FACILITY	0	1, 966, 978			30.00
31.00	03100 NURSING FACILITY	0	0	1		31.00
32.00	03200 1 CF/1 D	0	0			32.00
33.00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0			33.00
40.00	04000 RADI OLOGY	0	7, 206			40.00
	04100 LABORATORY	0	7, 597	1		41.00
	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0			42. 00 43. 00
	04400 PHYSI CAL THERAPY	0	294, 610	1		44.00
	04500 OCCUPATI ONAL THERAPY	0	103, 133	1		45. 00
	04600 SPEECH PATHOLOGY	0	13, 791	1		46.00
	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 36, 274	1		47. 00 48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	49, 637			49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1		50.00
	05100 SUPPORT SURFACES 05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	1		51. 00 52. 00
32.00	OUTPATIENT SERVICE COST CENTERS					32.00
	06000 CLI NI C	0	0			60.00
	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0			61. 00 62. 00
	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	O			63.00
	OTHER REIMBURSABLE COST CENTERS		-			
	07000 HOME HEALTH AGENCY COST	0	-	1		70.00
	07100 AMBULANCE 07200 CORF	0	0	1		71. 00 72. 00
	07300 CMHC	0	-	1		73.00
74.00	07400 OTHER REIMBURSABLE COST	0	0			74.00
80 OO	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	1 0	0	ı		80.00
	08100 INTEREST EXPENSE	0	0			81.00
	08200 UTI LI ZATI ON REVI EW	0	0	1		82.00
	08300 HOSPI CE	0	0	1		83.00
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	-663, 937	0 15, 393, 951	1		84. 00 89. 00
	NONREI MBURSABLE COST CENTERS	555,767	, _ , _ , _ , _ ,			37.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			90.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	55, 552 0			91. 00 92. 00
	09300 NONPALD WORKERS		0	1		93.00
94.00	09400 PATIENTS LAUNDRY	0	0			94.00
	O9500 OTHER NONREI MBURSABLE TOTAL	0	2, 977, 448	1		95.00
100.00	TOTAL	-663, 937	18, 426, 951	I		100.00

RECLASSI FI CATI ONS	Provi	ider No.: 315347	Peri od:	Worksheet A-6	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 8/2/2023 11:2	
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2. 00	3.00	4. 00	5. 00	
(1) A - RECLASS SALARIES					
1. 00	ADMINISTRATIVE & GENERAL	_ 4.0	244, 261	0	1.00
2. 00	PLANT OPERATION, MAINT.	& 5.0	22, 748	0	2.00
	REPAI RS				
3. 00	LAUNDRY & LINEN SERVICE	6. (00 43, 901	0	3.00
4. 00	DI ETARY	8. 0	00 37, 432	0	4. 00
5. 00	NURSING ADMINISTRATION	9. (293, 285	0	5. 00
6. 00	SOCIAL SERVICE	13. (00 77, 868	0	6.00
7. 00	ACTI VI TI ES	15. (00 119, 332	0	7.00
8. 00	OCCUPATI ONAL THERAPY	45. (00 103, 133	0	8.00
9. 00	SPEECH PATHOLOGY	46.0	00 13, 791	0	9.00
(1) B - RECLASSIFY OXYGEN COSTS					
10. 00	SKILLED NURSING FACILITY	7 30.0	00	971	10.00
TOTALS					
100. 00	Total Reclassifications	(Sum	955, 751	971	100.00
	of columns 4 and 5 must				
	equal sum of columns 8 a	and			
	9)				

KESWICK PINES, INC.

In Lieu of Form CMS-2540-10

Health Financial Systems

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

Health Financial Systems	KESWICK PINES,	I NC.		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 8/2/2023 11: 2	
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7.00	8. 00	9. 00	
(1) A - RECLASS SALARIES						
1. 00	HOUSEKEEPI NG		7. C	0 63, 777	0	1.00
2. 00	SKILLED NURSING FA	CLLITY	30. C	0 703, 859	0	2.00
3. 00	PHYSI CAL THERAPY		44. C	0 111, 488	0	3.00
4. 00	OTHER NONREI MBURSA	BLE	95. C	0 76, 627	0	4.00
5. 00			0. 0	0	0	5.00
6. 00			0. 0	0	0	6.00
7. 00			0. 0	0	0	7. 00
8. 00			0. 0	0	0	8. 00
9. 00			0. 0	0	0	9. 00
(1) B - RECLASSIFY OXYGEN COSTS						
10. 00	OXYGEN (INHALATION) THERAPY	43. C	0	971	10.00
TOTALS						
100. 00				955, 751	971	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS KESWICK PINES, INC. In Lieu of Form CMS-2540-10 Provi der No.: 315347 | Peri od: | Worksheet A-7 | From 01/01/2022 | To 12/31/2022 | Date/Ti me Prepa

				To	12/31/2022	Date/Time Pre 8/2/2023 11: 2	pared: 4 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1. 00	Land	2, 748, 541	0	0	0	0	1.00
2.00	Land Improvements	397, 005	1, 622		1, 622	0	2.00
3.00	Buildings and Fixtures	41, 102, 716	382, 723	0	382, 723	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fi xed Equi pment	8, 466, 256	194, 692		194, 692	0	5.00
6.00	Movable Equipment	3, 478, 194	58, 052		58, 052	0	6.00
7.00	Subtotal (sum of lines 1-6)	56, 192, 712	637, 089	0	637, 089	0	7.00
8.00	Reconciling Items	0 56, 192, 712	0	0	0	0	8.00
9. 00	9.00 Total (line 7 minus line 8)		637, 089	0	637, 089	0	9.00
	Description	Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
	T	6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE		_				
1. 00	Land	2, 748, 541	0				1.00
2.00	Land Improvements	398, 627	0				2. 00
3.00	Buildings and Fixtures	41, 485, 439	0				3.00
4. 00	Building Improvements	0	0				4.00
5. 00	Fi xed Equi pment	8, 660, 948	0				5.00
6. 00	Movable Equipment	3, 536, 246	0				6.00
7. 00	Subtotal (sum of lines 1-6)	56, 829, 801	0				7. 00
8.00	Reconciling Items	0	0				8.00
9. 00	Total (line 7 minus line 8)	56, 829, 801	0				9.00

Provi der No.: 315347

Worksheet A-8

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

				10 12/31/2022	8/2/2023 11: 2	4 am
			<u>'</u>	Expense Classification on		
				To/From Which the Amount is		
				To the minimum on the famount ha	to be haj deted	
	Description (1)	(2) Basis	Amount	Cost Center	Li ne No.	
		For				
		Adjustment				
		1. 00	2. 00	3.00	4. 00	
1. 00	Investment income on reathinted funds	B		CAP REL COSTS - BLDGS &		1, 00
1.00	Investment income on restricted funds	В	-260, 848		1.00	1.00
	(chapter 2)			FIXTURES		
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2.00
	(8)					
3.00	Refunds and rebates of expenses (chapter 8)		0)	0.00	3.00
4.00	Rental of provider space by suppliers		0		0.00	4.00
1. 00	(chapter 8)		O		0.00	1.00
F 00		^	20.020	ADMINICEDATIVE & CENEDAL	4 00	F 00
5. 00	Tel ephone services (pay stations excluded)	Α	-39, 838	ADMINISTRATIVE & GENERAL	4. 00	5.00
	(chapter 21)					
6. 00	Television and radio service (chapter 21)	Α	-102, 389	PLANT OPERATION, MAINT. &	5. 00	6. 00
				REPAI RS		
7.00	Parking Lot (chapter 21)		0		0.00	7.00
8. 00	Remuneration applicable to provider-based	A-8-2	0			8.00
0.00	physician adjustment	7 0 2	O			0.00
0.00			0		0.00	0.00
9.00	Home office cost (chapter 21)		U	1	0.00	
10.00	Sale of scrap, waste, etc. (chapter 23)		0	1	0.00	1
11. 00	Nonallowable costs related to certain		0		0.00	11.00
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	0			12.00
	related organizations (chapter 10)					
13. 00	Laundry and Linen service	В	10 021	LAUNDRY & LINEN SERVICE	6.00	13.00
			· ·	II	l .	1
14.00	Revenue - Employee meals	В		DI ETARY	8.00	1
15. 00	Cost of meals - Guests		0	1	0.00	1
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					
17.00	Sale of drugs to other than patients		0		0.00	17.00
18. 00	Sale of medical records and abstracts		0		0.00	1
19. 00	Vending machines	В	-2 045	DI ETARY	8.00	1
		ь .				1
20. 00	Income from imposition of interest, finance		0	1	0.00	20.00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0		0.00	21.00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW	82.00	22.00
22.00	(chapter 21)		· ·		02.00	22.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1 00	23. 00
23.00	Depreciationburidings and fratures		Ü		1.00	23.00
			_	FIXTURES		
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2. 00	24.00
				EQUI PMENT		
25.00	FINANCE CHARGES	В	-4, 399	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 02	CARE TO SHARE INVESTORS PROGRAM	В		ADMINISTRATIVE & GENERAL	4.00	25. 02
25. 03	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	1
25. 03	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	4.00	1
25. 05	BOARD EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 06	DONATI ONS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 07	PENALTI ES	Α	-15, 000	ADMINISTRATIVE & GENERAL	4.00	25. 07
100.00	Total (sum of lines 1 through 99) (Transfer		-663, 937	1		100.00
	to Worksheet A, col. 6, line 100)		,			
	1				ı	1

⁽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
COST ALLOCATION - GENERAL SERVICE COSTS

						To 12/31/2022	Date/Time Pre 8/2/2023 11:2	pared:
				CAPI TAL REL	_ATED COSTS		0/2/2023 11.2	4 alli
	Cost Center	Description	Net Expenses for Cost Allocation (from Wast A	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
			col. 7)	1. 00	2.00	3. 00	3A	
4 00	GENERAL SERVICE		0.745.004	0.745.004				1 00
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	00200 CAP REL COS 00300 EMPLOYEE BE 00400 ADMINISTRAT	TIVE & GENERAL ATION, MAINT. & REPAIRS LINEN SERVICE NG MINISTRATION RVICES & SUPPLY CORDS & LIBRARY	2, 745, 886 0 2, 479, 786 2, 232, 397 1, 322, 421 55, 773 617, 504 2, 955, 627 293, 285 0 0 77, 868	2, 745, 886 0 56, 049 86, 451 32, 877 29, 420 157, 265 3, 162 0 0 0 883		0 2, 479, 786 0 334, 523 0 99, 791 0 14, 133 0 172, 441 0 396, 812 0 94, 416 0 0 0 0 0 0	2, 622, 969 1, 508, 663 102, 783 819, 365 3, 509, 704 390, 863 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		ALLIED HEALTH EDUCATION	0	0		0 0	0	14. 00
15. 00	01501 ACTI VI TI ES	E SERVICE COST CENTERS	134, 178	32, 899		0 38, 416	205, 493	15. 00
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NUF 03100 NURSING FAC 03200 I CF/II D 03300 OTHER LONG	RSING FACILITY CILITY TERM CARE	1, 966, 978 0 0 0	154, 964 0 0 0		0 470, 589 0 0 0 0 0 0	2, 592, 531 0 0 0	30. 00 31. 00 32. 00 33. 00
40. 00	ANCI LLARY SERVI CI	E COST CENTERS	7, 206	1, 548		0 0	8, 754	40. 00
41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00	04100 LABORATORY 04200 I NTRAVENOUS 04300 OXYGEN (I NH 04400 PHYSI CAL TH 04500 OCCUPATI ONA 04600 SPEECH PATH 04700 ELECTROCARE 04800 MEDI CAL SUF	HALATION) THERAPY HERAPY AL THERAPY HOLOGY DIOLOGY PPLIES CHARGED TO PATIENTS	7, 597 0 0 294, 610 103, 133 13, 791 0 36, 274	1, 548 0 0 6, 423 6, 237 0 0 1, 592		0 0 0 0 0 0 0 0 74, 485 0 33, 201 0 4, 440 0 0 0	9, 145 0 0 375, 518 142, 571 18, 231 0	41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00
49. 00 50. 00	04900 DRUGS CHARC	GED TO PATIENTS E - TITLE XIX ONLY	49, 637	0		0 0	49, 637 0	49. 00 50. 00
51. 00	05100 SUPPORT SUF	RFACES	0	0		0 0	0	51.00
52.00	05200 OTHER ANCIL	LARY SERVICE COST CENTERS	0	0		0 0	0	52.00
60. 00 61. 00 62. 00 63. 00	06000 CLI NI C 06100 RURAL HEALT 06200 FQHC 06300 OTHER OUTPA	TH CLINIC	0 0	0 0		0 0 0 0 0 0	0 0	61.00 62.00
70. 00 71. 00 72. 00 73. 00 74. 00	07100 AMBULANCE 07200 CORF 07300 CMHC 07400 OTHER REIME	H AGENCY COST BURSABLE COST	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0 0	71. 00 72. 00 73. 00
80. 00 81. 00 82. 00 83. 00 84. 00 89. 00	08100 INTEREST EX 08200 UTI LI ZATI ON 08300 HOSPI CE 08400 OTHER SPECI	E PREMIUMS & PAID LOSSES (PENSE N REVIEW AL PURPOSE COST CENTERS (sum of lines 1-84)	0 0 15, 393, 951	0 0 571, 318		0 0 0 0 0 1, 758, 315	0 0 12, 497, 912	80. 00 81. 00 82. 00 83. 00 84. 00 89. 00
90. 00 91. 00 92. 00 93. 00 94. 00 95. 00 98. 00 99. 00 100. 0	09000 GIFT, FLOWE 09100 BARBER AND 09200 PHYSI CIANS 09300 NONPAID WOF 09400 PATIENTS LA 09500 OTHER NONRE Cross Foot Negative Co	ER, COFFEE SHOPS & CANTEEN BEAUTY SHOP PRIVATE OFFICES RKERS AUNDRY EI MBURSABLE Adj ustments	0 55, 552 0 0 0 2, 977, 448 0 0 18, 426, 951	3, 206 9, 454 0 0 0 2, 161, 908 0 0 2, 745, 886		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 206 82, 621 0 0 0 5, 843, 212 0 0 18, 426, 951	98. 00 99. 00

In Lieu of Form CMS-2540-10
Period: Worksheet B
From 01/01/2022 Part I
To 12/21/2022 Part Jime Propagate Provi der No.: 315347

					T	o 12/31/2022	Date/Time Pre	
		Cost Center Description	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	8/2/2023 11: 2 DI ETARY	4 alli
			E & GENERAL	OPERATION,	LINEN SERVICE			
				MAINT. & REPAIRS				
			4. 00	5. 00	6. 00	7. 00	8. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES						1. 00
2. 00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00		EMPLOYEE BENEFITS						3. 00
4. 00		ADMINISTRATIVE & GENERAL	2, 622, 969					4. 00
5. 00 6. 00	1	PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	250, 391 17, 059	1, 759, 054 22, 214				5. 00 6. 00
7. 00		HOUSEKEEPI NG	135, 989	19, 879		992, 211		7. 00
8. 00	00800	DI ETARY	582, 502	106, 261	· ·	O	4, 217, 418	8. 00
9.00		NURSI NG ADMINISTRATION	64, 871	2, 137		1, 316	0	9.00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	0	_	0	0	10. 00 11. 00
12. 00	1	MEDICAL RECORDS & LIBRARY		0	o o	o	0	12.00
13.00		SOCI AL SERVI CE	17, 231	597	0	368	0	13.00
14.00		NURSING AND ALLIED HEALTH EDUCATION	0	0	_	12 (02	0	14.00
15. 00		ACTIVITIES ENT ROUTINE SERVICE COST CENTERS	34, 105	22, 229	0	13, 693	0	15. 00
30.00		SKILLED NURSING FACILITY	430, 280	104, 706	86, 349	64, 500	926, 586	30.00
31. 00	1	NURSING FACILITY	0	0	_	0	0	31.00
32. 00 33. 00	1	ICF/IID OTHER LONG TERM CARE	0	0		0	0	32. 00 33. 00
33.00		LARY SERVICE COST CENTERS	l d	0	0	U _I	U	33.00
40.00		RADI OLOGY	1, 453	1, 046	0	645	0	40. 00
41.00	1	LABORATORY	1, 518	1, 046		645	0	41.00
42. 00 43. 00		INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	0	0	0	0	0	42. 00 43. 00
44. 00	1	PHYSI CAL THERAPY	62, 324	4, 340	0	2, 673	0	44. 00
45.00		OCCUPATI ONAL THERAPY	23, 662	4, 214	1, 530	2, 596	0	45.00
46.00		SPEECH PATHOLOGY	3, 026	0		0	0	46.00
47. 00 48. 00	1	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 6, 285	0 1, 076	_	0 663	0	47. 00 48. 00
49. 00		DRUGS CHARGED TO PATIENTS	8, 238	0		0	0	49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0	0	O	0	50. 00
51. 00 52. 00	1	SUPPORT SURFACES	0	0	0 0	0	0	51. 00 52. 00
32.00		OTHER ANCILLARY SERVICE COST CENTERS TIENT SERVICE COST CENTERS	j oj	0		U _I	U	32.00
60.00		CLINIC	0	0	0	0	0	60. 00
61.00	1	RURAL HEALTH CLINIC	0	0	0	0	0	
62. 00 63. 00	06200	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	62. 00 63. 00
03.00		REIMBURSABLE COST CENTERS	<u> </u>			<u> </u>	0	03.00
70.00	1	HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 07200	AMBULANCE	0	0	0	0	0	71. 00 72. 00
72. 00 73. 00	1			0	0	0	0	
74. 00	1	OTHER REIMBURSABLE COST	Ō	0	0	0		74. 00
		AL PURPOSE COST CENTERS						
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00		UTILIZATION REVIEW						82.00
83.00		HOSPI CE	0	0	0	0	0	83. 00
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	1, 638, 934	289, 745	123, 808	87, 099	926, 586	89. 00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	532	2, 166	0	1, 334	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	13, 713	6, 388	2, 144	3, 935	0	91.00
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPALD WORKERS	0	0	0	0	0	92. 00 93. 00
94.00	1	PATIENTS LAUNDRY		0	0	0	0	93.00
95.00		OTHER NONREI MBURSABLE	969, 790	1, 460, 755	16, 104	899, 843	3, 290, 832	95. 00
98.00		Cross Foot Adjustments	0	0	1	0	0	98.00
99. 00 100. 00		Negative Cost Centers TOTAL	2, 622, 969	0 1, 759, 054	_	0 992, 211	0 4, 217, 418	99. 00 100. 00
100.00	1		2,022,707	1, 757, 034	1 172,000	//2,211	1, 217, 410	. 55. 66

| Peri od: | Worksheet B | From 01/01/2022 | Part I | Date/Time Prepared: Provi der No.: 315347

			То	12/31/2022	Date/Time Pre 8/2/2023 11:2	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY	11 00	LI BRARY	10.00	
GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	12.00	13. 00	
1. 00 O0100 CAP REL COSTS - BLDGS & FIXTURES		T				1.00
2. 00 00200 CAP REL COSTS - MOVABLE EQUI PMEN						2.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIR	S					5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7. 00 00700 HOUSEKEEPI NG						7.00
8. 00 00800 DI ETARY 9. 00 00900 NURSI NG ADMI NI STRATI ON	459, 187					8. 00 9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	437, 107	0				10.00
11. 00 01100 PHARMACY	0	o	0			11.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	O	0	0		12.00
13. 00 01300 SOCI AL SERVI CE	0	O	0	0	122, 015	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCAT		0	0	0	0	14.00
15. 00 01501 ACTI VI TI ES	0	0	0	0	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 SKILLED NURSING FACILITY		٥	0	ما	100.015	20.00
30.00 03000 SKILLED NURSING FACILITY 31.00 03100 NURSING FACILITY	459, 187 0	0	0	0	122, 015 0	30. 00 31. 00
32. 00 03200 CF/IID	0	0	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	0	o	Ö	o	0	33.00
ANCILLARY SERVICE COST CENTERS		-1	-1	-1		
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 0XYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 0CCUPATI ONAL THERAPY	0	0	0	0	0	44. 00 45. 00
46. 00 04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	Ö	0	0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATI	ENTS 0	ō	0	Ö	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	o	0	О	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
52. 00 05200 OTHER ANCI LLARY SERVI CE COST CENT	TERS 0	0	0	0	0	52.00
60. 00 OCOOO CLINIC	0	0	0	ol	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0	o	0	0	0	61.00
62. 00 06200 FQHC					_	62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CE	NTER 0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 07100 AMBULANCE	0	0	0	0	0	71.00
72. 00 07200 CORF 73. 00 07300 CMHC	0	0	0	O O	0	72. 00 73. 00
74. 00 07400 OTHER REI MBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		7 1. 00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSS	ES					80.00
81.00 08100 INTEREST EXPENSE						81.00
82. 00 08200 UTI LI ZATI ON REVI EW						82.00
83. 00 08300 HOSPI CE	0	0	0	0	0	83.00
84. 00 08400 OTHER SPECIAL PURPOSE COST CENTE		0	0	0	122 015	84.00
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	459, 187	0	0	0	122, 015	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CAN	TEEN O	٥	0	nl	0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP		0	o	o o	0	91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	0	o	Ö	Ö	0	92.00
93.00 09300 NONPALD WORKERS	0	0	0	o	0	93. 00
94. 00 09400 PATI ENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 09500 OTHER NONREI MBURSABLE	0	0	0	0	0	95.00
98.00 Cross Foot Adjustments	0	0	2		0	98. 00 99. 00
99.00 Negative Cost Centers 100.00 TOTAL	459, 187	0	0	0	122, 015	
100.00 101AL	437, 107	ų ų	o _l	Ч	122,013	1.00.00

KESWICK PINES, INC.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					Γο 12/31/2022	Date/Time Pre 8/2/2023 11:2	
			OTHER GENERAL			0/2/2023 11.2	4 dili
	Cook Cooker December 1	NUDCING AND	SERVI CE	Cultatata	Doot Chanden	Tabal	
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATI ON			riaj as timorres		
	CENEDAL CEDILICE COCT CENTEDO	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00 5. 00	OO4OO ADMINISTRATIVE & GENERAL OO5OO PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE			•			6.00
7. 00	00700 HOUSEKEEPI NG						7.00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0					13. 00 14. 00
15. 00	01501 ACTI VI TI ES	0	275, 520				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	275, 520 0		4 O	5, 061, 674 0	30. 00 31. 00
32. 00	03200 CF/IID	0	0			0	1
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	1 0	Ιο	11, 89	3 0	11 000	40.00
	04100 LABORATORY	0	1	1		11, 898 12, 354	1
42.00	04200 I NTRAVENOUS THERAPY	0	Ö		0	0	1
	04300 OXYGEN (INHALATION) THERAPY	0	0	(0	0	
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0	444, 85! 174, 57:		444, 855 174, 573	1
46. 00	04600 SPEECH PATHOLOGY	0	Ö	21, 25		21, 257	1
	04700 ELECTROCARDI OLOGY	0	0	1	0	0	
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	45, 890 57, 879		45, 890 57, 875	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY			1		0 37, 875	1
51.00	05100 SUPPORT SURFACES	0	0	l .	0	0	1
52. 00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0)	0	0	52.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	1 0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	Ö	1	0	0	1
62.00	06200 FQHC					0	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	1	0	0	63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70.00
71. 00	07100 AMBULANCE	0	0	1	0	0	
	07200 CORF 07300 CMHC	0	0	1	0 0		
	07400 OTHER REIMBURSABLE COST	0	0	1			1
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00
	08200 UTI LI ZATI ON REVI EW						81.00 82.00
83.00	08300 HOSPI CE	0	0		0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	5 000 07	0	0	
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	275, 520	5, 830, 37	6 0	5, 830, 376	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			7, 238	
91.00	09100 BARBER AND BEAUTY SHOP	0	0			108, 801	
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	1	0 0	0	
94. 00	09400 PATIENTS LAUNDRY		0			0	1
95.00	09500 OTHER NONREI MBURSABLE	0	0	12, 480, 53		12, 480, 536	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0		0 0	0	1
100.00			275, 520		-		
	•	•		•	,		•

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared:

			10	5 12/31/2022	Date/IIme Pre 8/2/2023 11:2	
		CAPI TAL REL	ATED COSTS		0/2/2023 11.2	4 (111
Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	Assigned New Capital	FI XTURES	EQUI PMENT		BENEFITS	
	Related Costs					
	0	1. 00	2.00	2A	3. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00 00200 CAP REL COSTS - MOVABLE EQUI PMENT		0			0	2.00
3.00 00300 EMPLOYEE BENEFITS 4.00 00400 ADMINISTRATIVE & GENERAL	0	56, 049	0	56, 049	0	3. 00 4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS		86, 451	0	86, 451	0	5.00
6. 00 00600 LAUNDRY & LINEN SERVICE	O	32, 877	o	32, 877	0	6.00
7. 00 00700 HOUSEKEEPI NG	0	29, 420	0	29, 420	0	7. 00
8. 00 00800 DI ETARY	0	157, 265	0	157, 265	0	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	0	3, 162	0	3, 162	0	9.00
10. 00 01000 CENTRAL SERVI CES & SUPPLY	0	0	0	0	0	10.00 11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY		0	0	0	0	12.00
13. 00 01300 SOCI AL SERVI CE		883	Ö	883	0	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00 01501 ACTI VI TI ES	0	32, 899	0	32, 899	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 SKILLED NURSING FACILITY	0	154, 964	0	154, 964	0	30.00
31.00 03100 NURSING FACILITY 32.00 03200 CF/IID	0	0	0	0	0	31. 00 32. 00
33. 00 03200 CF711 D 33. 00 03300 OTHER LONG TERM CARE		0	0	0	0	33.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	o o	<u> </u>		33.00
40. 00 04000 RADI OLOGY	0	1, 548	0	1, 548	0	40.00
41. 00 04100 LABORATORY	0	1, 548	0	1, 548	0	41.00
42.00 04200 INTRAVENOUS 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 45. 00 04500 OCCUPATI ONAL THERAPY	0	6, 423 6, 237	0	6, 423 6, 237	0	44. 00 45. 00
46. 00 04600 SPEECH PATHOLOGY		0, 237	0	0, 237	0	46.00
47. 00 04700 ELECTROCARDI OLOGY		0	o	ol	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 592	0	1, 592	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
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	52.00
60. 00 06000 CLINIC	O	0	O	ol	0	60.00
61. 00 06100 RURAL HEALTH CLINIC		0	Ö	o	0	61.00
62. 00 06200 FQHC		-				62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000 HOME HEALTH AGENCY COST 71.00 07100 AMBULANCE	0	0	0	0	0	70. 00 71. 00
71. 00 07100 AMBULANCE 72. 00 07200 CORF	0	0	0	0	0	71.00
73. 00 07300 CMHC		0	0	o	0	73.00
74. 00 07400 OTHER REIMBURSABLE COST	O	Ö	Ö	o	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00 08100 I NTEREST EXPENSE						81.00
82. 00 08200 UTILIZATION REVIEW		0			0	82. 00 83. 00
83. 00 08300 HOSPI CE 84. 00 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89. 00 SUBTOTALS (sum of lines 1-84)		571, 318	Ö	571, 318	0	89.00
NONREI MBURSABLE COST CENTERS		37.173.13	<u> </u>	07.170.10		07.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	3, 206	0	3, 206	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	9, 454	0	9, 454	0	91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93. 00 09300 NONPALD WORKERS	0	0	0	0	0	93.00
94. 00 09400 PATI ENTS LAUNDRY 95. 00 09500 OTHER NONREI MBURSABLE	0	0 2, 161, 908	0	0 2, 161, 908	0	94. 00 95. 00
98.00 Cross Foot Adjustments	١	۷, ۱۵۱, ۱ ۵۶ ک		Z, 101, 908	U	98.00
99.00 Negative Cost Centers		o	0	ől	0	99.00
100. 00 TOTAL	O	2, 745, 886	-	2, 745, 886		100.00
	·		·			

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315347

Period: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

8/2/2023 11: 24 am Cost Center Description ADMI NI STRATI V **PLANT** LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATI ON, LINEN SERVICE E & GENERAL MAINT. & REPAI RS 4. 00 8. 00 6.00 7.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2 00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 56, 049 4.00 4.00 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5, 351 91.802 5.00 00600 LAUNDRY & LINEN SERVICE 34, 401 6.00 365 1, 159 6.00 7.00 00700 HOUSEKEEPI NG 2,906 1,037 4, 111 37, 474 7.00 8.00 00800 DI ETARY 12, 449 5, 546 4,589 179, 849 8.00 00900 NURSING ADMINISTRATION 1, 386 9.00 9.00 112 50 0 0 01000 CENTRAL SERVICES & SUPPLY 0 10.00 0 r 0 0 10.00 11.00 01100 PHARMACY 0 C 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 C 0 0 0 12.00 01300 SOCIAL SERVICE 0 13.00 13.00 31 14 0 368 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 Ω 0 0 0 14.00 15.00 01501 ACTI VI TI ES 15.00 729 1, 160 517 0 INPATIENT ROUTINE SERVICE COST CENTERS 39, 514 30 00 03000 SKILLED NURSING FACILITY 20, 912 2, 436 30.00 9.196 5, 464 31.00 03100 NURSING FACILITY 0 0 0 31.00 03200 | CF/IID 32.00 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 31 55 0 24 0 40.00 04100 LABORATORY 41.00 32 55 0 24 0 41.00 42 00 04200 I NTRAVENOUS THERAPY C 0 0 42 00 0 0 04300 OXYGEN (INHALATION) THERAPY 43.00 0 C 0 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 1, 332 226 0 101 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 506 220 370 98 0 45.00 04600 SPEECH PATHOLOGY 46,00 65 C 0 0 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 C 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 134 56 0 25 0 48.00 0 49 00 04900 DRUGS CHARGED TO PATIENTS 176 Ω O 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 0 0 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 61.00 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 Ω 0 0 63.00 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 0 0 0 0 70.00 07100 AMBULANCE 0 0 0 71.00 71.00 0 0 0 72.00 07200 CORF 0 0 0 72 00 73.00 07300 CMHC 0 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 O 74.00 SPECIAL PURPOSE COST CENTERS 80 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 08300 H0SPLCE 83.00 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 84.00 89 00 SUBTOTALS (sum of lines 1-84) 35, 026 15, 121 29, 982 3, 289 39, 514 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 11 113 50 0 90.00 09100 BARBER AND BEAUTY SHOP 293 519 149 91.00 91.00 333 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 92.00 0 0 0 09300 NONPALD WORKERS 93.00 0 C 0 0 0 93.00 09400 PATIENTS LAUNDRY 94.00 0 r 0 0 0 94.00 95.00 09500 OTHER NONREI MBURSABLE 20.719 76, 235 3.900 33, 986 140, 335 95.00 98.00 Cross Foot Adjustments 98.00 0 0 0 Negative Cost Centers 99 00 99.00 Λ 100.00 TOTAL 56, 049 91,802 34, 401 37, 474 179, 849 100. 00

Provi der No.: 315347

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

				To	12/31/2022	Date/Time Pre 8/2/2023 11:2	
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	4 diii
		9. 00	10. 00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01501 ACTIVITIES	4, 710 0 0 0 0 0	0 0 0 0 0	0 0 0 0	0 0 0 0	1, 296 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	4, 710	ol	O	ol	1, 296	30.00
		0 0	0 0 0	0 0 0	0 0 0	0 0	31. 00 32. 00 33. 00
42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	40.00 41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
60. 00 61. 00 62. 00 63. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC 06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0 0	0	0 0	0 0	0 0	61. 00 62. 00
70. 00 71. 00 72. 00 73. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07200 CORF 07300 CMHC	0 0	0 0 0	0 0 0	0 0 0	0 0 0	70.00 71.00 72.00 73.00
74.00	07400 OTHER REIMBURSABLE COST	Ö	ő	0	Ö	0	1
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 0 4, 710	0 0 0	0 0 0	0 0 0	0 0 1, 296	80. 00 81. 00 82. 00 83. 00 84. 00
91. 00 92. 00 93. 00 94. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0 0 4,710	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 1, 296	91.00 92.00 93.00 94.00 95.00 98.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315347

			T	o 12/31/2022	Date/Time Pre 8/2/2023 11:2	
		OTHER GENERAL			07272020 11.2	
		SERVI CE		_		
Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post	Total	
	ALLI ED HEALTH EDUCATI ON			Step-Down Adjustments		
	14. 00	15. 00	16.00	17. 00	18. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS - BLDGS & FLXTU						1.00
2. 00 00200 CAP REL COSTS - MOVABLE EQUI PI	MEN I					2.00
3. 00 00300 EMPLOYEE BENEFITS 4. 00 00400 ADMINISTRATIVE & GENERAL						3. 00 4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REP	ALRS					5.00
6. 00 00600 LAUNDRY & LINEN SERVICE						6.00
7. 00 00700 HOUSEKEEPI NG						7. 00
8. 00 00800 DI ETARY						8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON						9.00
10. 00 01000 CENTRAL SERVI CES & SUPPLY						10.00 11.00
12. 00 01100 FITANWACT			•			12.00
13. 00 01300 SOCIAL SERVICE						13.00
14.00 01400 NURSING AND ALLIED HEALTH EDU	CATION					14.00
15. 00 01501 ACTI VI TI ES		35, 305				15.00
INPATIENT ROUTINE SERVICE COST CENT		05.005			070 707	
30.00 03000 SKILLED NURSING FACILITY 31.00 03100 NURSING FACILITY			273, 797 0	0	273, 797 0	30. 00 31. 00
31. 00 03100 NORSTNG FACILITY 32. 00 03200 CF/IID			_ ~	0		31.00
33.00 03300 OTHER LONG TERM CARE				0		33.00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY		0	1, 658	0	1, 658	40.00
41. 00 04100 LABORATORY		0	.,		.,	1
42. 00 04200 I NTRAVENOUS THERAPY		0	0	0	0	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY 44.00 04400 PHYSI CAL THERAPY			8, 082	0	8, 082	43. 00 44. 00
45. 00 04500 OCCUPATI ONAL THERAPY			7, 431	0	7, 431	
46.00 04600 SPEECH PATHOLOGY		0	65	0	65	
47. 00 04700 ELECTROCARDI OLOGY		0	0	0	0	47.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PA	ATI ENTS (0	1, 807	0	1, 807	
49. 00 04900 DRUGS CHARGED TO PATIENTS			176 0	0	176	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 51. 00 05100 SUPPORT SURFACES		1	1	0	0	50. 00 51. 00
52. 00 05200 OTHER ANCILLARY SERVICE COST	l l					52.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C		0	0	0		60.00
61.00 06100 RURAL HEALTH CLINIC		0	0	0	0	
62. 00 06200 FQHC 63. 00 06300 OTHER OUTPATIENT SERVICE COST	CENTED	o	0	0	0	62. 00 63. 00
OTHER REIMBURSABLE COST CENTERS	CENTER	<u> </u>	<u> </u>		0	03.00
70. 00 07000 HOME HEALTH AGENCY COST		ol o	0	0	0	70.00
71. 00 07100 AMBULANCE		0	0	0	0	
72. 00 07200 CORF		0	0	0	0	72.00
73. 00 07300 CMHC		0	0	0	0	1
74. 00 07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS) 0	0	0	0	74.00
80. 00 08000 MALPRACTICE PREMIUMS & PAID LO)SSES					80.00
81. 00 08100 NTEREST EXPENSE						81.00
82.00 08200 UTILIZATION REVIEW						82.00
83. 00 08300 HOSPI CE		0	0	0	0	83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST CEI		0	0	0	0	
89. 00 SUBTOTALS (sum of lines 1-84)		35, 305	294, 675	0	294, 675	89.00
90.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & 0	CANTEEN	ol o	3, 380	0	3, 380	90.00
91. 00 09100 BARBER AND BEAUTY SHOP		ol o	10, 748		10, 748	
92.00 09200 PHYSICIANS PRIVATE OFFICES		o o	0	0	0	
93. 00 09300 NONPALD WORKERS		0	0	0	0	93.00
94. 00 09400 PATI ENTS LAUNDRY		0	0	0	0	
95.00 O9500 OTHER NONREIMBURSABLE 98.00 Cross Foot Adjustments		0	2, 437, 083	0	2, 437, 083 0	
99.00 Negative Cost Centers			0	0	0	98.00
100. 00 TOTAL		35, 305	2, 745, 886	0		
1 1	ı	•		'		•

Heal th Financial Systems KESWICK PINES, INC. In Lieu of Form CMS-2540-10

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315347
Period:
From 01/01/2022
To 12/31/2022
Date/Time Prepared:
8/2/2023 11: 24 am

					Т	o 12/31/2022	Date/Time Pre 8/2/2023 11:2	
			CAPITAL RE	ATED COSTS			0,2,2020 11.2	
		Cost Center Description	BLDGS &	MOVABLE	 EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
		2000 Comes. 2000 Pt. C.	FI XTURES	EQUI PMENT	BENEFITS	n	E & GENERAL	
			(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM. COST)	
			1. 00	2.00	SALARI ES) 3. 00	4A	4. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT	251, 812	251, 812				1.00
3. 00		EMPLOYEE BENEFITS	0	251, 612				3.00
4. 00	00400	ADMINISTRATIVE & GENERAL	5, 140	5, 140			15, 803, 982	1
5.00		PLANT OPERATION, MAINT. & REPAIRS	7, 928				1,,	1
6. 00 7. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	3, 015 2, 698				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	•
8. 00	1	DI ETARY	14, 422					1
9.00	1	NURSING ADMINISTRATION	290	290	293, 285	0	390, 863	1
10. 00 11. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	0	0		0	0	
12. 00	1	MEDICAL RECORDS & LIBRARY		0	Ö	0	Ö	
13.00	01300	SOCIAL SERVICE	81	81	77, 868	0	103, 819	1
14.00		NURSING AND ALLIED HEALTH EDUCATION	3, 017	0	0 119, 332	_		
15. 00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	3,017	3, 017	119, 332	0	205, 493	15.00
30.00	03000	SKILLED NURSING FACILITY	14, 211	14, 211	1, 461, 794		, ,	
31. 00 32. 00	1	NURSING FACILITY ICF/IID	0	0	0			
		OTHER LONG TERM CARE		0				1
		LARY SERVICE COST CENTERS						
		RADI OLOGY LABORATORY	142 142					1
41.00	1	INTRAVENOUS THERAPY	142	0				1
	1	OXYGEN (INHALATION) THERAPY	0	0		0	Ō	1
44.00	1	PHYSI CAL THERAPY	589				0,0,0.0	•
45. 00 46. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	572	572 0			142, 571 18, 231	1
	1	ELECTROCARDI OLOGY		o o			0	1
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	146			0	37, 866	1
49. 00 50. 00	1	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0	0		0	49, 637	1
51. 00		SUPPORT SURFACES		0		_	0	1
	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	•
60.00		TIENT SERVICE COST CENTERS CLINIC		0	0	0	0	60.00
61.00	1	RURAL HEALTH CLINIC		0			1	
62.00	06200							62.00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER REIMBURSABLE COST CENTERS	0	0	0	0	0	63.00
70. 00		HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
		AMBULANCE	0	0	0	0	1	
72. 00 73. 00			0	0	0	0	0	
		OTHER REIMBURSABLE COST		0	0		1	1
		AL PURPOSE COST CENTERS	1	ı		I	1	1
		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80.00
82.00	08200	UTILIZATION REVIEW						82.00
83. 00	08300	HOSPI CE	0	0	0	0	-	1
84. 00 89. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	52, 393	52 202	0 5, 461, 862	2 622 060	0 9, 874, 943	
69.00	NONRE	IMBURSABLE COST CENTERS	52, 393	52, 393	5, 401, 602	-2, 622, 969	9, 674, 943	09.00
	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	294					1
91.00		BARBER AND BEAUTY SHOP	867	867	54, 718	0	,	
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS		0) 	0	0	
94.00		PATI ENTS LAUNDRY	0	0	0	0	Ō	1
95.00	09500	OTHER NONREIMBURSABLE	198, 258	198, 258	2, 186, 380	0	5, 843, 212	
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00)	Cost to be allocated (per Wkst. B,	2, 745, 886	0	2, 479, 786		2, 622, 969	1
102.00		Part I)	10. 904508	0.00000	0 221024		0 145040	102.00
103.00 104.00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	10. 904508	0. 000000	0. 321926 0		0. 165969 56, 049	103.00
		Part II)						
105.00		Unit cost multiplier (Wkst. B, Part II)			0. 000000		0.003547	105.00
	I	· · /	I	I	I	I	1	1

Provi der No.: 315347

| Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

				То	12/31/2022	Date/Time Pre 8/2/2023 11:2	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION, MAINT. &	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	ADMINISTRATIO N	
		REPAI RS	LAUNDRY)	JERVI JE	OLIVED)	(DI RECT	
		(SQUARE FEET)	/ 00	7.00	0.00	NRSI NG HRS)	
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 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 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	238, 744					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	3, 015	l e				6. 00
7. 00	00700 HOUSEKEEPI NG	2, 698			004 554		7.00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	14, 422 290	45, 100	0 290	224, 556	48, 743	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	Ö	0	0	0	10.00
11. 00	01100 PHARMACY	0	0	0	0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	81	0	81	0	0	13. 00 14. 00
15. 00	01501 ACTI VI TI ES	3, 017	Ö	3, 017	0	o o	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	14, 211	205, 495		49, 336	48, 743	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0 0	0	0	0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	Ö	ő	0	ő	33.00
	ANCILLARY SERVICE COST CENTERS						
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	142		142 142	0	0 0	40.00
41.00	04200 I NTRAVENOUS THERAPY	142	ł	142	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	Ö	Ö	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	589	l e	589	0	0	44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	572 0	3, 640	572 0	0	0 0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	146	Ö	146	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0 0	0	0	0	0	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS				0	0	52.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	l	0	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		U	Ü	61. 00 62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	0	0	0	70. 00 71. 00
71.00	07200 CORF		0		0	0	71.00
	07300 CMHC	0	Ö	Ō	0	0	
74. 00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	1						81.00
82.00	08200 UTI LI ZATI ON REVI EW						82.00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	83. 00 84. 00
89.00		39, 325	294, 639	19, 190	49, 336		89.00
	NONREI MBURSABLE COST CENTERS	2:, ===	_: .,:	,	,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	294	l e	294	0	0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	867	l '	867	0	0	91. 00 92. 00
93. 00	09300 NONPAI D WORKERS	0	ő	Ö	Ö	Ö	93.00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREI MBURSABLE Cross Foot Adjustments	198, 258	38, 325	198, 258	175, 220	0	95. 00 98. 00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B,	1, 759, 054	142, 056	992, 211	4, 217, 418	459, 187	•
102 0	Part I)	7. 367951	0 420202	A E20747	10 701141	0 420572	102 00
103. 00 104. 00		7. 367951 91, 802	0. 420202 34, 401	1	18. 781141 179, 849	9. 420573 4. 710	103.00
	Part II)	71,002	31, 131	37, 174	.,,,,,,,,,		
105.00		0. 384521	0. 101758	0. 171420	0. 800909	0. 096629	105. 00
	1)	I	I	ı		I	I

		cial Systems TON - STATISTICAL BASIS	KESWICK PIN		No. : 315347 Pe	In Lie	u of Form CMS-2 Worksheet B-1	
						om 01/01/2022		
		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	8/2/2023 11: 2 NURSI NG AND	4 am
		·	SERVI CES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	SERVICE (TOTAL PATI	ALLIED HEALTH EDUCATION	
			(TOTAL PATI	REGUI 3.)	(TOTAL PATI	ENT DAYS)	(ASSI GNED	
			ENT DAYS) 10.00	11. 00	ENT DAYS) 12.00	13. 00	TIME) 14.00	
1 00		AL SERVICE COST CENTERS						1.00
1. 00 2. 00	1	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3.00		EMPLOYEE BENEFITS						3.00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6.00		LAUNDRY & LINEN SERVICE						6.00
7. 00 8. 00	1	HOUSEKEEPI NG DI ETARY						7. 00 8. 00
9. 00	00900	NURSING ADMINISTRATION						9.00
	1	CENTRAL SERVICES & SUPPLY PHARMACY	16, 448	C				10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	Ö	C	16, 448			12.00
		SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	0	C	0	16, 448 0	0	13. 00 14. 00
		ACTIVITIES	0		1	0	0	1
20.00		ENT ROUTINE SERVICE COST CENTERS	16 440		16 449	14 440	0	30.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	16, 448 0	C	16, 448	16, 448 0	0	31.00
	03200	ICF/IID	0	C	1	0	0	32.00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	C	0	0]	0	33.00
	04000	RADI OLOGY	0	C		0	0	
	1	LABORATORY INTRAVENOUS THERAPY	0	C	0	0	0	41. 00 42. 00
43.00	04300	OXYGEN (INHALATION) THERAPY	Ö	C	o o	O	0	43.00
	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	C	0	0	0	44. 00 45. 00
		SPEECH PATHOLOGY	o	C	o o	Ö	0	46.00
	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	O	C	0	0	0	47. 00 48. 00
	1	DRUGS CHARGED TO PATTENTS	0	C	0	0	0	49.00
50.00		DENTAL CARE - TITLE XIX ONLY	0	C	0	0	0	50.00
		SUPPORT SURFACES OTHER ANCILLARY SERVICE COST CENTERS	0	C	0	0	0	51. 00 52. 00
(0.00		TIENT SERVICE COST CENTERS				۰		,,,,,,
	1	CLINIC RURAL HEALTH CLINIC	0 0	C	0	0	0	60. 00 61. 00
62.00	06200	FQHC						62.00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER REIMBURSABLE COST CENTERS	0	C	0	0]	0	63.00
	07000	HOME HEALTH AGENCY COST	0	C	0	0	0	
71. 00 72. 00	07100 07200	AMBULANCE CORF	0	C	0	0	0	71. 00 72. 00
73.00	07300	CMHC	0	C	0	0	0	73. 00
74. 00		OTHER REIMBURSABLE COST AL PURPOSE COST CENTERS	0	C	0	0	0	74.00
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	1	INTEREST EXPENSE UTILIZATION REVIEW						81. 00 82. 00
83.00	08300	HOSPI CE	0	C	0	0	0	83.00
84. 00 89. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0 16, 448	C	0 16, 448	0 16, 448	0	1
07.00		MBURSABLE COST CENTERS	10, 440		10, 440	10, 440	0	
90. 00 91. 00	1	GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0	C	•	0	0	
		PHYSICIANS PRIVATE OFFICES	o o	C	o o	0	0	
		NONPALD WORKERS PATIENTS LAUNDRY	0	C	0	0	0	93. 00 94. 00
		OTHER NONREI MBURSABLE	0	C	0	0	0	95.00
98.00		Cross Foot Adjustments						98.00
99. 00 102. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	О	C	o	122, 015	0	99. 00 102. 00
		Part I)	0.000000	0.000000	0.00000			
103.00 104.00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 000000	0. 000000 C	0.00000	7. 418227 1, 296	0. 000000 0	103.00
		Part II)	0.000000	0.00000	0.000000			
105.00	'	Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 000000	0.000000	0. 078794	0. 000000	105.00
			. '		. '	'		•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS KESWICK PINES, INC. In Lieu of Form CMS-2540-10

Peri od: From 01/01/2022 To 12/31/2022 Worksheet B-1 Date/Ti me Prepared: 8/2/2023 11:24 am Provi der No.: 315347

				3/2/2023 11:24 am
			OTHER GENERAL	
			SERVI CE	
		Cost Center Description	ACTIVITIES	
			(TOTAL PATI	
			ENT DAYS) 15.00	
	GENER	AL SERVICE COST CENTERS	13.00	
1. 00		CAP REL COSTS - BLDGS & FLXTURES		1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00		EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS		5. 00
6. 00	1	LAUNDRY & LINEN SERVICE		6.00
7.00	1	HOUSEKEEPI NG		7.00
8. 00 9. 00	1	DI ETARY NURSI NG ADMI NI STRATI ON		8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY		10.00
11. 00	1	PHARMACY		11.00
12. 00	1	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION		14.00
15. 00		ACTI VI TI ES	16, 448	15. 00
		I ENT ROUTI NE SERVI CE COST CENTERS	47.440	
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	16, 448	30. 00 31. 00
32.00		ICF/IID	0 0	32.00
33. 00		OTHER LONG TERM CARE	0	33.00
00.00		LARY SERVICE COST CENTERS	<u> </u>	00.00
40.00		RADI OLOGY	0	40.00
41.00	1	LABORATORY	0	41.00
42.00		INTRAVENOUS THERAPY	0	42.00
		OXYGEN (INHALATION) THERAPY	0	43.00
44. 00 45. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	44. 00 45. 00
46.00		SPEECH PATHOLOGY	0	46. 00
		ELECTROCARDI OLOGY	0	47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	o	48.00
		DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	1	SUPPORT SURFACES	0	51.00
52. 00		OTHER ANCILLARY SERVICE COST CENTERS	0	52.00
60. 00		TIENT SERVICE COST CENTERS CLINIC	0	60.00
61.00	1	RURAL HEALTH CLINIC	0	61.00
62. 00	06200			62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	63.00
		REIMBURSABLE COST CENTERS		
		HOME HEALTH AGENCY COST	0	70.00
	07100	AMBULANCE	0	71.00
73.00			0	72. 00 73. 00
		OTHER REIMBURSABLE COST	o	74.00
		AL PURPOSE COST CENTERS		
80.00		MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81. 00		INTEREST EXPENSE		81.00
82.00		UTILIZATION REVIEW		82.00
83. 00 84. 00		HOSPICE OTHER SPECIAL PURPOSE COST CENTERS	0	83. 00 84. 00
89.00	06400	SUBTOTALS (sum of lines 1-84)	16, 448	89.00
07.00	NONRE	IMBURSABLE COST CENTERS	10, 440	07.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	91.00
92.00		PHYSICIANS PRIVATE OFFICES	0	92.00
93. 00		NONPAI D WORKERS	0	93.00
94.00		PATIENTS LAUNDRY	0	94.00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE Cross Foot Adjustments	ا	95. 00 98. 00
98.00		Negative Cost Centers		99.00
102.00		Cost to be allocated (per Wkst. B,	275, 520	102.00
		Part I)	_, 0, 020	1.52.50
103.00)	Unit cost multiplier (Wkst. B, Part I)	16. 750973	103. 00
104.00)	Cost to be allocated (per Wkst. B,	35, 305	104. 00
105.00		Part II)	2 44/4/6	405 00
105. 00	,	Unit cost multiplier (Wkst. B, Part	2. 146462	105. 00
	1	11)	ı I	1

Health Financial Systems KESWICK PINES,	I NC.		In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der		eri od:	Worksheet C	
			rom 01/01/2022 o 12/31/2022	Date/Time Pre	narodi
		'	0 12/31/2022	8/2/2023 11: 2	
Cost Center Description		Total (from	Total Charges		- Cili
,		Wkst. B, Pt	3	di vi ded by	
		I, col. 18)		col. 2	
		1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS					
40. 00 04000 RADI OLOGY		11, 898	5, 817	2. 045384	40.00
41. 00 04100 LABORATORY		12, 354	3, 544	3. 485892	41.00
42. 00 04200 I NTRAVENOUS THERAPY		(0	0.000000	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY		[C	0	0.000000	43.00
44. 00 O4400 PHYSI CAL THERAPY		444, 855		0. 689564	44.00
45. 00 04500 OCCUPATI ONAL THERAPY		174, 573		0. 445908	45.00
46. 00 O4600 SPEECH PATHOLOGY		21, 257	32, 100	0. 662212	46.00
47. 00 04700 ELECTROCARDI OLOGY		(ا ۱	0.000000	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		45, 890		1. 595563	48.00
49. 00 O4900 DRUGS CHARGED TO PATIENTS		57, 875	58, 180	0. 994758	49.00
50.00 O5000 DENTAL CARE - TITLE XIX ONLY		(0	0.000000	50.00
51. 00 05100 SUPPORT SURFACES		(0	0.000000	51.00
52.00 O5200 OTHER ANCI LLARY SERVI CE COST CENTERS		[C	0	0. 000000	52.00
OUTPATIENT SERVICE COST CENTERS					
60. 00 06000 CLI NI C		(0	0. 000000	60.00
61.00 06100 RURAL HEALTH CLINIC					61.00
62. 00 06200 FQHC					62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER			0	0. 000000	
71. 00 07100 AMBULANCE		7.0	0	0. 000000	
100. 00 Total		768, 702	1, 165, 027		100. 00

Health Financial Systems	KESWICK PII	NES. INC.		In lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	KLSWICK FII			Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I	pared:
		Title	XVIII (1)	Skilled Nursing Facility		
		Heal th Care Pi	rogram Charges	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	TENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	2. 045384		(6, 928	0	
41. 00 04100 LABORATORY	3. 485892	'	(9, 506	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000	l .	(0	0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000		9	0	0	
44. 00 04400 PHYSI CAL THERAPY	0. 689564			131, 310	0	1
45. 00 04500 OCCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY	0. 445908	,		76, 847	0	1 .0.00
47. 00 04700 ELECTROCARDI OLOGY	0. 662212 0. 000000			5, 397	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 595563	l .)		0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 994758)	40, 653	0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000		`	40, 033		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000		1	o o	0	
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0	0	
OUTPATIENT SERVICE COST CENTERS				-		
60. 00 06000 CLI NI C	0. 000000	0	(0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0	0	63.00
71.00 07100 AMBULANCE (2)	0. 000000				0	
100.00 Total (Sum of lines 40 - 71)		417, 894		270, 641	0	100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	y.					

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

Health Financial Systems KESWICK PINES, INC. In Lieu of Form CMS-2540-10								
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		RESWICK FIT			Period: From 01/01/2022 To 12/31/2022	Worksheet D Parts II-III	pared:	
	Title XVIII Skilled Nursing Facility							
	Cos	st Center Description		· '				
		·					1. 00	
		- APPORTIONMENT OF VACCINE COST						
1. 00 2. 00 3. 00	Pro Pro	ngs charged to patients - ratio of co ngram vaccine charges (From your reco ngram costs (Line 1 x line 2) (Title	rds, or the PS	5&R)		,	0. 994758 0 0	1
		Part I, line 18)			1	1		
	Cos	st Center Description	Total Cost (From Wkst.	Nursing & Allied Health	Ratio of Nursing &	Program Part A Cost (From	Part A Nursing &	
			B, Part I,	(From Wkst.	Allied Healt		Allied Health	
			Col. 18	B, Part I,	Costs to	I, Col. 4)	Costs for	
			001. 10	Col . 14)	Total Costs		Pass Through	
					Part A (Col.		(Col. 3 x	
					2 / Col. 1)		Col . 4)	
			1. 00	2. 00	3. 00	4. 00	5. 00	
		- CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
		Y SERVICE COST CENTERS						
	04000 RAD		11, 898	l e	0.00000		0	
	04100 LAB		12, 354	0	0.00000		0	41.00
		RAVENOUS THERAPY 'GEN (INHALATION) THERAPY	0		0. 00000 0. 00000		0	42. 00 43. 00
		SICAL THERAPY	444, 855	0	0.00000			44.00
		CUPATI ONAL THERAPY	174, 573	l e	0.00000		0	45.00
		ECH PATHOLOGY	21, 257		0. 00000		0	
		CCTROCARDI OLOGY	21, 23,		0. 00000		Ö	ł
		DICAL SUPPLIES CHARGED TO PATIENTS	45, 890	0	0.00000		0	ł
		JGS CHARGED TO PATIENTS	57, 875		0.00000		0	ł
50.00	05000 DEN	ITAL CARE - TITLE XIX ONLY	0	0	0. 00000	0 0	0	50.00
		PPORT SURFACES	0	0	0.00000		0	
		HER ANCILLARY SERVICE COST CENTERS	0	0	0.00000		0	52.00
100.00	Tot	al (Sum of lines 40 - 52)	768, 702	0	1	270, 641	0	100.00

Heal th	Financial Systems KESWICK PINES,	I NC.	In Lie	u of Form CMS-2	2540-10
	ATION OF INPATIENT ROUTINE COSTS	Provi der No. : 315347	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 8/2/2023 11:2	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
			raciiity		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days including private room days			16, 448	
2.00	Private room days			0	
3. 00 4. 00	Inpatient days including private room days applicable to the Pi Medically necessary private room days applicable to the Program			1, 206	3. 00 4. 00
5. 00	Total general inpatient routine service cost	П		5, 061, 674	
0.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			0,001,071	0.00
6.00	General inpatient routine service charges			6, 670, 588	
7.00	General inpatient routine service cost/charge ratio (Line 5 d	vided by line 6)		0. 758805	
8. 00 9. 00	Enter private room charges from your records	o O divided by privete	room dovo line	0.00	8. 00 9. 00
9.00	Average private room per diem charge (Private room charges ling)	e 8 divided by private	room days, rine	0.00	9.00
10.00	Enter semi-private room charges from your records			6, 670, 588	10.00
11.00	Average semi-private room per diem charge (Semi-private room	charges line 10, divid	ed by	405. 56	11.00
40.00	semi -pri vate room days)				40.00
12. 00 13. 00	Average per diem private room charge differential (Line 9 minus Average per diem private room cost differential (Line 7 times			0. 00 0. 00	
14. 00	Private room cost differential adjustment (Line 2 times line 1)		0.00		
15. 00			minus line 14)	5, 061, 674	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 div	ded by line 1)		307. 74	
17.00	Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (ling 4 times line 12)		371, 134 0	17. 00 18. 00
19. 00	Total program general inpatient routine service cost (Line 17)			371, 134	
20.00	Capital related cost allocated to inpatient routine service cost		rt II column 18,	273, 797	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)				
21.00				16. 65	
22.00	Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22)			20, 080 351, 054	
	Aggregate charges to beneficiaries for excess costs (From pro	vider records)		351, 054	24.00
	Total program routine service costs for comparison to the cost		inus line 24)	351, 054	
	Enter the per diem limitation (1)				26. 00
	Inpatient routine service cost limitation (Line 3 times the pe				27.00
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)	line 2/)		28. 00	
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be us	ed for title V and or	title XIX		l
(1)			THE XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days			16, 448	1
2. 00 3. 00	Program inpatient days (see instructions) Total nursing & allied health costs. (see instructions)(Do not	complete for titles V	or XLX)	1, 206 0	3.00
4. 00	Nursing & allied health ratio. (line 2 divided by line 1)	Comprete for titles v	OI AIA)	0. 073322	4.00
5. 00	Program nursing & allied health costs for pass-through. (line	0 4: 1: 4)	ŀ	0	

Health Financial Systems	KESWICK PINES,	I NC.	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	TITLE XVIII	Provi der No.: 315347	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 8/2/2023 11:24 am
		Title XVIII	Skilled Nursing	PPS
			Facility	

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				4 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT		1. 00	
1. 00	Inpatient PPS amount (See Instructions)	PEIVIEIN I		818, 316	1. 00
2. 00	Nursing and Allied Health Education Activities (pass through pa	nymants)		010, 310	2. 00
3. 00	Subtotal (Sum of lines 1 and 2)	rymerrt3)		818, 316	3.00
4. 00	Primary payor amounts			010, 310	4. 00
5. 00	Coinsurance			71, 187	5.00
6. 00	Allowable bad debts (From your records)			-4, 663	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ictions)		0	7. 00
8. 00	Adjusted reimbursable bad debts. (See instructions)			-3, 031	8. 00
9. 00	Recovery of bad debts - for statistical records only			4, 663	9. 00
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			744, 098	11.00
12.00	Interim payments (See instructions)			737, 129	12.00
13.00				-3, 031	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14.50
14. 55	Demonstration payment adjustment amount after sequestration			0	14.55
14. 75	Sequestration for non-claims based amounts (see instructions)			0	14.75
14. 99	Sequestration amount (see instructions)			10, 000	14. 99
15. 00				0	15.00
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17.00				0	17.00
18.00				0	18.00
19.00	,			0	19.00
20. 00 21. 00				0	20. 00 21. 00
21.00	,			0	21.00
23. 00				0	23. 00
24. 00				0	24.00
24. 00	Allowable Bad debts for dual eligible beneficiaries (see instru	ictions)		0	24. 00
24. 01		10113)		0	24. 01
25. 00	, ,			0	25. 00
26. 00				0	26. 00
27. 00				0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50				0	28. 50
28. 55				0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
	Balance due provider/program (see instructions)			0	29.00
	Protested amounts (Nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	section 115.2	0	30.00

Title XVIII Skilled Nursing PPS Facility Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1. 00 2.00 3.00 4.00 737, 129 1.00 Total interim payments paid to provider 1.00 2.00 Interim payments payable on individual bills, either 2.00 0 submitted or to be submitted to the contractor for services rendered in the cost reporting period. 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 3.01 0 3.01 3.02 0 0 3.02 0 3.03 0 3.03 3.04 0 0 3.04 0 3.05 0 3.05 Provider to Program 3.50 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 0 3.51 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.99 - 3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 737, 129 0 4.00 (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER O n 5.01 0 5.02 0 5.02 5.03 0 0 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 06/26/2023 n 5 50 3.031 5.51 0 5.51 0 5.52 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 -3.031 0 5.99 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) PROGRAM TO PROVIDER 6.01 0 6.01 PROVIDER TO PROGRAM 0 6.02 6.02 0

734, 098

Novitas Solutions

Contractor Name

1.00

0

Contractor Number

2.00

12001

7.00

8.00

Total Medicare program liability (see instructions)

7.00

8.00 Name of Contractor

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

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

Period: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared: 8/2/2023 11: 24 am

oni y)		10	6 6	E . I I	8/2/2023 11: 2	<u>4 am</u>
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets	1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	487, 848	0	0	0	
2. 00	Temporary investments	844, 951	0	0		
3.00	Notes recei vable	124 012	0	0	0	
4. 00 5. 00	Accounts receivable Other receivables	436, 013 158	0	0		
5. 00	Less: allowances for uncollectible notes and accounts	0	0	0	0	
	recei vabl e					
7. 00	Inventory	0	0	0	0	
3.00	Prepai d expenses	272, 853		0	0	
9. 00 10. 00	Other current assets Due from other funds	0	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 041, 823	0	0	l	
	FIXED ASSETS	2,011,020	<u> </u>			1
12.00	Land	2, 748, 541	0	0	0	12.0
13.00	Land improvements	398, 627	0	0	1	
14.00	Less: Accumulated depreciation	0	0	0	0	
15. 00 16. 00	Buildings Less Accumulated depreciation	41, 485, 439 -40, 691, 363		0	0	
17. 00	Leasehold improvements	-40, 691, 363 0	0	0	0	
18. 00	Less: Accumulated Amortization	0	Ö	0	Ö	
19. 00	Fi xed equipment	8, 660, 948	0	0	0	
20. 00	Less: Accumulated depreciation	0	0	0	0	20.0
21. 00	Automobiles and trucks	195, 015		0	0	
22.00	Less: Accumulated depreciation	0	0	0	0	
23. 00 24. 00	Major movable equipment Less: Accumulated depreciation	3, 341, 231	0	0	0	
25. 00	Mi nor equi pment - Depreci abl e		0	0	0	
26. 00	Mi nor equi pment nondepreci able	0	0	0	o o	
27. 00	Other fixed assets	13, 277	0	0	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	16, 151, 715	0	0	0	28. (
	OTHER ASSETS	1				
29. 00 30. 00	Investments Deposits on leases	0	0	0	0	
31. 00	Due from owners/officers		0	0		
32. 00	Other assets	6, 111, 057	0	0	Ö	
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	6, 111, 057	0	0	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	24, 304, 595	0	0	0	34. (
	Liabilities and Fund Balances					
35. 00	CURRENT LIABILITIES Accounts payable	581, 397	0	0	0	35. (
36.00	Salaries, wages, and fees payable	674, 087		0	1	
37. 00	Payrol I taxes payable	0	Ö	0	Ö	
38. 00	Notes & Loans payable (Short term)	1, 467, 302	0	0	0	38.0
39. 00	Deferred income	0	0	0	0	
10.00	Accel erated payments	0				40.0
41.00	Due to other funds	0	0	0	0	1
12. 00 13. 00	Other current liabilities TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 722, 786	0	0	l	
10.00	LONG TERM LIABILITIES	2,722,700	<u> </u>			10
14.00	Mortgage payable	9, 441, 581	0	0	0	44. (
45.00	Notes payable	0	0	0		
16. 00	Unsecured Loans	0	0	0	0	1
17.00	Loans from owners:	11 404 200	0	0	0	1
18. 00 19. 00	Other long term liabilities OTHER (SPECIFY)	11, 494, 298	0	0	0	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	20, 935, 879		0	0	
1.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	23, 658, 665		0	l	
	CAPITAL ACCOUNTS					
2.00	General fund balance	645, 930	1			52.
3.00	Specific purpose fund		0			53.
4. 00 5. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 55.
6.00	Governing body created - endowment fund balance			0		56.
7. 00	Plant fund balance - invested in plant			0	0	
8. 00	Plant fund balance - reserve for plant improvement,				Ö	
	replacement, and expansion					
				0		1 50
59. 00 50. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	645, 930 24, 304, 595		Ü	0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES KESWICK PINES, INC. In Lieu of Form CMS-2540-10 Provi der No.: 315347

| Peri od: | Worksheet G-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

					To 12/31/2022	Date/Time Pre 8/2/2023 11:2	
		Genera	Fund	Special P	urpose Fund	Endowment	
						Fund	
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1. 00	2. 00 3, 365, 842	3. 00	4. 00	5. 00	1.00
2. 00	Net income (loss) (from Wkst. G-3, line 31)		-2, 749, 172				2.00
3. 00	Total (sum of line 1 and line 2)		616, 670		0		3.00
4.00	Additions (credit adjustments)						4.00
5.00	CONTRI BUTI ONS	29, 267				0	5.00
6.00		0				0	
7. 00		0		(0	
8.00		0		(0	8.00
9.00	Total additions (sum of line F 0)	0	20 247	(0	9. 00 10. 00
10. 00 11. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)		29, 267 645, 937		0		11.00
12. 00	Deductions (debit adjustments)		043, 737				12.00
13. 00	NET ASSETS RELEASED	0				0	13.00
14.00	ROUNDI NG	7				0	14.00
15.00		0				0	15.00
16.00		0				0	16.00
17. 00		0	_	(0	0	17.00
18.00	Total deductions (sum of lines 13 - 17)		/ 45, 020		0		18.00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)		645, 930		0		19. 00
	Sheet (Line II - Iiile 10)	Endowment	PI ant	Fund			
		Fund					
4 00	I	6. 00	7. 00	8. 00			4 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	O		(D		1.00 2.00
3. 00	Total (sum of line 1 and line 2)	0					3.00
4. 00	Additions (credit adjustments)	Ö		· ·			4.00
5. 00	CONTRI BUTI ONS		0				5. 00
6.00			0				6.00
7.00			0				7. 00
8.00			0				8. 00
9.00	T. I.		0				9.00
10.00	Total additions (sum of line 5 - 9)	0					10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments)	U		(ار		11. 00 12. 00
13.00	NET ASSETS RELEASED		0				13.00
14. 00	ROUNDI NG		0				14.00
15. 00			0				15.00
16.00			0				16.00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 13 - 17)	0					18.00
19. 00	Fund balance at end of period per balance	0		(O		19. 00
	sheet (Line 11 - line 18)			I	1		I

Heal th	Financial Systems KESWICK PINES,	I NC.		In Li∈	eu of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre 8/2/2023 11:2	pared:
	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		6, 670, 58		6, 670, 588	1.00
2.00	NURSING FACILITY			0	0	2.00
3.00	I CF/IID			0	0	3. 00
4. 00	OTHER LONG TERM CARE			0	0	4. 00
5. 00	Total general inpatient care services (Sum of lines 1 - 4)		6, 670, 58	38	6, 670, 588	5.00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		1, 165, 02	27 0	1, 165, 027	6.00
7. 00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	
9.00	AMBULANCE			0	0	,
	RURAL HEALTH CLINIC			0	0	10.00
	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11.00
	CORF			0	0	11. 10
	HOSPI CE			0	0	12.00
	ASSISTED AND INDEPENDENT LIVING		11, 008, 77			
14.00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	3 to	18, 844, 39	94 0	18, 844, 394	14.00
	Worksheet G-3, Line 1)					
	Cost Center Description					
	I			1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				19, 090, 888	1
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	0.00
9.00	Deduct (Specify)			0)	9. 00
10 00					il .	1 10 00

10.00

11. 00 12. 00 13. 00

14.00

19, 090, 888 15. 00

14.00 Total Deductions (Sum of lines 9 - 13)
15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

10.00

11. 00 12. 00 13. 00

Heal th	Financial Systems	KESWICK PINES,	I NC.	In Lie	u of Form CMS-2	2540-10
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der No.: 31534	From 01/01/2022	Worksheet G-3 Date/Time Pre 8/2/2023 11:2	pared:
					07272023 11.2	4 alli
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part	I, col. 3, line	14)		18, 844, 394	1.00
2.00	Less: contractual allowances and discounts on	patients accounts	S		1, 983, 173	2.00
3.00	Net patient revenues (Line 1 minus line 2)				16, 861, 221	3.00
4.00	Less: total operating expenses (From Worksheet	G-2, Part II, I	ine 15)		19, 090, 888	4.00
5.00	Net income from service to patients (Line 3 min	nus 4)	•		-2, 229, 667	5.00
	Other income:	,				1
6.00	Contributions, donations, bequests, etc				15, 337	6.00
7 00	Incomo from invostments				260 040	7 00

		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	18, 844, 394	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1, 983, 173	2.00
3.00	Net patient revenues (Line 1 minus line 2)	16, 861, 221	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	19, 090, 888	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-2, 229, 667	5. 00
	Other income:		
6.00	Contributions, donations, bequests, etc	15, 337	6.00
7.00	Income from investments	260, 848	7.00
8.00	Revenues from communications (Telephone and Internet service)	51, 967	8. 00
9.00	Revenue from television and radio service	116, 937	9.00
10.00	Purchase discounts	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	19, 031	
14.00	Revenue from meals sold to employees and guests	100, 080	
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17. 00
18. 00	Revenue from sale of medical records and abstracts	0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen	3, 383	
21. 00	Rental of vending machines	2, 045	
22. 00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	TRIP REVENUE	494	
24. 01	BARBER AND BEAUTY	78, 085	
24. 02	FINANCE CHARGES	4, 399	
24. 03	RESIDENT INTEREST / LATE FEES	0	24. 03
24. 04	PROCESSING FEES	5, 900	
24. 05	RESTRICTED INVESTMENT INCOME	0	24. 05
24. 06	GAIN / LOSS ON ASSET DISPOSAL	0	24. 06
24. 07	NET ASSETS RELEASED	1, 700	
24. 08	CARE TO SHARE INVESTORS REVENUE	1, 190	
24. 09	INTEREST ON PROMISSORY NOTE	18	24. 09
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25.00	Total other income (Sum of lines 6 - 24)	661, 414	
26.00	Total (Line 5 plus line 25)	-1, 568, 253	
27.00	RESTRICTED INVESTMENT LOSS	1, 180, 919	
28. 00		0	28. 00
29. 00		0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)	1, 180, 919	
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-2, 749, 172	31.00