	required by I aw (42 USC 1395g; 42 CFR 413.	BUCKINGHAM AT NORWOOD In 3.20(b)). Failure to report can result in all inte g period being deemed overpayments (42 USC 1395g).			u of Form CMS-2540-10 FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315290	Period: From 01/01/2023 To 12/31/2023	
PART I - COST I	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost re	port		Date: 6/3/202	4 Time: 2:40 pm
use only	2. [] Manually prepared cost report				
-	3. [0] If this is an amended report en	ter the numbe	r of times the provide	r resubmitted thi	s cost report
	3.01 [] No Medicare Utilization. Enter '				·
Contractor	4. [1]Cost Report Status	6. Contractor			
use only	(1) As Submitted	7 [N] Firs	t Cost Report for this	Provider CCN	
, and a g	(2) Settled without audit		Cost Report for this		
	(3) Settled with audit		COST Report FOI this	FIOVILLEI CCN	
	(4) Reopened	9. NPR Date:			
	(5) Amended	10.[0] f	ine 4, column 1 is "4"	: Enter number of	times reopened
		11.Contracto	r Vendor Code	4	
	5. Date Received:		care Utilization. Ente	er "F" for full, '	'L" for low, or "N"

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 BUCKINGHAM AT NORWOOD (315290) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1	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	-10, 705	0	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
100.00	TOTAL	0	-10, 705	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.

Heal th	Financial Systems	BUCKIN	IGHAM AT NOF	RMOOD		I	n Lie	u of For	m CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI				No.: 315290	Peri od:		Workshe		
COMPLE	X INDENTIFICATION DATA					From 01/01/ To 12/31/		Part I Date/Ti	me Pre	nared
						10 12/01/	2020	6/3/202		
	1.00		2.00		3.00					
1 00	Skilled Nursing Facility and Skilled Nursing Street: 100 MCCLELLAN STREET	PO Box:	Complex Ad	dress:						1.00
1.00 2.00	City: NORWOOD	State: N.	I	Zip Code	07648					2.00
	County: BERGEN	CBSA Code		Urban/Ru						3.00
3.01		CBSA Code								3.01
			Compon	ent Name	Provi der		Paym	ent Syst		
					CCN	Certified	L	0, or N	í	-
			1	. 00	2.00	3.00	V 4.0	XVIII 0 5.00	XI X 6.00	
	SNF and SNF-Based Component Identification:		1	. 00	2.00	3.00	4.0	5 5.00	0.00	
4.00	SNF		BUCKI NGHAM	AT NORWOO	D 315290	01/01/1990	N	Р	0	4.00
5.00	Nursing Facility									5.00
6.00	I CF/IID									6.00
	SNF-Based HHA									7.00
8.00 9.00	SNF-Based RHC SNF-Based FQHC									8.00 9.00
	SNF-Based CMHC									10.00
	SNF-Based OLTC									11.00
12.00	SNF-Based HOSPICE									12.00
13.00	SNF-Based CORF									13.00
						From:		To		-
14 00	Cost Reporting Period (mm/dd/yyyy)					1.00		2.0		14.00
	Type of Control (See Instructions)					01/01/2	4	12/31/	2025	15.00
10100								Y/	N	10100
								1.0	00	
	Type of Freestanding Skilled Nursing Facilit									
16.00	Is this a distinct part skilled nursing facil	lity that	meets the	requi reme	nts set forth	n in 42 CFR		Y		16.00
17 00	section 483.5? Is this a composite distinct part skilled nu	rsing faci	ility that u	meets the	requirements	set forth	in	N		17.00
17.00	42 CFR section 483.5?	i si ng Tuoi	integration in a construction of the second s	10013 1110	r oqui i omorito					17.00
	Are there any costs included in Worksheet A [·]							Y		18.00
	organizations as defined in CMS Pub. 15-1, cl	hapter 10'	? If yes, o	complete	Norksheet A-8	8-1.				-
10 00	Miscellaneous Cost Reporting Information If this is a low Medicare utilization cost re	oport in	dicato with		or vos or "N	" for po		N		19.00
	If line 19 is yes, does this cost report mee						е	N N		19.00
	utilization cost report, indicate with a "Y",	, for yes,	, or "N" fo	r no.	Ũ					
	Depreciation - Enter the amount of depreciat	ion repor	ted in this	SNF for	the method in	ndicated on	Li nes			
	Straight Line							2	296, 868	20.00
	Declining Balance Sum of the Year's Digits									21.00 22.00
	Sum of line 20 through 22								296.868	23.00
	If depreciation is funded, enter the balance	e as of th	he end of tl	he period					(
	Were there any disposal of capital assets du							N		25.00
26.00	Was accelerated depreciation claimed on any a	assets in	the curren	t or any	prior cost re	eporting per	i od?	N		26.00
27 00	(Y/N) Did you coose to participate in the Medicare	program	at and of t	ha nariad	to which thi	s cost ropo	r+	N		27.00
27.00	Did you cease to participate in the Medicare applies? (Y/N)	program a		ne periou		s cost repo	ιι			27.00
28.00	Was there a substantial decrease in health in	nsurance p	proportion (of allowa	ble cost from	n prior cost		N		28.00
	reports? (Y/N)						-			
								APart B		-
	If this facility contains a public or non-pu	blic prov	ider that a	ualifies	for an evemp	tion from th	<u> 1.0</u>		3.00	
	of the lower of the costs or charges enter "								•	
	exemption.		•	51						
	Skilled Nursing Facility						N	N		29.00
	Nursing Facility								N	30.00
	ICF/IID SNF-Based HHA						N	N		31.00
	SNF-Based RHC							, N		32.00
	SNF-Based FQHC						1			34.00
	SNF-Based CMHC							N		35.00
36.00	SNF-Based OLTC									36.00
						Y/N		2.0	0	
37 00	Is the skilled nursing facility located in a	state the	at certifie	s the pro	vider as a SM	1.00 IF Y		2.0	.0	37.00
2	regardless of the level of care given for Ti				as a bi					
	Are you legally-required to carry malpractice	e insurano	ce? (Y/N)			Y				38.00
39.00	Is the malpractice a "claims-made" or "occur "alaims made" anter 1 lf the policy is "occur			e policy	is	1				39.00
	<u>"claims-made" enter 1. If the policy is "occu</u>	urrence",	enter 2.		Premiums	Paid Los	SPS	l SelfIns	urance	
					1.00	2.00	200	3.0		
41.00	List malpractice premiums and paid losses:				0	0		0		41.00

Heal th	Financial Systems	BUCKINGHAM AT NO	RWOOD	In Lieu	u of Form CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3152		Worksheet S-2	
COMPLE	X INDENTIFICATION DATA			From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	pared.
				10 12/01/2020	6/3/2024 2:40	
					Y/N	
	1				1.00	
	Are malpractice premiums and paid losse				N	42.00
	center? Enter Y or N. If yes, check box	c, and submit supporting s	schedule listing co	st centers and		
	amounts.					
	Are there any home office costs as defi				N	43.00
	If line 43 is yes, enter the home offic	ce chain number and enter	the name and addres	ss of the home		44.00
-	office on lines 45, 46 and 47.					
	1.00	2.00		3.00		
	If this facility is part of a chain org	ganization, enter the nam	e and address of th	ne home office on the	lines	
	bel ow.	1				
45.00	Name:	Contractor's Name:	Conti	ractor's Number:		45.00
46.00	Street:	PO Box:				46.00
47.00	Ci ty:	State:	Zip (Code:		47.00

	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Pro	ovider N		Period: From 01/01/2023 To 12/31/2023		epared:
					Y/N	Date	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column 1,	"Y" for	Yes or "N"	1.00 for No. For all	2.00 the date	
00	Provider Organization and Operation Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)			mn 2. (see	N		1.0
			_	Y/N 1.00	Date 2.00	V/I 3.00	-
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac	of termination and in c	olumn	<u>N</u>	2.00	3.00	2.0
0	contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personne	ontracts, with individuals or entities (e.g., chain home offices, drug medical supply companies) that are related to the provider or its fficers, medical staff, management personnel, or members of the board directors through ownership, control, or family and other similar elationships? (see instructions)					3.0
			_	Y/N	Туре	Date	
	Financial Data and Reports			1.00	2.00	3.00	-
0	Column 1: Were the financial statements prep. Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If Are the cost report total expenses and total		Y	С		4.0	
	those on the filed financial statements? If reconciliation.	column 1 is "Y", submit			Y/N	Legal Oper.	
					1.00	2.00	
0	Approved Educational Activities Column 1: Were costs claimed for Nursing Schulegal operator of the program? (Y/N)	ool? (Y/N) Column 2: I	s the p	rovider the	N	N	6. 0
00	Were costs claimed for Allied Health Program						
	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set	ng the cost reporting p		or Nursing	N N		
	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	ng the cost reporting p		or Nursing		Y/N 1.00	7.0
00	Were approvals and/or renewals obtained duri	ng the cost reporting p ee instructions. d debts? (Y/N) see inst	ructions	S.	N		9. (
00 00 00 . 00	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived	rructions nge duri	s. ing this cos ", see instr	N t reporting uctions.	1.00 Y N N	8. (9. (10. (11. (
00 00 00	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived	rructions nge duri	s. ing this cos ", see instru	N t reporting uctions. ctions.	1.00 Y N N	
00 00 00	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period?	rructions nge duri	s. ing this cos ", see instr , see instru Pa	N t reporting uctions. ctions. urt A	1.00 Y N N Part B	8. (9. (10. (11. (
000000000000000000000000000000000000000	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived	rructions nge duri	s. ing this cos ", see instru	N t reporting uctions. ctions.	1.00 Y N N	8. (9. (10. (11. (
000000000000000000000000000000000000000	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and 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	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description	rructions nge duri	s. ing this cos ", see instru , see instru Pa Y/N	N t reporting uctions. ctions. irt A Date	1.00 Y N N Part B Y/N	8. (9. (10. (11. (12. (
	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and 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	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	rructions nge duri	s. ing this cos ", see instru , see instru Pa Y/N 1.00	N t reporting uctions. ctions. urt A Date 2.00	1.00 Y N N Part B Y/N 3.00	8. (9. (10. (11. (12. (13. (
	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and 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 used for total and the provider's records for allocation? If either col. 1 or 3 is "Y"	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	rructions nge duri	s. ing this cos ", see instru , see instru Pa Y/N 1.00 Y	N t reporting uctions. ctions. urt A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	8. (9. (10. (11. (
	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions.	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	rructions nge duri	s. ing this cos ", see instru , see instru Pa Y/N 1.00 Y	N t reporting uctions. ctions. urt A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	8. (9. (10. (11. (12. (13. (14. (
00	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and 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	ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period? Description 0	rructions nge duri	s. ing this cos ", see instru pa Y/N 1.00 Y N	N t reporting uctions. ctions. urt A Date 2.00	1.00 Y N Part B Y/N 3.00 Y N	8. (9. (10. (11. (12. (13. (14. (15. (

Heal th	Financial Systems	BUCKINGHAM A	T NORWOOD		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY X REIMBURSEMENT QUESTIONNAIRE	HEALTH CARE	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre	
					10 12/31/2023	6/3/2024 2:40	pareu. pm
			1.	00	2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/p	position	CHARLES		REED		19.00
	held by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost rep	port	EXECUCARE ASSO	OCI ATES			20.00
	preparer.						
21.00	Enter the telephone number and email address of	f the cost	(609)738-3200		CRWASSC@NETSCAF	PE. NET	21.00
	report preparer in columns 1 and 2, respectivel						

Heal th	Financial Systems	BUCKI NGHAM A	T NORWOOD	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provider No.: 315290	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 6/3/2024 2:40	pared:
		Part B				
	PS&R Data	1.00				
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	05/21/2024				13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
		-	3.00			
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		VI CE-PRESI DENT			19.00
20.00	Enter the employer/company name of the cost	report				20.00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

	Financial Systems D NURSING FACILITY AND SKILLED NURSI X STATISTICAL DATA		T NORWOOD Provi der	F	eriod: rom 01/01/2023 o 12/31/2023		parec
				l np	atient Days/Vis		
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
00	SKILLED NURSING FACILITY	240	87, 600	0	4, 189	43, 216	1. (
00	NURSING FACILITY	0	0	0		0	2. (
00		0	0			0	3. (
00	HOME HEALTH AGENCY COST		0	0	0	0	4. (5. (
00 00	Other Long Term Care SNF-Based CMHC	0	0				5. 6.
00	HOSPICE	0	0	0	0	0	7.
00	Total (Sum of lines 1-7)	240	87, 600	0		43, 216	8.
		Inpatient Da			Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
00	SKILLED NURSING FACILITY	7,079	54, 484	0		142	1.
00 00	NURSING FACILITY ICF/IID	0	0	0		0	2. 3.
00	HOME HEALTH AGENCY COST	0	0			0	4.
00	Other Long Term Care	o	0				5.
00	SNF-Based CMHC						6.
00	HOSPI CE	0	0	0	0	0	7.
00	Total (Sum of lines 1-7)	7,079	54, 484	0	156	142	8.
		Di scha	irges	Aver	age Length of	Stay	
	Component	0ther 11.00	Total 12,00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
00	SKILLED NURSING FACILITY	187	485	0.00		304.34	1.
00	NURSING FACILITY	0	0	0.00		0.00	2.
00	ICF/IID	0	0			0.00	3.
00	HOME HEALTH AGENCY COST						4.
00	Other Long Term Care	0	0				5.
00	SNF-Based CMHC		0	0.00	0.00	0.00	6.
00	HOSPICE Total (Sum of lines 1-7)	187	485	0.00 0.00		0.00 304.34	7. 8.
		Average Length	403		sions	304.34	0.
	Component	of Stay		T; +1 o V)/111	Title XIX	Other	
	Component	Total 16.00	Title V 17.00	Title XVIII 18.00	19.00	20.00	
00	SKILLED NURSING FACILITY	112.34	0	10.00	87	188	1.
00	NURSING FACILITY	0.00	0		0	0	2.
00	ICF/IID	0.00			0	0	3.
00	HOME HEALTH AGENCY COST					_	4.
00	Other Long Term Care	0.00				0	5.
00	SNF-Based CMHC HOSPI CE	0.00	0	0	0	0	6. 7.
00	Total (Sum of lines 1-7)	112.34	0	191		188	8.
-		Admi ssi ons	Full Time				
	Component	Total	Employees on	Nonpai d	1		
		21.00	Payrol I	Workers	-		
00	SKILLED NURSING FACILITY	21.00	22.00 200.61	23.00			1.
00	NURSING FACILITY	400	0.00	0.00			2.
00	ICF/IID	0	0.00	0.00			3.
00	HOME HEALTH AGENCY COST		0.00				4.
00	Other Long Term Care	0	0.00				5.
0C	SNF-Based CMHC HOSPI CE		0.00 0.00	0.00 0.00			6. 7.
00		0					

Heal th	Financial Systems	BUCKI NGHAM			In Lie	u of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION				Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 6/3/2024 2:40	pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARIES	1	1	1		1	
1.00	Total salaries (See Instructions)	10, 498, 437	0	10, 498, 43			
2.00	Physician salaries-Part A	0	0		0 0.00		2.00
3.00	Physician salaries-Part B	0	0		0 0.00		3.00
4.00	Home office personnel	0	0		0 0.00		4.00
5.00	Sum of lines 2 through 4	0	0	10,100,10	0.00		5.00
6.00	Revised wages (line 1 minus line 5)	10, 498, 437	0	10, 498, 43			6.00
7.00	Other Long Term Care	0	0		0 0.00		
8.00	HOME HEALTH AGENCY COST	0			0 0.00 0 0.00		
9.00 10.00	HOSPI CE	0			0 0.00		
10.00	Other excluded areas	0			0 0.00		
12.00	Subtotal Excluded salary (Sum of lines 7	0			0 0.00		
	through 11)	0					
13.00	Total Adjusted Salaries (line 6 minus line 12)	10, 498, 437	C	10, 498, 43	417, 261. 00	25.16	13.00
	OTHER WAGES & RELATED COSTS	1					
14.00	Contract Labor: Patient Related & Mgmt	1, 104, 304	C	1, 104, 30	21, 339. 00	51.75	14.00
15.00	Contract Labor: Physician services-Part A	0	0)	0 0.00	0.00	15.00
16.00	Home office salaries & wage related costs	0	0		0 0.00	0.00	16.00
	WAGE-RELATED COSTS						1
17.00	Wage-related costs core (See Part IV)	895, 256	C	895, 25	56		17.00
18.00	Wage-related costs other (See Part IV)	0	0		0		18.00
19.00	Wage related costs (excluded units)	0	0		0		19.00
20.00	Physician Part A - WRC	0	0		0		20.00
21.00	Physician Part B - WRC	0	0		0		21.00
22.00	Total Adjusted Wage Related cost (see	895, 256	0	895, 25	56		22.00
	instructions)						

Heal th	Financial Systems	BUCKI NGHAM	AT NORWOOD		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period: From 01/01/2023 To 12/31/2023		pared:
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col	. Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0		0 0.00	0.00	1.00
2.00	Administrative & General	885, 537	0	885, 53	7 17, 242. 00	51.36	2.00
3.00	Plant Operation, Maintenance & Repairs	165, 309	0	165, 30	9 7,447.00	22.20	3.00
4.00	Laundry & Linen Service	0	0		0 0.00	0.00	4.00
5.00	Housekeepi ng	602, 627	0	602, 62	7 33, 704. 00	17.88	5.00
6.00	Dietary	1, 156, 792	0	1, 156, 79	2 58, 306. 00	19.84	6.00
7.00	Nursing Administration	741, 328	0	741, 32	8 22, 352.00	33.17	7.00
8.00	Central Services and Supply	72, 175	0	72, 17	5 3, 337. 00	21.63	8.00
9.00	Pharmacy	0	0		0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	38, 787	0	38, 78	7 2, 075. 00	18.69	10.00
11.00	Social Service	101, 960	0	101, 96	0 2, 690. 00	37.90	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	445, 586	0	445, 58	6 22, 969. 00	19.40	13.00
14.00	Total (sum lines 1 thru 13)	4, 210, 101	0	4, 210, 10	1 170, 122. 00	24.75	14.00

lealth Financial S	ystems	BUCKINGHAM AT NORWOOD	In Lie	u of Form CMS-2	2540-1
SNF WAGE RELATED (.OSTS	Provi der No.: 31529	0 Period: From 01/01/2023 To 12/31/2023		pared
				Amount	
				Reported	
				1.00	
PART IV - W	AGE RELATED COSTS				
Part A - Co					
RETI REMENT	COST				
	er Contributions			0	
2.00 Tax Shelter	ed Annuity (TSA) Employer Co	tri buti on		0	2.0
	nd Non-Qualified Pension Plan			69, 231	3.0
4.00 Prior Year	Pension Service Cost			0	4.0
PLAN ADMINI	STRATIVE COSTS (Paid to Exter	nal Organization)			
5.00 401K/TSA PI	an Administration fees			0	5.0
5.00 Legal /Accou	nting/Management Fees-Pension	PI an		0	6. C
7.00 Employee Ma	naged Care Program Administra	tion Fees		0	7.C
HEALTH AND	INSURANCE COST				
8.00 Health Insu	rance (Purchased or Self Fun	ed)		0	8.0
00 Prescriptic	n Drug Plan			0	9.0
	ring and Vision Plan			-3, 164	10.0
1.00 Life Insura	nce (If employee is owner or	benefi ci ary)		0	11.0
2.00 Accident In	surance (If employee is owned	or beneficiary)		0	12.0
3.00 Disability	Insurance (If employee is own	er or beneficiary)		0	13.0
4.00 Long-Term C	are Insurance (If employee is	owner or beneficiary)		0	
	mpensation Insurance			-53, 355	15.0
6.00 Retirement	Health Care Cost (Only current	t year, not the extraordinary accrual requi	red by FASB 106.	0	16.0
	ive portion)				
TAXES					
	ers Portion Only			786, 392	
	xes - Employers Portion Only			0	
9.00 Unemploymen				0	1
	deral Unemployment Taxes			96, 152	20.0
OTHER					
	eferred Compensation			0	
	st and Allowances			0	
3.00 Tuition Rei				0	1
24.00 Total Wage	Related cost (Sum of lines 1	- 23)		895, 256	24.0
				Amount	
				Reported	
				1.00	
Part B - Ot	her than Core Related Cost				

Heal th	Financial Systems	BUCKINGHAM A	T NORWOOD		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES				Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)	. Related to	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 267, 382	185, 244				1.00
2.00	Licensed Practical Nurses (LPNs)	2, 842, 425	415, 457				2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2, 166, 153	316, 611	2, 482, 76	4 136, 485. 00	18. 19	3.00
4.00	Total Nursing (sum of lines 1 through 3)	6, 275, 960	917, 312	7, 193, 27			4.00
5.00	Physical Therapists	0	0		0 0.00		5.00
6.00	Physical Therapy Assistants	0	0		0 0.00		6.00
7.00	Physical Therapy Aides	0	0		0 0.00		7.00
8.00	Occupational Therapists	0	0		0 0.00		8.00
9.00	Occupational Therapy Assistants	0	0		0 0.00		9.00
10.00	Occupational Therapy Aides	0	0		0 0.00		
11.00	Speech Therapists	0	0		0 0.00		11.00
12.00	Respiratory Therapists	0	0		0 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)	0			0 0.00		14.00
15.00	Licensed Practical Nurses (LPNs)	0			0 0.00		15.00
16.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	0			0 0.00	0.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	0			0 0.00	0.00	17.00
18.00	Physical Therapists	513, 661		513, 66			18.00
19,00	Physical Therapy Assistants	0		313,00	0 0.00		
20.00	Physical Therapy Aides	0			0 0.00		20.00
21.00	Occupational Therapists	443, 053		443, 05			21.00
21.00	Occupational Therapy Assistants	443,033			0 0.00		21.00
23.00	Occupational Therapy Aides	0			0 0.00		
24.00	Speech Therapists	140, 466		140, 46			
25.00	Respiratory Therapists	7, 124		7, 12			25.00
26.00	Other Medical Staff	0			0 0.00		26.00
		-1					

lealth Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	BUCKINGHAM AT	Provi der No.: 31529	0 Period:	eu of Form CMS Worksheet S	
			From 01/01/2023 To 12/31/2023	Date/Time P	
			Group	6/3/2024 2: Days	40 pm
			1.00	2.00	
. 00			RUX		1.0
2. 00			RUL RVX		2.0
. 00			RVL		4.0
. 00			RHX		5.0
. 00			RHL		6.0
. 00 . 00			RMX RML		7.0
.00			RLX		9.0
0. 00			RUC		10.0
1.00			RUB		11.0
2.00 3.00			RUA RVC		12.0
4.00			RVB		14.0
5. 00			RVA		15.0
6.00			RHC		16.0
7.00 8.00			RHB RHA		17.0 18.0
9.00			RMC		19.0
0.00			RMB		20.0
1.00			RMA		21.0
2. 00 3. 00			RLB RLA		22. 0 23. 0
4. 00			ES3		23.0
5.00			ES2		25.0
6. 00			ES1		26.0
7.00			HE2		27.0
8. 00 9. 00			HE1 HD2		28.0 29.0
0.00			HD1		30.0
1.00			HC2		31.0
2.00			HC1		32.0
3. 00 4. 00			HB2 HB1		33. C 34. C
5.00			LE2		34.0
6.00			LE1		36.0
7.00			LD2		37.0
8. 00 9. 00			LD1		38.0
0.00			LC2 LC1		39.0 40.0
1.00			LB2		41.0
2.00			LB1		42. C
3. 00			CE2		43.0
4. 00 5. 00			CE1 CD2		44.0 45.0
6.00			CD1		46.0
7.00			CC2		47. C
8. 00			CC1		48. C
9. 00 0. 00			CB2 CB1		49. C 50. C
1.00			CA2		51.0
2. 00			CA1		52. C
3. 00			SE3		53.0
4. 00 5. 00			SE2 SE1		54. 0 55. 0
5.00			SSC		56.0
7.00			SSB		57.0
3. 00			SSA		58.0
0. 00 0. 00			I B2 I B1		59. 0 60. 0
. 00			I A2		61.0
2. 00			I A1		62.0
3.00			BB2		63.0
4. 00 5. 00			BB1		64. 0 65. 0
5.00			BA2 BA1		66.0
7.00			PE2		67.0
3. 00			PE1		68.0
9.00			PD2		69.0
0. 00 1. 00			PD1 PC2		70. C
2.00			PC2 PC1		72.0
3. 00			PB2		73.0
4.00			PB1	1	74. C

Health Financial Systems	BUCKINGHAM AT NO	RWOOD		In Lie	u of Form CMS	S-2540-10		
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315290	Period: From 01/01/2023	Worksheet S	-7		
				To 12/31/2023				
				Group	Days			
				1.00	2.00			
76.00				PA1		76.00		
99.00				AAA		99.00		
100. 00 TOTAL						100.00		
			Expenses	Percentage	Y/N			
			1.00	2.00	3.00			
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)								
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, Lin	ne 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00		

	Financial Systems	BUCKINGHAM AT				u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315290	Period: From 01/01/2023	Worksheet A	
					To 12/31/2023	Date/Time Pre 6/3/2024 2:40	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col. 2)	ons	Trial Balance	
					Increase/Decre	(col. 3 +- col. 4)	
					ase (Fr Wkst A-6)	COI. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 934, 277	1, 934, 27		1, 934, 277	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		327, 710			327, 710	
3.00	00300 EMPLOYEE BENEFITS	005 527	1, 534, 480			1, 534, 480	3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	885, 537 165, 309	3, 379, 822 602, 086	4, 265, 35 767, 39		4, 265, 359 767, 395	4.00 5.00
5.00 6.00	00600 LAUNDRY & LINEN SERVICE	105, 309	256	25		256	6.00
7.00	00700 HOUSEKEEPING	602, 627	112, 879			715, 506	
8.00	00800 DI ETARY	1, 156, 792	619, 740	1, 776, 53		1, 776, 532	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	741, 328	79, 418	820, 74		820, 746	
10.00	01000 CENTRAL SERVICES & SUPPLY	72, 175	304, 942	377, 11	7 -35	377, 082	10.00
11.00	01100 PHARMACY	0	9, 935	9, 93	35 0	9, 935	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	38, 787	0	38, 78	37 0	38, 787	12.00
13.00	01300 SOCIAL SERVICE	101, 960	60	102, 02		102, 020	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15.00	01500 ACTIVITIES	445, 586	7, 601	453, 18	37 0	453, 187	15.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	6, 288, 336	0	4 200 22	36 0	6, 288, 336	30.00
	03100 NURSING FACILITY	0, 200, 330	0	6, 288, 33		0, 200, 330	30.00
32.00	03200 CF/I D	0	0		0 0	0	32.00
	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCI LLARY SERVICE COST CENTERS	-		1			
40.00	04000 RADI OLOGY	0	3, 084	3, 08	34 0	3, 084	40.00
41.00	04100 LABORATORY	0	21, 025	21, 02		21, 025	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 28	28	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	7, 124	7, 12		7, 124	
44.00	04400 PHYSI CAL THERAPY	0	1, 098, 161	1, 098, 16		514, 642	44.00
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0 443, 053	443, 053	
48.00	04700 ELECTROCARDI OLOGY	0	0		0 140, 466	140, 466 0	48.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 35	35	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	185, 193	185, 19		185, 165	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS					<u> </u>	62.00
70 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	27, 717				71.00
	07300 CMHC	0	0		0 0		73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0 0	0	80.00
81.00	08100 I NTEREST EXPENSE		0		0 0	0	
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 10, 498, 437	10 255 510	20, 753, 94	0 0	0	83.00 89.00
69.00	NONREI MBURSABLE COST CENTERS	10, 490, 437	10, 255, 510	20, 755, 92	·/ U	20, 753, 947	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP	o	0		0 0	0	
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY	0	0		0 0	0	
100.00	TOTAL	10, 498, 437	10, 255, 510	20, 753, 94	17 0	20, 753, 947	100. 00

Heal th	Financial Systems	BUCKI NGHAM	AT NORWOOD		In Lie	u of Form CMS-	2540-10
	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315290	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nored.
					To 12/31/2023	6/3/2024 2:40	
	Cost Center Description	Adjustments to	Net Expenses				
		Expenses (Fr	For Allocation	1			
		Wkst A-8)	(col. 5 +-				
			col. 6)	-			
		6.00	7.00				
1 00	GENERAL SERVICE COST CENTERS	000.011	1 044 0//	1			1 1 00
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT	-890, 211		1			1.00
2.00 3.00	00300 EMPLOYEE BENEFITS	0	327, 710 1, 534, 480	1			2.00 3.00
4.00	00400 ADMINI STRATI VE & GENERAL	-283, 079		1			4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	-203, 077	767, 395	1			5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	256	1			6.00
7.00	00700 HOUSEKEEPI NG	0	715, 506				7.00
8.00	00800 DI ETARY	0	1, 776, 532				8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	20, 152	840, 898	1			9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	377, 082	2			10.00
11.00	01100 PHARMACY	0	9, 935	j l			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	38, 787	r			12.00
13.00	01300 SOCIAL SERVICE	0	102, 020				13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1			14.00
15.00	01500 ACTI VI TI ES	0	453, 187				15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			
	03000 SKI LLED NURSI NG FACI LI TY	26, 500					30.00
	03100 NURSING FACILITY	0	0				31.00
32.00	03200 I CF/I I D	0					32.00 33.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0		/			33.00
40.00	04000 RADI OLOGY	0	3, 084				40.00
40.00	04100 LABORATORY	0	21, 025	1			41.00
42.00	04200 I NTRAVENOUS THERAPY	0	21, 023				42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	7, 124	1			43.00
44.00	04400 PHYSI CAL THERAPY	0	514, 642				44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	443, 053	1			45.00
46.00	04600 SPEECH PATHOLOGY	0	140, 466				46.00
47.00	04700 ELECTROCARDI OLOGY	0	0				47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35				48.00
	04900 DRUGS CHARGED TO PATIENTS	0	185, 165				49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	1			50.00
51.00	05100 SUPPORT SURFACES	0	0				51.00
(0.00	OUTPATIENT SERVICE COST CENTERS	0					1 / 0 . 00
60.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0		•			60.00
		0					61.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS	I	1	1			62.00
70.00	07000 HOME HEALTH AGENCY COST	0	C				70.00
	07100 AMBULANCE	0	-	1			71.00
	07300 CMHC	0		1			73.00
10100	SPECIAL PURPOSE COST CENTERS						10100
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	C)			80.00
81.00	08100 INTEREST EXPENSE	0	0				81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF	0	0				82.00
83.00	08300 HOSPI CE	0	0				83.00
89.00	SUBTOTALS (sum of lines 1-84)	-1, 126, 638	19, 627, 309				89.00
	NONREI MBURSABLE COST CENTERS	1	1	1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	-	1			90.00
	09100 BARBER AND BEAUTY SHOP	0	0				91.00
	09200 PHYSICIANS PRIVATE OFFICES	0					92.00
	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY						93.00 94.00
94.00 100.00		-1, 126, 638	19, 627, 309				100.00
100.00		- 1, 120, 030	1 17,027,309	1			1.00.00

Health Financial Systems BUCKINGHAM AT NORWOOD				In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS	Pro	ovider No.: 315290	Period: From 01/01/2023	Worksheet A-6			
				Date/Time Pre 6/3/2024 2:40	pared: pm		
		Increases					
	Cost Center	Line #	Sal ary	Non Salary			
	2.00	3.00	4.00	5.00			
(1) A - RECLASS OT							
1.00	OCCUPATI ONAL THERAPY	45.	0 00	443, 053	1.00		
2.00	SPEECH PATHOLOGY	46.	0 0	140, 466	2.00		
(1) C - RECLASS MED SUPP CHARGED							
3. 00	MEDI CAL SUPPLI ES CHARGI PATI ENTS	ED TO 48.0	0 00	35	3.00		
(1) D - RECLASS IV CHARGED					1		
4.00	INTRAVENOUS THERAPY	42.	0 00	28	4.00		
TOTALS							
100.00	Total Reclassifications of columns 4 and 5 mus equal sum of columns 8 9)	t	0	583, 582	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 BUCKINGHAM AT NORWOOD					In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS		Provider No.: 315290		Period: From 01/01/2023	Worksheet A-6			
				To 12/31/2023	Date/Time Pre 6/3/2024 2:40	pared:		
			Decreases					
	Cost Cente	r	Line #	Sal ary	Non Salary			
	6.00		7.00	8.00	9.00			
(1) A - RECLASS OT								
1.00	PHYSI CAL THERAPY		44.0	0 0	443, 053	1.00		
2.00	PHYSI CAL THERAPY		44.0	0 0	140, 466	2.00		
(1) C - RECLASS MED SUPP CHARGED								
3.00	CENTRAL SERVICES &	SUPPLY	10. 0	0 0	35	3.00		
(1) D - RECLASS IV CHARGED								
4.00	DRUGS CHARGED TO PA	TIENTS	49.0	0 0	28	4.00		
TOTALS								
100.00				0	583, 582	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.

Heal th	Financial Systems	BUCKI NGHAM	AT NORWOOD		In Lie	eu of Form CMS-2	2540-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315290	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nared
					10 12/31/2023	Date/Time Pre 6/3/2024 2:40	pm
				Acqui si ti on	s		
	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 BALANCE	S a	-				
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	4 204 522	0		0 0	0	3.00
4.00 5.00	Building Improvements	4, 386, 532	0			27,024	4.00 5.00
	Fixed Equipment Movable Equipment	536, 444 1, 522, 143	0			1, 500 32, 966	
6.00 7.00	Subtotal (sum of lines 1-6)) 32, 966 61, 490	
7.00 8.00	Reconciling Items	6, 445, 119	0			01,490	8.00
8.00 9.00	Total (line 7 minus line 8)	6, 445, 119	0			61, 490	
9.00					0 0	01,490	9.00
	Description	Endi ng Bal ance	Fully Depreciated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE		7.00	<u> </u>			
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	4, 359, 508	0				4.00
5.00	Fixed Equipment	534, 944	0				5.00
6.00	Movable Equipment	1, 489, 177	0				6.00
7.00	Subtotal (sum of lines 1-6)	6, 383, 629	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	6, 383, 629	0				9.00

	Financial Systems MENTS TO EXPENSES	BUCKINGHAM AT		No.: 315290	Peri od:	u of Form CMS-2 Worksheet A-8	
5051	WIEWIS TO EXIENSES		TTOVIDEI	110 313270	From 01/01/2023 To 12/31/2023		
					10 12/31/2023	Date/Time Pre 6/3/2024 2:40	
					lassification on	Worksheet A	
				To/From Whic	ch the Amount is [·]	to be Adjusted	
	Description (1)	(2) Basis For Adjustment	Amount	Cos	t Center	Line No.	
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds	В	-1, 059	ADMI NI STRATI	VE & GENERAL	4.00	1
00	(chapter 2) Trade, quantity, and time discounts (chapter		0			0.00	2
50	8)		0			0.00	4
00	Refunds and rebates of expenses (chapter 8)		0			0.00	3
00	Rental of provider space by suppliers		0)		0.00	
	(chapter 8)						
00	Telephone services (pay stations excluded)		0)		0.00	5
20	(chapter 21)		-			0.00	
00	Television and radio service (chapter 21)		0			0.00	
00 00	Parking lot (chapter 21) Remuneration applicable to provider-based	A-8-2	0			0.00	8
50	physician adjustment	A-0-2	0				'
00	Home office cost (chapter 21)		0			0.00	9
00	Sale of scrap, waste, etc. (chapter 23)		0)		0.00	
00	Nonallowable costs related to certain		0			0.00	11
	Capital expenditures (chapter 24)						
. 00	Adjustment resulting from transactions with	A-8-1	-677, 507				12
~~	related organizations (chapter 10)					0.00	
. 00	Laundry and Linen service		0			0.00	
	Revenue - Employee meals Cost of meals - Guests		0			0.00 0.00	
. 00	Sale of medical supplies to other than		0			0.00	
	patients		0			0100	
. 00	Sale of drugs to other than patients		0)		0.00	17
	Sale of medical records and abstracts	В	-903	ADMI NI STRATI	VE & GENERAL	4.00	18
. 00	Vending machines		0			0.00	19
. 00	Income from imposition of interest, finance		0			0.00	20
~~	or penalty charges (chapter 21)		0			0.00	1
. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	
	overpayments						
. 00	Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	REVIEW - SNF	82.00	22
	(chapter 21)						
. 00	Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23
				FI XTURES			
. 00	Depreciationmovable equipment		0	CAP REL COST	S - MOVABLE	2.00	24
00	LEGAL-COLLECTIONS NON REI	^	0.240	EQUI PMENT ADMI NI STRATI		4.00	2
	ADVERTI SI NG	A		ADMI NI STRATI		4.00	
02	MARKETING	A		ADMI NI STRATI		4.00	
03	LATE FEES	A		ADMI NI STRATI		4.00	
	PENALTIES	A		ADMI NI STRATI		4.00	
	NJ BAIT TAX	A		ADMI NI STRATI		4.00	
	BAD DEBTS DI SALLOWED	A		ADMI NI STRATI		4.00	
	OTHER MISC EXPENSE	A		ADMI NI STRATI		4.00	
	OTHER MISC INCOME	В		ADMI NI STRATI	VE & GENERAL	4.00	
0.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1, 126, 638				100

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

Health Financial Systems	BUCKI NGHAM	AT NORWOOD		In Lie	u of Form CMS	6-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet A- Parts I-II Date/Time Pr 6/3/2024 2:4	repared:
	Line No.	Cost (Expense		
	1.00	2.		3.		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	OR	
1.00		CAP REL COSTS FIXTURES	- BLDGS &	RENT		1.00
2. 00		CAP REL COSTS	- BLDGS &	RENT-HUD ADJUS	IMENTS	2.00
3.00		ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES	5	3.00
4.00		NURSING ADMINI		WINDSOR NURSING		4.00
5.00	30.00	SKILLED NURSIN	G FACILITY	WINDSOR RN		5.00
6.00	0.00					6.00
7.00	0.00					7.00
8.00	0.00					8.00
9.00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line 12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu	s		
	Cost	Wkst. A, col. 5	col. 5)			
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	OR	
1.00	971, 264	1, 692, 250	-720, 98	36		1.00
2.00	0	169, 225				2.00
3.00	1, 142, 072	976, 020				3.00
4.00	20, 152	0				4.00
5.00	26, 500	0	26, 50	00		5.00
6.00	0	0		0		6.00
7.00	0	0		0		7.00
8.00 9.00	0	0		0		8.00
	2 150 000	2 927 405		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line	2, 159, 988	2, 837, 495	-677, 50	,,		10.00
12.						
1	1	I	I	I		I

Health Financial Systems	ancial Systems BUCKINGHAM AT NORWO			ieu of Form CMS-2540-1	
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provi der No.: 315290	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-8- Parts I-II Date/Time Prep 6/3/2024 2:40	ared:
	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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

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

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

1.00	A	HYMAN JACOBS	70.00	1.00
2.00	A	LIVIA JACOBS	30.00	2.00
3.00	A	HYMAN JACOBS	70.00	3.00
4.00	A	LIVIA JACOBS	30.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100. 00
speci fv				

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

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

related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Rel ated Organi	zation(s) and/	or Home Office	
	Name	Percentage of	Type of Business	
		Ownership	51	
	4.00	5.00	6.00	1
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/OR HOME OFFICE:			

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

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

1.00	BUCKINGHAM CANTERBURY PARENT	70.00 REAL ESTATE	1.00
	LLC		
2.00	BUCKINGHAM CANTERBURY PARENT	30.00 REAL ESTATE	2.00
3.00	WINDSOR HEALTHCARE	70.00 HEALTHCARE MANAGEMENT	3.00
	MANAGEMENT		
4.00	WINDSOR HEALTHCARE	30.00 HEALTHCARE MANAGEMENT	4.00
	MANAGEMENT		
5.00		0.00	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems		BUCKINGHAM A	T NORWOOD		In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - GENERAL	. SERVICE COSTS		Provi der	No.: 315290	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 6/3/2024 2:40	pared:
			CAPI TAL REL	ATED COSTS			
Cost Center I	Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFI TS	Subtotal	
		0	1.00	2.00	3.00	3A	
GENERAL SERVICE CO	ST CENTERS S - BLDGS & FIXTURES	1,044,066	1,044,066				1.00
2.00 00200 CAP REL COST 3.00 00300 EMPLOYEE BEN 4.00 00400 ADMI NI STRATI 1 5.00 00500 PLANT OPERAT 6.00 00600 LAUNDRY & LI 1 7.00 00700 HOUSEKEEPI NG	S - MOVABLE EQUIPMENT EFITS /E & GENERAL ON, MAINT. & REPAIRS	327, 710 1, 534, 480 3, 982, 280 767, 395 256 715, 506	0 51, 995 25, 732 37, 793 8, 544	327, 71 16, 32 8, 07 11, 86 2, 68	0 1, 534, 480 20 129, 433 27 24, 162 33 0 32 88, 082	4, 180, 028 825, 366 49, 912 814, 814	2.00 3.00 4.00 5.00 6.00 7.00
8.00 00800 DI ETARY 9.00 00900 NURSI NG ADMI I 10.00 01000 CENTRAL SERV		1, 776, 532 840, 898 377, 082	134, 579 2, 860 0	42, 24 89		2, 122, 433 953, 011 387, 631	8.00 9.00 10.00
11.00 01100 PHARMACY 12.00 01200 MEDICAL RECOL 13.00 01300 SOCIAL SERVIO 14.00 01400 NURSI NG AND	RDS & LI BRARY	9, 935 38, 787 102, 020 0	0 5, 235 1, 052 0	1, 64 33	0 0 13 5, 669 30 14, 903 0 0	9, 935 51, 334 118, 305 0	11. 00 12. 00 13. 00 14. 00
15.00 01500 ACTIVITIES	SERVICE COST CENTERS	453, 187	71, 638	22, 48	65, 128	612, 439	15.00
30.00 03000 SKI LLED NURS 31.00 03100 NURSI NG FACI 32.00 03200 I CF/I I D 33.00 03300 OTHER LONG TI	NG FACILITY LITY ERM CARE	6, 314, 836 0 0 0	696, 769 0 0 0	218, 69	98 919, 119 0 0 0 0 0 0 0 0	8, 149, 422 0 0 0	30. 00 31. 00 32. 00 33. 00
40.00 04000 RADI OLOGY	COST CENTERS	3, 084	0		0 0	3, 084	40.00
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS ⁻ 43. 00 04300 OXYGEN (I NHAI		21, 025 28 7, 124	0 0 0			21, 025 28 7, 124	41.00 42.00
44. 00 04400 PHYSI CAL THE 45. 00 04500 OCCUPATI ONAL 46. 00 04600 SPEECH PATHO	THERAPY	514, 642 443, 053 140, 466	3, 939 3, 930 0			519, 818 448, 217 140, 466	45.00
47.00 04700 ELECTROCARDI 48.00 04800 MEDI CAL SUPP 49.00 04900 DRUGS CHARGEI 50.00 05000 DENTAL CARE	LIES CHARGED TO PATIENTS TO PATIENTS	0 35 185, 165 0	0 0 0 0		0 0 0 0 0 0 0 0	0 35 185, 165 0	47.00 48.00 49.00 50.00
51.00 05100 SUPPORT SURF		0	0		0 0	0	51.00
60.00 06000 CLINIC 61.00 06100 RURAL HEALTH 62.00 06200 FQHC		00	0		0 0 0 0	0	60.00 61.00 62.00
70.00 07000 HOME HEALTH		0	0		0 0	0	70.00
71.00 07100 AMBULANCE 73.00 07300 CMHC		27, 717 0	0 0		0 0 0 0	27, 717 0	71.00 73.00
81.00 08100 INTEREST EXP 82.00 08200 UTILIZATION I	PREMIUMS & PAID LOSSES ENSE						80.00 81.00 82.00
83. 00 08300 HOSPI CE 89. 00 SUBTOTALS (si NONREI MBURSABLE CO	um of lines 1-84) ST CENTERS	19, 627, 309	0 1, 044, 066	327, 71	0 1, 534, 480	0 19, 627, 309	83.00 89.00
90.00 09000 GI FT, FLOWER 91.00 09100 BARBER AND BI 92.00 09200 PHYSI CI ANS PI 93.00 09300 NONPAI D WORKI	COFFEE SHOPS & CANTEEN EAUTY SHOP RIVATE OFFICES ERS	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0 0	90.00 91.00 92.00 93.00
94.00 09400 PATIENTS LAUI 98.00 Cross Foot Ar 99.00 Negative Coss 100.00 TOTAL	justments	0 0 0 19, 627, 309	0 0 0 1, 044, 066	327, 71	0 0 0 0 0 0 0 1, 534, 480	0 0 19, 627, 309	94.00 98.00 99.00 100.00

Heal th	Financial Systems	BUCKI NGHAM A	T NORWOOD		In Lie	u of Form CMS-:	2540-10
	LLOCATION - GENERAL SERVICE COSTS				Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1.00 2.00 3.00 4.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 DATE OFFENTION MAINT & DEPAILOR	4, 180, 028	1 040 710				1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00 10.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	223, 344 13, 506 220, 489 574, 330 257, 885 104, 893	1, 048, 710 41, 015 9, 273 146, 051 3, 104 0	104, 43	3 0 1, 044, 576 0 152, 802 0 3, 247 0 0	2, 995, 616 0 0	5.00 6.00 7.00 8.00 9.00 10.00
11. 00 12. 00 13. 00 14. 00 15. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	2, 688 13, 891 32, 013 0 165, 726	0 5, 681 1, 142 0 77, 745		0 0 0 0 0 1, 195 0 0 0 81, 339	0 0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		75/ 450			0.005.444	
30.00 31.00 32.00 33.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	2, 205, 227 0 0 0	756, 159 0 0 0		3 791, 114 0 0 0 0 0 0	2, 995, 616 0 0 0	30.00 31.00 32.00 33.00
	ANCI LLARY SERVICE COST CENTERS			1			
40.00 41.00 42.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	835 5, 689 8	0 0 0		0 0 0 0 0 0	0 0 0	40.00 41.00 42.00
43.00 44.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	1, 928 140, 663	0 4, 275		0 0 0 4, 473	0	43.00
45.00 46.00 47.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	121, 288 38, 010 0	4, 265 0 0		0 4, 463 0 0	0 0 0	45.00 46.00 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	9	0		0 0	0	48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	50, 106 0	0		0 0 0 0	0	49.00 50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVICE COST CENTERS	0	0		0 0	0	51.00
60.00 61.00 62.00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0 0 0	0	60. 00 61. 00 62. 00
70.00	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	70.00
71.00	07100 AMBULANCE 07300 CMHC	7, 500 0	0			0	71.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0	0		0	0	82.00 83.00
83.00 89.00	SUBTOTALS (sum of lines 1-84) NONREL MBURSABLE COST CENTERS	4, 180, 028	1, 048, 710	104, 43	3 1, 044, 576		89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0			0	91.00 92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
94. 00 98. 00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0			0	94.00 98.00
99.00	Negative Cost Centers	0	0		0 0	0	99.00
100.00	TOTAL	4, 180, 028	1, 048, 710	104, 43	3 1, 044, 576	2, 995, 616	100. 00

	Financial Systems	BUCKI NGHAM A				u of Form CMS-2	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315290	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 6/3/2024 2:40	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
1 00	GENERAL SERVICE COST CENTERS				-		1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00 2.00
2.00	00300 EMPLOYEE BENEFITS						3.00
3.00 4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION	1, 217, 247					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	492, 524				10.00
11.00	01100 PHARMACY	0	0	12, 6	23		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0 76, 849		12.00
13.00	01300 SOCIAL SERVICE	0	0		0 0	152, 655	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15.00		0	0		0 0	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 017 047	402 524	10 (22 7/ 0/0	150 / 55	20.00
30.00 31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	1, 217, 247	492, 524			152, 655 0	30.00 31.00
32.00	03200 I CF/I I D	0	0		0 0	-	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0		33.00
00.00	ANCI LLARY SERVICE COST CENTERS						00.00
40.00	04000 RADI OLOGY	0	0		0 0	0	40.00
41.00	04100 LABORATORY	0	0		0 0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	49.00 50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0		51.00
51.00	OUTPATIENT SERVICE COST CENTERS	0	0	I	0	0	51.00
60.00	06000 CLINIC	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0		61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0		70.00
71.00	07100 AMBULANCE	0	0		0 0		71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	1, 217, 247	492, 524	12, 6			89.00
	NONREI MBURSABLE COST CENTERS			, 0			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
93.00	09300 NONPAID WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
98.00	Cross Foot Adjustments	0	0		-	_	98.00
99.00	Negative Cost Centers	1 217 247	402 524	10 /			99.00
100.00	D TOTAL	1, 217, 247	492, 524	12, 6	23 76, 849	152, 655	100.00

Heal th	Financial Systems	BUCKI NGHAM	AT NORWOOD		In Lie	u of Form CMS-:	2540-10
	LLOCATION - GENERAL SERVICE COSTS			No.: 315290	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 6/3/2024 2:40	pared:
			OTHER GENERAL				
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	SERVI CE ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00 3.00
3.00 4.00	00400 ADMINISTRATIVE & GENERAL						4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION						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
	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITIES	0	937, 249				15.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	937, 249	17, 891, 1	18 0	17, 891, 118	30.00
	03100 NURSING FACILITY	0	937, 249		0 0	0	30.00
32.00	03200 CF/IID	0	-		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0		1	0 0	0	33.00
00.00	ANCI LLARY SERVICE COST CENTERS				<u> </u>		
40.00	04000 RADI OLOGY	0	0	3, 9	19 0	3, 919	40.00
41.00	04100 LABORATORY	0	0	26, 7	14 0	26, 714	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		36 0	36	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	9,0		9, 052	
44.00	04400 PHYSI CAL THERAPY	0	0	669, 2		669, 229	•
45.00	04500 OCCUPATIONAL THERAPY	0	0	578, 2		578, 233	•
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0		178, 4	0 0	178, 476 0	46.00 47.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			44 0	44	47.00
	04900 DRUGS CHARGED TO PATIENTS	0		235, 2		235, 271	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	Ö		0 0	0	
51.00	05100 SUPPORT SURFACES	0	0)	0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0			0 0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0		0 0	0	
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0					71.00
	07300 CMHC	0	Ő		0 0	00,217	1
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
	08300 HOSPI CE	0	0	10 (07 0	0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	937, 249	19, 627, 3	0 00	19, 627, 309	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP				0 0	0	
	09200 PHYSICIANS PRIVATE OFFICES				0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	l o		0 0	0	1
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	
98.00	Cross Foot Adjustments	0	0		0 0	0	98.00
99.00	Negative Cost Centers	0	0		0 0	0	
100.00	TOTAL	0	937, 249	19, 627, 3	0 0	19, 627, 309	100. 00

Heal th	Financial Systems	BUCKINGHAM A	T NORWOOD		In Lie	u of Form CMS-	2540-10
ALLOC	ATION OF CAPITAL RELATED COSTS				Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 6/3/2024 2:40	epared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REL BLDGS & FI XTURES	LATED COSTS MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		0	1.00	2.00	2A	3.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	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		0 51, 995 25, 732 37, 793 8, 544 134, 579 2, 860 0	8, 07 11, 86 2, 68 42, 24	77 33, 809 53 49, 656 52 11, 226 52 176, 821	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 5.00 6.00 7.00 8.00 9.00
11. 00 12. 00 13. 00 14. 00 15. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES		0 5, 235 1, 052 0 71, 638	33	80 1, 382 0 0	0 0 0 0	12.00 13.00 14.00
30. 00 31. 00 32. 00 33. 00	I NPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0 0	696, 769 0 0 0		28 915, 467 0 0 0 0 0 0 0 0	0 0 0 0	31.00 32.00
40.00 41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00	ANDI LLARY SERVICE COST CENTERS 04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS 05000 DENTAL CARE - TI TLE XI X ONLY 05100 SUPPORT SURFACES 0UTPATI ENT SERVICE COST CENTERS		0 0 3, 939 3, 930 0 0 0 0 0 0 0 0 0 0 0	1, 23 1, 23			41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00
60.00 61.00 62.00	06100 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC OTHER REIMBURSABLE COST CENTERS	0	0 0		0 0 0 0	0	
71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	
80. 00 81. 00 82. 00 83. 00 89. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONDEL MULDARELE COST CENTERS	0	0 1, 044, 066	327, 71	0 0 0 1, 371, 776	0	
90.00 91.00 92.00 93.00 94.00 98.00 99.00 100.00	NONREI MBURSABLE COST CENTERS O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers TOTAL		0 0 0 0 0 1,044,066	327, 71	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1, 371, 776	0 0 0 0 0 0 0	91.00 92.00 93.00 94.00 98.00

Heal th	Financial Systems	BUCKI NGHAM A	T NORWOOD		In Lie	u of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 01/01/2023 Fo 12/31/2023	Worksheet B Part II Date/Time Pre 6/3/2024 2:40	epared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	L	4.00	5.00	6.00	7.00	8.00	
4 00	GENERAL SERVICE COST CENTERS	1		1	1		1 1 00
1.00 2.00 3.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						1.00 2.00 3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	68, 315					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	3, 650	37, 459	1			5.00
6.00	00600 LAUNDRY & LINEN SERVICE	221	1, 465				6.00
7.00	00700 HOUSEKEEPING	3,603	331		15, 160		7.00
8.00		9, 385	5, 217		2, 218	193, 641	
9.00	00900 NURSI NG ADMI NI STRATI ON	4,214	111		47	0	
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	1, 714 44	0			0	
12.00	01200 MEDICAL RECORDS & LIBRARY	227	203		86	0	
12.00	01300 SOCIAL SERVICE	523	41		17	0	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			0	
	01500 ACTI VI TI ES	2, 708	2, 777		1, 180	0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	36, 043	27,009	51, 342	2 11, 482	193, 641	30.00
31.00	03100 NURSING FACILITY	0	0	(0 0	0	31.00
32.00	03200 CF/I D	0	0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	(0 0	0	33.00
	ANCI LLARY SERVICE COST CENTERS	1			-1 -1	-	
40.00	04000 RADI OLOGY	14	0		0	0	
41.00	04100 LABORATORY	93	0			0	
42.00 43.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0 32	0			0	
43.00	04400 PHYSI CAL THERAPY	2, 299	153		65	0	
45.00	04500 OCCUPATI ONAL THERAPY	1, 982	153		65	0	
46.00	04600 SPEECH PATHOLOGY	621	0	1	0	0	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	819	0	0	0 0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	(0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS			1		-	1 / 0 . 00
60.00	06000 CLINIC	0	0		0	0	
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0	0	61.00 62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	(0 0	0	70.00
	07100 AMBULANCE	123	0	1	o o	0	
	07300 CMHC	0	0	(0 0		73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	(0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	68, 315	37, 459	51, 342	2 15, 160	193, 641	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN					0	90.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0			0	
91.00	09200 PHYSICIANS PRIVATE OFFICES	0	0			0	
92.00 93.00	09300 NONPALD WORKERS	0	0			0	
94.00	09400 PATIENTS LAUNDRY	0	0			0	
98.00	Cross Foot Adjustments		0		ol ol	0	
99.00	Negative Cost Centers	0	0	0	o o	0	
100.00	TOTAL	68, 315	37, 459	51, 342	2 15, 160	193, 641	100.00

Cost Center Description NURSING ADMINISTRATION SERVICES A 9.00 PHARMACY INFORMAL SERVICES A PHARMACS PHARMACY INFORMAL SERVICES A ILBRANA SERVICE ADMINISTRATION SERVICES A ILBRANA SERVICE DOTOCIDE INFORMAL SERVICES A ILBRANA SERVICES A ILBRANA		Financial Systems TION OF CAPITAL RELATED COSTS	BUCKINGHAM A		No.: 315290	Peric		eu of Form CMS-2 Worksheet B Part II	2010 10
ADDI MI STRATI ON BUDY SERVICES & ILBRANZ PECORDS & ILBRANZ 0 00000 10.00 11.00 12.00 13.00 2.00 00200 (AP RLL COSTS - MUXBLE LOU PHENT SUDDOWNEE REPRICE OSTS - MUXBLE LOU PHENT SUDDOWNEE REPRICE OSTS - MUXBLE LOU PHENT SUDDOWNEE REPRICE 000000 (AUMINISTRATIVE & CENERAL SUDDOWNEE REPRICE 000000 (AUMINISTRATIVE & CENERAL SUDDOWNEE REPRICE 000000 (AUMINISTRATIVE & CENERAL SUDDOWNEE REPRICE 000000 (AUMINISTRATIVE & CENERAL SUDDOWNEE REPRICE 000000 (AUMINISTRATIVE 000000 (AUMINISTRATIVE 00000 (AUMINISTRATIVE 000000 (AUMINISTRATI								Date/Time Pre	
GENERAL SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 1.00 00100 (AP REL COSTS - BLOSS & FIXTURES		Cost Center Description		SERVICES &	PHARMACY	R	ECORDS &		
CHURAL SLEWICE COST CLIVIERS 1 1.00 00100 (AP REL COSTS - BUGS & FIXTURES 2.0 2.00 00200 (AP REL COSTS - BUGS & FIXTURES 3.0 4.00 D0400 (ADIL NEL COSTS - BUGS & FIXTURES 3.0 0.0000 (DURIT OPERATION, MINT & GEPRIARL 5.0 0.0000 (DURIT OPERATION, MINT & REPAIRS 6.0 0.0000 (DURIT OPERATION & BLIERARY 0 0.00100 (DURISSING ADALLED HEALTH EDUCATION 8.130 1.00 0.0000 (DURISSING ADALLED HEALTH EDUCATION 0 1.200 D1200 (PHARLAGY 0 0 1.300 01300 (SOLAL SERVICE 0 0 0 1.400 D1400 (HIRSING ADALLED HEALTH EDUCATION 0 0 0 1.000 D1500 (ALTIVITIES 0 0 0 0 1.000 D1500 (ALTIVITIES 0 0 0 0 0 1.000 D1500 (ALTIVITIES 0 0 0 0 0 0 1.100 D1200 (ALTIVITIES 0 0 0 0 0 0 </td <td></td> <td></td> <td>9,00</td> <td></td> <td>11.00</td> <td></td> <td></td> <td>13.00</td> <td></td>			9,00		11.00			13.00	
2: DO 00200 CAP. REL COSTS - MUXABLE EQUIPMENT 2. DO 30: 003000 DEFUNCYCE ENTERFIT AS 4. OD 00400 ADMI NISTRATIVE & GENERAL 5. DO 40: 004000 ADMI NISTRATIVE & GENERAL 5. DO 5. DO 5. DO 00: 005000 DETURTOR SERVICE 7. DO 7. DO 00: 00000 DETURTOR SERVICE 7. DO 6. DO 6. DO 00: 00000 DETURTAL SERVICE 5. SUPLY 0 1. 77.4 1. DO 10: 000 01000 CHTRAL SERVICE SA SUPLY 0 0 4. DO 10. DO 11: 000 01000 CHTRAL SERVICE SA SUPLY 0 0 0 1. T74 1. DO 12: 00 <td< td=""><td></td><td>GENERAL SERVICE COST CENTERS</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>		GENERAL SERVICE COST CENTERS	1						
3. 00 00200 EMPLOYCE BEREFITS 3.0 0.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>									1.00
4.00 00400 ADMI IN STRATI VE & GENERAL 4.0 5.00 00500 (LAUNORY & LINEN SERVICE 5.0 6.00 00500 (DI CTARY 8.10 0.00 00500 (DI STARY 8.10 0.00 00500 (DI STARY 8.10 0.00 00500 (DI STARY 0 0.00 00500 (DI STARY 0 0.00 00500 (DI STARY 0 0.00 00700 (CENTRAL SERVICES & SUBRARY 0 0 0.00 00700 (DI STAL SERVICES & SUBRARY 0 0 0 0.00 00700 (DI STAL SERVICE OS & LI BRARY 0 0 0 0 0.01000 (DI STAL SERVICE OS & LI BRARY 0 0 0 0 0 0.01000 (DI STAL SERVICE OS & LI BRARY 0 0 0 0 0 0 0.01000 (DI WER MA ALLED HEALTH EDUCATION 0 0 0 0 0 0 0.0000 (DI OSC WER HARDICT DE TENT CARE 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>2.00</td>									2.00
5:00 00500 PLANT OPERATION, MAINT, & REPAIRS 5:00 0:00 0 0 0 0 1:00 1:00 1:00 0:00 0 0 0 1:00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>3.00</td>									3.00
6.00 000000 LAUMOPY & LINEN SERVICE 6.00 7.00 00700 NURSI NG ADM NI STRATI ON 8.130 0.00 000000 INERI NG ADM NI STRATI ON 8.130 0.00 01000 CENTRAL SERVICES & SUPPLY 0 0.100 01000 CENTRAL SERVICES & SUPPLY 0 0.1000 INERI NG ADM NI STRATI ON 8.130 0.0000 OWEDI CALL RECORDS & LIBRARY 0 0 0.0000 OWEDI CALL RECORDS & LIBRARY 0 0 0 0.0000 OWEDI CALL RECORDS & LIBRARY 0 0 0 0 10.00 01000 CENTRAL NG AND ALLED HEALTH EDUCATION 0 0 0 0 10.00 01000 SKILLED NURSI NG FACILITY 8.130 1, 714 1, 963 31.0 30.00 03000 SKILLED NURSI NG FACILITY 8.130 1, 714 1, 963 30.0 30.00 03000 SKILLED NURSI NG FACILITY 8.130 1, 714 1, 963 30.0 30.00 03000 SKILLED NURSI NG FACILITY 8.130 1, 714 1, 963 30.0 20.00 03200 IFFA LONGY 0									4.00
7. 00 00700 HOUSEKEEPING 7. 00 00700 HOUSEKEEPING 7. 00 9. 00 009000 NURSING ADMINISTRATION 8. 130 8. 0 9. 00 00700 CUTRAL SERVICES & SUPPLY 0 1. 714 9. 00 0100 PHARMACY 0 0 0 0100 DISCIELAL SERVICES & SUPPLY 0 1. 714 10. 0 10. 00 10. 00 10. 00 10. 00 10. 00 0 0 0 0 10. 0 10. 00 10. 00 0 0 0 10. 0 10. 0 10. 0 10. 0 0 0 0 10. 0 10. 0 0 0 0 0 14. 0 10. 0 0 0 0 0 14. 0 10. 0 0 0 0 13. 0 30. 0									
8.00 000000 DIETARY 8.10 8.00 9.00 000000 NRSI KG ANDAIN ISTRATION 8.10 10.00 10.00 01000 CENTRAL SERVICES & SUPPLY 0 1.7,74 11.00 01000 CENTRAL SERVICES & SUPPLY 0 0.44 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 13.00 01300 CALL RECORDS & LIBRARY 0 0 0 0 14.00 01400 NURSING AND ALLED HEALTH EDUCATION 0									
9.00 00900 NURS ING ADMINI STRATION 8.130 1.00 01.00 01000 CHRICAL SERVI CES & SUPPLY 0 1.714 10.0 11.00 01100 PHARMACY 0 1.714 10.0 12.00 01200 SUPPLY 0 0 7.394 10.0 12.00 01200 NURSIN & ADA LLIED HALTH EDUCATION 0 0 0 11.00 14.00 14.00 01400 NURSIN & FARULLITY 8.130 1.714 44 7.394 1.963 30.0 31.00 03000 SKI LLED NURSIN & FARULLITY 8.130 1.714 44 7.394 1.963 30.0 32.00 03200 IFF.I NR FORTHER STORE 0 0 0 0 0 0 32.0 30.00 03200 IFF.I NR FORTHER STORE COST CENTERS 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
10.00 01000 CENTRAL SERVICES & SUPPLY 0 1.714 10.0 11.00 0100 PHARMACY 0 0 44 10.0 12.00 01020 HEDICAL RECORDS & LIBRARY 0 0 0 12.00 17.014 12.00 17.014 12.00 17.014 12.00 17.014 12.00 17.014 12.00 17.014 12.00 17.014 12.00 17.014 14.00 0 0 0 0 15.00 15			8 130						
11.00 01100 PHARMACY 0 0 44 11.0 12.00 01200 PECORS & LIBRARY 0 0 7.394 12.0 13.00 01300 SOCIAL SERVICE 0 0 0 14.0 14.00 01400 NURSING AND ALLIED HEALTH EQUCATION 0 0 0 15.0 11.00 01500 ACTIVITIES 0 0 0 0 0 15.0 11.00 03000 SKILLED NURSING FACILITY 8.130 1.714 44 7.394 1.963 30.0 31.00 03300 OTFKE LONG TERM CARE 0 0 0 0 32.0 33.0 30.00 03300 OTFKE LONG TERM CARE 0 <td< td=""><td></td><td></td><td></td><td>1, 714</td><td></td><td></td><td></td><td></td><td>10.00</td></td<>				1, 714					10.00
12.00 01200 HEDICAL, BECORDS & LIBRARY 0 0 7,394 12.0 13			0			44			11.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 14.00 0 0 0 15.00 15.00 1			0	0			7, 394		12.00
15.00 0 <td>13.00</td> <td>01300 SOCIAL SERVICE</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>1, 963</td> <td>13.00</td>	13.00	01300 SOCIAL SERVICE	0	0		0	0	1, 963	13.00
INPATIENT NOUTINE SERVICE COST CENTERS - 00 03000 SKILLED NUESING FACILITY 8,130 1,714 44 7,394 1,963 30.00 31.00 00 0	14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
30:00 03000 SKI LLED NURSING FACILLITY 8,130 1,714 44 7,394 1,963 30.0 31:00 03000 NURSING FACILLITY 0 0 0 0 33.0 33:00 03200 IOFHER LONG TERM CARE 0 0 0 0 0 33.0 33:00 03300 OTHER LONG TERM CARE 0	15.00		0	0		0	0	0	15.00
131.00 OD3000 INC FACILITY 0 0 0 0 0 31.0 332.00 033000 IFFR LONG TERN CARE 0 0 0 0 33.0 40.00 CADOOI RADIOLOGY 0			1 1			-			
32:00 03:00 03:00 <									30.00
33.00 03300 01 0				-				-	
ANCILLARY SERVICE COST CENTERS 0 <th< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td></th<>				-					
40.00 IODOC (ADOC) CANDIOLOCY 0<	33.00		0	0		0	0	0	33.00
11.00 04100 LABORATORY 0 0 0 0 0 1.0 42.00 04300 INTRAVENOUS THERAPY 0<	40.00		0	0		0	0	0	1 10 00
42.00 04200 INTRAVENOUS THERAPY 0<			0	-				-	
43.00 04300 DAYGEN (I NHALATION) THERAPY 0			0	0		0	0	-	42.00
44.00 04400 PHYSICAL THERAPY 0 0 0 0 0 44.00 45.00 04500 OCUPATIONAL THERAPY 0 0 0 0 0 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0 0 0 46.00 47.00 04600 SPEECH PATHOLOGY 0 0 0 0 46.00 48.00 04600 MOICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 47.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 49.00 50.00 OSODO DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 0 50.00 50.00 50.00 50.00 50.00 50.00 0 0 0 0 0 0 51.00 51.00 50.00 60.00 61.00 60.00 61.00 60.00 61.00 60.00 61.00 60.00 61.00 62.00 71.00 70.00 73			0	0		0	0	-	43.00
46.00 04600 SPEECH PATHOLOGY 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>44.00</td>			0	0		0	0	0	44.00
47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 47.00 48.00 04800 MEDI CAL. SUPPLIES CHARGED TO PATIENTS 0 0 0 0 47.0 49.00 04900 DRUSC, CHARGED TO PATIENTS 0 0 0 0 47.0 50.00 DENTAL CARE - TITLE XI X ONLY 0 0 0 0 0 0 50.0 000TPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 61.00 0 0 0 0 0 61.00 62.00 62.00 0 0 0 0 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 70.0	45.00	04500 OCCUPATIONAL THERAPY	0	0		0	0	0	45.00
48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 48.0 49.00 04900 DRUGS CHARGED TO PATI ENTS 0 0 0 0 49.0 50.00 DS000 DENTAL CARE - TITLE XI X ONLY 0 </td <td>46.00</td> <td>04600 SPEECH PATHOLOGY</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>46.00</td>	46.00	04600 SPEECH PATHOLOGY	0	0		0	0	0	46.00
49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 50.00 0 0 0 0 0 50.00 0 0 0 0 0 0 0 0 0 0 0 50.00 0 <td< td=""><td>47.00</td><td>04700 ELECTROCARDI OLOGY</td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>47.00</td></td<>	47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0			0	0		0	0	Ű	48.00
51.00 05100 SUPPORT SURFACES 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>-</td> <td>49.00</td>			0	0		0	0	-	49.00
OUTPATI ENT SERVICE COST CENTERS 60.00 OGOOD (CLINIC O			0	-		-	-	-	50.00
60.00 06000 CLINIC 0	51.00		0	0		0	0	0	51.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.0 62.0 04200 FOHC 0 0 0 0 62.0 62.0 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 70.00 0 0 0 0 70.00 0 0 0 0 0 70.00 0 0 0 0 0 0 0 70.00 0 0 0 0 0 70.00 0 0 0 0 0 71.00 0 0 0 0 0 0 73.00 73.00 0 0 0 0 0 73.0	60 00		0	0		0	0	0	60.00
62.00 06200 FOHC 62.0 OTHER REI MBURSABLE COST CENTERS 62.0 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 70.0 71.00 07100 AMBULANCE 0 0 0 0 71.0 0 0 0 0 71.0 0 0 0 0 0 71.0 0 0 0 0 0 0 0 0 71.0 0<				-		-			
OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 70.00 70.00 07100 AMBULANCE 0 0 0 0 0 71.00 73.00 07300 CMHC 0 0 0 0 0 0 73.0 78.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 81.00 81.00 81.00 81.00 81.00 81.00 82.0 82.0 82.0 82.0 83.00 98300 HOSPI CE 0 0 0 0 0 83.0 83.0 83.0 83.0 83.0 83.0 83.0 83.0 89.0 0 0 0 0 0 0 0 0 0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0			0	0		U	0	0	62.00
70.00 07000 HOME HEALTH AGENCY COST 0<			1 1						
73.00 07300 CMHC 0 0 0 0 0 0 73.0 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 80.0 80.0 80.0 80.0 80.0 80.0 80.0 80.0 81.00 08100 INTEREST EXPENSE 80.0 81.0 81.0 82.0 80.0 81.0 81.0 82.0 82.0 83.00 08200 HILIZATION REVIEW - SNF 82.0 83.0 83.0 83.0 83.0 83.0 83.0 83.0 83.0 83.0 89.0 89.0 89.0 89.0 90.00 90000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90.0 90.00 90.00 90.00 90.0 9	70.00		0	0		0	0	0	70.00
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 80.00 80.00	71.00	07100 AMBULANCE	0	0		0	0	0	71.00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.0 81.00 08100 INTEREST EXPENSE 81.0 82.00 08200 UTILIZATION REVIEW - SNF 82.0 83.00 08300 HOSPICE 0 0 0 83.00 08300 HOSPICE 0 0 0 83.0 89.00 SUBTOTALS (sum of lines 1-84) 8,130 1,714 44 7,394 1,963 90.00 OPROOF GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.0 91.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 91.00 92.00 09200 NONREI MURES 0 0 0 0 92.0 93.00 09300 NONPAID WORKERS 0 0 0 0 93.0 94.00 09400 PATIENTS LAUNDRY 0 0 0 98.0 98.00 Cross Foot Adjustments 0 0	73.00		0	0		0	0	0	73.00
81.00 08100 INTEREST EXPENSE 81.00 81.00 81.00 81.00 82.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 92.00 92.00 92.00 <td></td> <td></td> <td>-1 F</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>			-1 F						
82.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 83.00 90.00 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00									80.00
83.00 08300 HOSPICE 0 0 0 0 83.0 83.0 89.00 SUBTOTALS (sum of lines 1-84) 8,130 1,714 44 7,394 1,963 89.0 NONREI MBURSABLE COST CENTERS 90.00 09100 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92.0 93.00 09300 NONREI BUNCKERS 0 0 0 93.0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 94.0 98.00 Cross Foot Adjustments 0 0 0 98.0 98.0									81.00
89.00 SUBTOTALS (sum of lines 1-84) 8,130 1,714 44 7,394 1,963 89.0 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0				0		0	0	0	
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0			0 120						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90.00 90.0 90.00 91.00 91.00 91.00 92.00 92.00 92.00 94.00 0 0 0 0 0 0 92.00 93.00 93.00 93.00 93.00 93.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 98.00 96.00 97.00	89.00		8,130	1, 714		44	7, 394	1, 903	89.00
91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 93.0 93.00 90300 NONPAI D WORKERS 0 0 0 0 93.0 93.0 94.00 94.00 94.00 0 0 0 0 94.0 94.0 94.0 94.0 98.0 98.0 0 0 0 0 98.0	90 00			0		0	0	0	90 00
92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.0 92.0 93.00 09300 NONPAI D WORKERS 0 0 0 0 93.0 93.0 94.00 9400 PATIENTS LAUNDRY 0 0 0 0 94.0 94.00 94.00 94.00 98.00 98.00 0 0 0 98.00 0 0 0 98.00 98.00 0 0 98.00 0 0 98.00 98.00 0 0 0 98.00 0 0 98.00 98.00 98.00 0 0 0 98.00			0	0				-	
93.00 09300 NONPAI D WORKERS 0 0 0 93.0 93.0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94.0 94.0 94.0 94.0 94.0 98.00 0 0 0 98.0 98.00 0 0 0 98.0 98.00 98.00 0 0 0 98.00 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>õ</td> <td></td> <td>-</td> <td>92.00</td>			0	0		õ		-	92.00
94.00 09400 PATIENTS LAUNDRY 0 0 0 94.0			0	0		0	0	-	93.00
98.00 Cross Foot Adjustments 0 0 0 98.0			0	0		0	0		94.00
		Cross Foot Adjustments	0	0		0			98.00
	99.00	Negative Cost Centers	0	0		0	0	0	
100.00 TOTAL 8, 130 1, 714 44 7, 394 1, 963 100.0	100.00	TOTAL	8, 130	1, 714		44	7, 394	1, 963	100. 00

Heal th	Financial Systems	BUCKI NGHAM	AT NORWOOD		In Lie	u of Form CMS-:	2540-10
	TION OF CAPITAL RELATED COSTS			No.: 315290	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 6/3/2024 2:40	pared:
			OTHER GENERAL SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS	1	1	1			1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00 2.00
2.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						12.00
13.00 14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					13.00 14.00
14.00	01500 ACTIVITIES						15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS		100,702	1			15.00
30.00	03000 SKILLED NURSING FACILITY	0	100, 789	1, 355, 0	18 0	1, 355, 018	30.00
31.00	03100 NURSING FACILITY	0			0 0	0	31.00
32.00	03200 CF/IID	0	0 0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0 0)	0 0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS		1	1	-		
40.00	04000 RADI OLOGY	0			14 0	14	40.00
41.00	04100 LABORATORY	0			93 0	93	
42.00 43.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	0			0 0 32 0	0	
43.00	04400 PHYSI CAL THERAPY			7,6		7, 693	
45.00	04500 OCCUPATI ONAL THERAPY	0		7,3		7,363	1
46.00	04600 SPEECH PATHOLOGY	0		6		621	46.00
47.00	04700 ELECTROCARDI OLOGY	0			0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0 0	8	19 0	819	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	-		0 0	0	
51.00	05100 SUPPORT SURFACES	0	0 0)	0 0	0	51.00
(0.00	OUTPATI ENT SERVI CE COST CENTERS				0 0	0	40.00
60.00 61.00	06100 RURAL HEALTH CLINIC				0 0 0 0	0	60.00 61.00
62.00	06200 FQHC				0 0	0	62.00
02.00	OTHER REIMBURSABLE COST CENTERS			1			02.00
70.00	07000 HOME HEALTH AGENCY COST	0) (0 0	0	70.00
71.00	07100 AMBULANCE	0	0 0	1:	23 0	123	71.00
73.00	07300 CMHC	0	0 0)	0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS	1	1	Т			
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00 83.00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0			0	0	82.00 83.00
83.00 89.00	SUBTOTALS (sum of lines 1-84)		100, 789	, 1, 371, 7 ⁻	0 0 76 0	1, 371, 776	
07.00	NONREI MBURSABLE COST CENTERS		100,702	1,371,7	0	1, 371, 770	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0 0	þ	0 0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0) c		0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0 0)	0 0	0	•
94.00	09400 PATIENTS LAUNDRY	0)	0 0	0	
98.00	Cross Foot Adjustments	0		2	0	0	
99.00 100.00	Negative Cost Centers			1 271 7	76 0	0	
100.00	TOTAL	1 0	100, 789	p 1, 371, 7	76 0	1, 371, 776	100.00

	Financial Systems	BUCKI NGHAM		N- 045000		u of Form CMS-	
CUSTA	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2023	Worksheet B-1	
				-	To 12/31/2023	Date/Time Pre 6/3/2024 2:40	
		CAPI TAL REI	ATED COSTS			0,0,2021 2110	
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation		
	cost center bescription	FIXTURES	EQUI PMENT	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
		1.00	2.00	SALARIES) 3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4A	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	116, 083					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		116, 083		-		2.00
3.00 4.00	00300 EMPLOYEE BENEFI TS 00400 ADMI NI STRATI VE & GENERAL	0 5, 781	-			15, 447, 281	3.00 4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	2, 861				825, 366	1
6.00	00600 LAUNDRY & LINEN SERVICE	4, 202			0 0	49, 912	
7.00	00700 HOUSEKEEPING	950				814, 814	
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	14, 963 318				2, 122, 433 953, 011	8.00 9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0				387, 631	
11.00	01100 PHARMACY	0	C		0 0	9, 935	
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	582				51, 334 118, 305	
	01400 NURSING AND ALLIED HEALTH EDUCATION	0				0	1
	01500 ACTIVITIES	7, 965	7, 965	445, 58	6 0	612, 439	
	INPATIENT ROUTINE SERVICE COST CENTERS	77.440		(000 00		0.440.400	
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	77,469	77, 469		6 0 0 0	8, 149, 422 0	
	03200 CF/IID	0	-		0 0	0	1
	03300 OTHER LONG TERM CARE	0	0		0 0	0	1
10.00	ANCI LLARY SERVI CE COST CENTERS					0.004	1 40 00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0			0 0 0 0	3, 084 21, 025	1
	04200 I NTRAVENOUS THERAPY	0			0 0	21, 023	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	7, 124	43.00
	04400 PHYSI CAL THERAPY	438			0 0	519, 818	
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	437	437			448, 217 140, 466	
47.00	04700 ELECTROCARDI OLOGY	0			0 0	0	1
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	35	1
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	185, 165	
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0			0 0 0 0	0	
51.00	OUTPATIENT SERVICE COST CENTERS			1	0 0	0	1 51.00
	06000 CLI NI C	0			0 0	0	
61.00	06100 RURAL HEALTH CLINIC	0	C		0 0	0	
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	C	1	0 0	27, 717	
	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	73.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF	_	_			_	82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 116, 083	0 116, 083	10, 498, 43	0	0 15, 447, 281	1
89.00	NONREI MBURSABLE COST CENTERS	110,083	110,003	10, 498, 43	7 -4, 180, 028	15, 447, 201	09.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0				0	
93.00 94.00	09400 PATIENTS LAUNDRY	0			0 0	0	
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers	1.044.044	207 710	1 524 40		4 100 000	99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1, 044, 066	327, 710	1, 534, 48		4, 180, 028	102.00
103.00		8. 994134	2. 823066	0. 14616	3	0. 270600	103.00
104.00	Cost to be allocated (per Wkst. B,				0		104.00
	Part II)	1	1	1	1		1
105.00				0.00000	0	0.004422	105 00

	Financial Systems	BUCKI NGHAM		N 015055		eu of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2023	Worksheet B-1	
					o 12/31/2023	Date/Time Pre 6/3/2024 2:40	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	piii
		OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. & REPAIRS	(PATIENT DAYS)			(PATIENT DAYS)	
		(SQUARE FEET)					
_		5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFI TS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	107.114					4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	107, 441 4, 202	54, 484				5.00 6.00
7.00	00700 HOUSEKEEPING	4, 202		102, 289			7.00
8.00	00800 DI ETARY	14, 963					8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	318	0	318	0	54, 484	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	-	0	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	582		0 582	-	0	11.00
	01300 SOCIAL SERVICE	117		117		0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0				
15.00	01500 ACTI VI TI ES	7, 965	0	7, 965	0	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	77.440	E4 404	77.440	1/2 /52	E4 404	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	77,469	54, 484	77,469		54, 484	30.00
32.00	03200 CF/IID	0	0	-	-		32.00
33.00	03300 OTHER LONG TERM CARE	0					
	ANCI LLARY SERVI CE COST CENTERS		ľ	1	1	ľ	
	04000 RADI OLOGY	0	-		-		
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0		0		0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0		0	-	0	43.00
44.00	04400 PHYSI CAL THERAPY	438	0	438	0	0	44.00
	04500 OCCUPATI ONAL THERAPY	437	0	437		0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0			0	0	47.00
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	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	0	0		0	60.00
	06100 RURAL HEALTH CLINIC	0					
62.00	06200 FQHC				_		62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0					
	07100 AMBULANCE 07300 CMHC	0	0		-		71.00 73.00
/ 5. 00	SPECIAL PURPOSE COST CENTERS		0		0		/ 5. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	107, 441	54, 484	102, 289	163, 452	0 54, 484	
07.00	NONREI MBURSABLE COST CENTERS	107,441		102,207	103, 432		07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	0	0	0	92.00 93.00
93.00 94.00	09400 PATIENTS LAUNDRY				0		1
98.00	Cross Foot Adjustments			Ĭ			98.00
99.00	Negative Cost Centers						99.00
102.00		1, 048, 710	104, 433	1, 044, 576	2, 995, 616	1, 217, 247	102.00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	9. 760799	1. 916765	10 212007	10 227101	22 211244	103 00
103.00		9. 760799					103.00
		57, 457	01, 042	13,100	175, 041	0,130	1.2.1.00
	Part II)						
105.00		0. 348647	0. 942332	0. 148208	1. 184696	0. 149218	105.00

	Financial Systems ALLOCATION - STATISTICAL BASIS	BUCKINGHAM		No.: 315290	Period:	worksheet B-1	
		_	_		From 01/01/2023 To 12/31/2023	Date/Time Pre 6/3/2024 2:40	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (PATI ENT DAYS)	PHARMACY (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS	SOCI AL SERVI CE (PATI ENT DAYS))	NURSING AND ALLIED HEALTH	
	OFNEDAL OFDILLOF ODOT OFNITEDO	10.00	11.00	12.00	13.00	14.00	
1.00 2.00 3.00 4.00 5.00 7.00 3.00 7.00 3.00 9.00 11.00 12.00 13.00 14.00 15.00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS - BLDGS & FIXTURES O0200 CAP REL COSTS - MOVABLE EQUIPMENT O0300 EMPLOYEE BENEFITS O0400 ADMINISTRATIVE & GENERAL O0500 PLANT OPERATION, MAINT. & REPAIRS O0600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY CO9000 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	54, 484 C C C C C C C C C C C C	54, 484 C C C C C	54, 48	4 0 54, 484 0 0	0	
0.00	INPATIENT ROUTINE SERVICE COST CENTERS	F4 404	F4 404	F4 40	4 54 404		
30.00 31.00 32.00 33.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	54, 484 C C			4 54,484 0 0 0 0 0 0	0 0 0	31. 00 32. 00
10.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0			0 0	0	40.00
1.00	04100 LABORATORY	C	0		0 0		
12.00 13.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	C			0 0	0	
14.00	04400 PHYSI CAL THERAPY				0 0	0	
15.00	04500 OCCUPATI ONAL THERAPY	C	0		0 0	0	45.0
16.00		C	0		0 0	0	46.0
17.00 18.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS					0	
19.00	04900 DRUGS CHARGED TO PATIENTS	C			0 0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	C		0 0	0	
51.00	05100 SUPPORT SURFACES	C	0 0		0 0	0	51.0
50.00	OUTPATI ENT SERVI CE COST CENTERS	C			0 0	0	60.0
51.00	06100 RURAL HEALTH CLINIC				0 0		
52.00	06200 FQHC		_				62.0
	OTHER REIMBURSABLE COST CENTERS			1			
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE				0 0		
	07300 CMHC		, s		0 0	, s	1
	SPECIAL PURPOSE COST CENTERS		-	1			
30.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.0
31.00 32.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW – SNF						81.0 82.0
33.00	08300 HOSPI CE	C	o c		o o	0	
39.00	SUBTOTALS (sum of lines 1-84)	54, 484	54, 484	54, 48	4 54, 484		
	NONREI MBURSABLE COST CENTERS			1			
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP			1	0 0 0 0		
2.00	09200 PHYSI CLANS PRI VATE OFFI CES	C		1	0 0	0	
93.00	09300 NONPAID WORKERS	C	0 0		0 0	0	
94.00	09400 PATIENTS LAUNDRY	C	0		0 0	0	
8.00	Cross Foot Adjustments			-			98.0
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	492, 524	12, 623	76, 84	9 152, 655	n	99. 0 102. 0
52.00	Part I)	772, 324	12,020	, , , , , , , , , , , , , , , , , , , ,	, 152,000		02.0
03.00	Unit cost multiplier (Wkst. B, Part I)						
04.00		1, 714	44	7, 39	4 1, 963	0	104.0
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 031459	0. 000808	0. 13571	0 0. 036029	0. 000000	105 0
	in the second of the second se	0.001407	1 0.00000		0.00027	I 0.00000	1.00.0

OST A	Financial Systems LLOCATION - STATISTICAL BASIS	BUCKINGHAM A	Provi der No. : 315290	Peri od:	u of Form CMS-254 Worksheet B-1
				From 01/01/2023 To 12/31/2023	Dato/Timo Propar
				10 12/31/2023	Date/Time Prepar 6/3/2024 2:40 pm
		OTHER GENERAL			
	Cost Center Description	SERVICE ACTIVITIES			
	obst conter bescription	(PATIENT DAYS)			
		15.00			
	GENERAL SERVICE COST CENTERS	1 1			
. 00	00100 CAP REL COSTS - BLDGS & FIXTURES				1
. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT				2
. 00	00300 EMPLOYEE BENEFITS				
. 00 . 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS				2
. 00	00600 LAUNDRY & LINEN SERVICE				
. 00	00700 HOUSEKEEPI NG				
. 00	00800 DI ETARY				8
. 00	00900 NURSI NG ADMI NI STRATI ON				q
0. 00	01000 CENTRAL SERVICES & SUPPLY				10
1. 00	01100 PHARMACY				11
2.00	01200 MEDI CAL RECORDS & LI BRARY				12
3.00	01300 SOCIAL SERVICE				13
4.00	01400 NURSING AND ALLIED HEALTH EDUCATION	E4 404			14
5.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	54, 484			15
0.00	03000 SKILLED NURSING FACILITY	54, 484			30
1.00	03100 NURSING FACILITY	0			31
2.00	03200 I CF/I I D	0			32
3.00	03300 OTHER LONG TERM CARE	0			33
	ANCI LLARY SERVI CE COST CENTERS				
0. 00	04000 RADI OLOGY	0			40
1. 00	04100 LABORATORY	0			41
2.00	04200 I NTRAVENOUS THERAPY	0			42
	04300 OXYGEN (INHALATION) THERAPY	0			43
4.00	04400 PHYSI CAL THERAPY	0			44
5.00 6.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0			45
7.00	04700 ELECTROCARDI OLOGY	0			40
8.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			48
9.00	04900 DRUGS CHARGED TO PATIENTS	0			49
0. 00	05000 DENTAL CARE - TITLE XIX ONLY	0			50
1. 00	05100 SUPPORT SURFACES	0			51
	OUTPATIENT SERVICE COST CENTERS	1 1			
0. 00	06000 CLINIC	0			60
1.00	06100 RURAL HEALTH CLINIC	0			61
2.00					62
0 00	OTHER REIMBURSABLE COST CENTERS				
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0			70
	07300 CMHC	0			73
5.00	SPECIAL PURPOSE COST CENTERS	0			/`
0. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES				80
1.00	08100 I NTEREST EXPENSE				81
2.00	08200 UTI LI ZATI ON REVIEW - SNF				82
3.00	08300 HOSPI CE	0			83
9.00	SUBTOTALS (sum of lines 1-84)	54, 484			89
	NONREI MBURSABLE COST CENTERS				
0.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90
1.00 2.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0			91 92
2.00	09300 NONPAID WORKERS	0			92
4.00	09400 PATIENTS LAUNDRY				94
3.00	Cross Foot Adjustments				98
9.00	Negative Cost Centers				99
02.00	5	937, 249			102
	Part I)				
03.00		17. 202280			103
04.00		100, 789			104
	Part II)	1 0 1005-			105
05.00	Unit cost multiplier (Wkst. B, Part	1.849883			

Health Financial Systems BUCKINGHAM AT NORWOOD		In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provider		Period:	Worksheet C	
		From 01/01/2023 To 12/31/2023	Date/Time Pre 6/3/2024 2:40	
Cost Center Description	Total (from	Total Charges		
	Wkst. B, Pt I	<i>i</i>	di vi ded by	
	col. 18)		col. 2	
	1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS	0.01			
40. 00 04000 RADI 0L0GY	3, 91			
41.00 04100 LABORATORY	26, 71			
42.00 04200 I NTRAVENOUS THERAPY	3	-	1.285714	
43.00 04300 0XYGEN (INHALATION) THERAPY	9, 05			
44. 00 04400 PHYSI CAL THERAPY	669, 22			
45. 00 04500 OCCUPATI ONAL THERAPY	578, 23			
46.00 04600 SPEECH PATHOLOGY	178, 47	6 306, 028		
47. 00 04700 ELECTROCARDI OLOGY		0 0	0.000000	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	4		1. 257143	•
49.00 04900 DRUGS CHARGED TO PATIENTS	235, 27	1 192, 010	1. 225306	
50.00 05000 DENTAL CARE - TITLE XIX ONLY		0 0	0.00000	
51.00 05100 SUPPORT SURFACES		0 0	0.00000	51.00
OUTPATIENT SERVICE COST CENTERS	1	1		
60. 00 06000 CLINIC		0 0	0.00000	
61.00 06100 RURAL HEALTH CLINIC				61.00
62.00 06200 FQHC				62.00
71.00 07100 AMBULANCE	35, 21			•
100. 00 Total	1, 736, 19	1 2, 648, 325		100. 00

Health Financial Systems	BUCKI NGHAM	BUCKINGHAM AT NORWOOD			In Lieu of Form CMS-2540-10		
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315290	Period: From 01/01/2023	Worksheet D Part I		
				To 12/31/2023		epared:	
					6/3/2024 2:40		
		Title	XVIII (1)	Skilled Nursing	PPS		
	T			Facility			
		Health Care Pr	rogram Charge	s Health Care	Program Cost		
	Ratio of Cost	Part A	Part B	Part A (col. 1			
	to Charges			x col. 2)	x col. 3)		
	(Fr. Wkst. C						
	<u>Column 3)</u> 1.00	2.00	3.00	4.00	5.00		
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	3.00	4.00	5.00		
ANCI LLARY SERVICE COST CENTERS						-	
40. 00 04000 RADI OLOGY	0. 392057	0		0 0	0	40.00	
41. 00 04100 LABORATORY	1. 270583			0 750	0		
42.00 04200 INTRAVENOUS THERAPY	1. 285714			0 0	0		
43.00 04300 0XYGEN (INHALATION) THERAPY	1. 270634			0 0	0		
44. 00 04400 PHYSI CAL THERAPY	0. 598009			0 172, 401	0	44.00	
45.00 04500 OCCUPATI ONAL THERAPY	0. 599040	329, 295		0 197, 261	0	45.00	
46.00 04600 SPEECH PATHOLOGY	0. 583202	105, 761		0 61,680	0	46.00	
47.00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 257143	35		0 44	0	48.00	
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 225306	9, 138		0 11, 197	0	49.00	
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00	
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00	
OUTPATIENT SERVICE COST CENTERS							
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00	
61.00 06100 RURAL HEALTH CLINIC						61.00	
62.00 06200 FQHC						62.00	
71.00 07100 AMBULANCE (2)	1. 270592			0		71.00	
100.00 Total (Sum of Lines 40 - 71)		733, 111		0 443, 333	0	100.00	
(1) Fare that a Variative variation of the set of the s							

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

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

Health Financial Systems	BUCKINGHAM	AT NORWOOD		In Lie	u of Form CMS-:	2540-10	
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315290	Period: From 01/01/2023 To 12/31/2023		pared: pm	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS		
Cost Center Description					1.00		
PART LL - APPORTIONMENT OF VACCINE COST							
1.00 Drugs charged to patients - ratio of cc 2.00 Program vaccine charges (From your record)			t C, column 3	, line 49)	1. 225306 0	1.00 2.00	
3.00 Program costs (Line 1 x line 2) (Title E, Part I, line 18)			er this amoun	t to Worksheet	0	3.00	
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A			
	(From Wkst. B,			Cost (From	& Allied		
		(From Wkst. B,			Heal th Costs		
	18		Costs to Tota		for Pass		
		14)	Costs - Part		Through (Col. 3 x Col. 4)		
			(Col . 2 / Col 1)	•	3 X COI. 4)		
	1.00	2.00	3.00	4.00	5.00		
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH					
ANCI LLARY SERVICE COST CENTERS							
40. 00 04000 RADI OLOGY	3, 919	C	0.0000	0 0	0	40.00	
41. 00 04100 LABORATORY	26, 714	C	0.0000	0 750	0	41.00	
42.00 04200 INTRAVENOUS THERAPY	36	C	0.0000	0 0	0	42.00	
43.00 04300 OXYGEN (INHALATION) THERAPY	9, 052	C	0.0000		0	43.00	
44. 00 04400 PHYSI CAL THERAPY	669, 229	C	0.0000		0	44.00	
45.00 04500 OCCUPATI ONAL THERAPY	578, 233	C	0.0000		0	45.00	
46.00 04600 SPEECH PATHOLOGY	178, 476	C	0.0000	0 61, 680	0	46.00	
47.00 04700 ELECTROCARDI OLOGY	0	C	0.0000		0	47.00	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	44	C	0.0000		0	48.00	
49.00 04900 DRUGS CHARGED TO PATIENTS	235, 271	C	0.0000			49.00	
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	C	0.0000		0	50.00	
51.00 05100 SUPPORT SURFACES	0	C	0.0000		0	51.00	
100.00 Total (Sum of lines 40 - 52)	1, 700, 974	C		443, 333	0	100. 00	

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315290	Period: From 01/01/2023 To 12/31/2023		pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
. 00	Inpatient days including private room days			54, 484	1.0
2.00	Private room days			0	2.0
8.00	Inpatient days including private room days applicable to the			4, 189	
1.00	Medically necessary private room days applicable to the Prog	jram (0	
5.00	Total general inpatient routine service cost			17, 891, 118	5.0
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
o. 00	General inpatient routine service charges			23, 466, 125	
. 00	General inpatient routine service cost/charge ratio (Line 5	i divided by line 6)		0. 762423	
. 00	Enter private room charges from your records			0 0.00	
. 00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)				9.0
0.00	Enter semi-private room charges from your records			0	10.0
1.00	Average semi-private room per diem charge (Semi-private roo semi-private room days)	m charges line 10, divide	d by	0.00	11. (
2.00	Average per diem private room charge differential (Line 9 mi	nus line 11)		0.00	12. (
3.00	Average per diem private room cost differential (Line 7 time				13.0
4.00	Private room cost differential adjustment (Line 2 times line			0.00	
	General inpatient routine service cost net of private room c		minus line 14)	17, 891, 118	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
6.00	Adjusted general inpatient service cost per diem (Line 15 d	livided by line 1)		328.37	16. (
7.00	Program routine service cost (Line 3 times line 16)	5		1, 375, 542	17.0
8.00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18.0
9.00	Total program general inpatient routine service cost (Line	17 plus line 18)		1, 375, 542	19. (
0. 00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	1, 355, 018	20. (
1.00	Per diem capital related costs (Line 20 divided by line 1)			24.87	21.0
2.00	Program capital related cost (Line 3 times line 21)			104, 180	22.0
3. 00	Inpatient routine service cost (Line 19 minus line 22)			1, 271, 362	23.
1.00	Aggregate charges to beneficiaries for excess costs (From p	provider records)		0	24.
5.00	Total program routine service costs for comparison to the co	ost limitation (Line 23 mi	nus line 24)	1, 271, 362	25.
5.00	Enter the per diem limitation (1)			l	26.
	Inpatient routine service cost limitation (Line 3 times the			l	27.
8.00	Reimbursable inpatient routine service costs (Line 22 plus	the lesser of line 25 or	line 27)		28.

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	54, 484	1.00
2.00	Program inpatient days (see instructions)	4, 189	2.00
3.00	Total nursing & allied health costs. (see instructions) (Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 076885	4.00
	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Т

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315290	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 6/3/2024 2:40	pared:
		Title XIX	Skilled Nursing Facility	Cost	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
1.00	Inpatient days including private room days			54, 484	1.00
2.00	Private room days			0	2.00
3.00	Inpatient days including private room days applicable to the F			43, 216	3.00
4.00	Medically necessary private room days applicable to the Progra	am		0 17, 891, 118	4.00
5.00					5.00
(00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			22 4/4 125	1 (00
6.00	General inpatient routine service charges	divided by Line ()		23, 466, 125 0. 762423	
7.00					7.00 8.00
8.00 9.00					9.00
9.00	2)				9.00
10.00	Enter semi-private room charges from your records			23, 466, 125	10.00
11.00					
	semi-private room days)			430.70	
12.00	Average per diem private room charge differential (Line 9 minu	us line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times	line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 1	13)		0	14.00
15.00	General inpatient routine service cost net of private room cos	st differential (Line 5	minus line 14)	17, 891, 118	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
	Adjusted general inpatient service cost per diem (Line 15 div	/ided by line 1)		328.37	
17.00	Program routine service cost (Line 3 times line 16)			14, 190, 838	
	Medically necessary private room cost applicable to program (0	18.00
19.00	Total program general inpatient routine service cost (Line 17			14, 190, 838	
20.00	Capital related cost allocated to inpatient routine service co	osts (From Wkst. B, Par	t II column 18,	1, 355, 018	20.00
21.00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			24.87	21.00
21.00	Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21)			24.87	
	Inpatient routine service cost (Line 3 times fine 21)			13, 116, 056	
	Aggregate charges to beneficiaries for excess costs (From pro	wider records)		13, 110, 050	23.00
	Total program routine service costs for comparison to the cost		nus line 24)	13, 116, 056	
	Enter the per diem limitation (1)			0.00	
27.00	Inpatient routine service cost limitation (Line 3 times the pe	er diem limitation line	26) (1)	0.00	
	Reimbursable inpatient routine service costs (Line 22 plus th			14, 190, 838	
	(Transfer to Worksheet E, Part II, line 4) (See instructions)		,		1

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	54, 484	1.00
2.00	Program inpatient days (see instructions)	43, 216	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 793187	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315290	Period:	Worksheet E	
			From 01/01/2023 To 12/31/2023	Part I Date/Time Prep 6/3/2024 2:40	
		Title XVIII	Skilled Nursing	PPS	•
			Facility		
			-	1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIME	BURSEMENT	I		
1.00	Inpatient PPS amount (See Instructions)			3, 775, 047	1.0
2.00	Nursing and Allied Health Education Activities (pass through	h payments)		0	2. (
3.00	Subtotal (Sum of lines 1 and 2)			3, 775, 047	3. (
4.00	Primary payor amounts			0	4.0
5.00	Coinsurance			342, 800	5.0
5.00	Allowable bad debts (From your records)			237, 397	6.0
7.00	Allowable Bad debts for dual eligible beneficiaries (See ins	structions)		99, 140	7.0
3.00	Adjusted reimbursable bad debts. (See instructions)			154, 308	8.0
9.00	Recovery of bad debts - for statistical records only			0	9. (
0.00	Utilization review			0	10. (
1.00	Subtotal (See instructions)			3, 586, 555	11.0
2.00	Interim payments (See instructions)			3, 525, 529	12.
3.00	Tentati ve adjustment			0	13.
4.00	OTHER adjustment (See instructions)			0	14.
4.50	Demonstration payment adjustment amount before sequestration	n		0	14.
4.55	Demonstration payment adjustment amount after sequestration			0	14.
4.75	Sequestration for non-claims based amounts (see instructions	s)		3, 086	14.
4.99	Sequestration amount (see instructions)			68, 645	14.
5.00	Balance due provider/program (see Instructions)			-10, 705	15.
6.00	Protested amounts (Nonallowable cost report items in accorda			0	16.
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESS	SER OF COST OR CHARGES - T	ITLE XVIII ONLY		
7.00	Ancillary services Part B			0	17.0
8.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. (
9.00	Total reasonable costs (Sum of lines 17 and 18)			0	19.
20.00	Medicare Part B ancillary charges (See instructions)			0	20.
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.
22.00	Primary payor amounts			0	22.
23.00	Coinsurance and deductibles			0	23.
24.00	Allowable bad debts (From your records)			0	24.
24.01	Allowable Bad debts for dual eligible beneficiaries (see ins	structions)		0	24.
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24.
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.
26.00	Interim payments (See instructions)			0	26.
27.00	Tentati ve adjustment			0	27.
28.00	Other Adjustments (See instructions) Specify			0	28. (
28.50	Demonstration payment adjustment amount before sequestration			0	28.
28.55	Demonstration payment adjustment amount after sequestration			0	28.
28. 99	Sequestration amount (see instructions)			0	28.
29.00	Balance due provider/program (see instructions)			0	29.
0 00	Protested amounts (Nonallowable cost report items) in accord	dance with CMS Pub 15-2 s	ection 115 2	0	30.

lear th	Financial Systems BU	CKINGHAM AT N	ORWOOD	In Lie	u of Form CMS-2	<u>2540-1</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITL	E XIX ONLY	Provider No.: 315290	Peri od:	Worksheet E	
				From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	narod
				10 12/31/2023	6/3/2024 2:40	
			Title XIX	Skilled Nursing	Cost	
				Facility	0001	
					1.00	
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient ancillary services (see Instructions)				0	1.0
2.00	Nursing & Allied Health Cost (From Worksheet D-1,	Pt. II, line	e 5)		0	2.0
3.00	Outpatient services				0	3.0
4.00	Inpatient routine services (see instructions)				14, 190, 838	4.0
5.00	Utilization reviewphysicians' compensation (from	m provider red	cords)		0	5.0
6.00	Cost of covered services (Sum of lines 1 - 5)	•			14, 190, 838	6.00
7.00	Differential in charges between semiprivate accomm	modations and	less than semiprivate	accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)				14, 190, 838	8.0
9.00	Primary payor amounts				0	9.0
10.00	Total Reasonable Cost (Line 8 minus line 9)				14, 190, 838	10.0
	REASONABLE CHARGES					1
11.00	Inpatient ancillary service charges				0	11.0
12.00	Outpatient service charges				0	12.0
	Inpatient routine service charges				0	13.0
14.00	Differential in charges between semiprivate accomm	modations and	less than semiprivate	accommodations	0	14.0
	Total reasonable charges				0	15.0
	CUSTOMARY CHARGES					1
16.00	Aggregate amount actually collected from patients	liable for pa	ayment for services on	a charge basis	0	16.0
17.00	Amounts that would have been realized from patient	ts liable for	payment for services o	n a charge basis	0	17.0
	had such payment been made in accordance with 42 (CFR 413.13(e)		Ũ		
18.00	Ratio of line 16 to line 17 (not to exceed 1.00000	00)			0.00000	18.0
19.00	Total customary charges (see instructions)				0	19.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
20. 00	Cost of covered services (see Instructions)				0	20.0
21.00	Deducti bl es				0	21.0
22.00	Subtotal (Line 20 minus line 21)				0	22.0
23.00	Coinsurance				0	23.0
24.00	Subtotal (Line 22 minus line 23)				0	24.0
25.00	Allowable bad debts (from your records)				0	25.0
26.00	Subtotal (sum of lines 24 and 25)				0	26.0
27.00	Unrefunded charges to beneficiaries for excess cos	sts erroneousl	y collected based on c	orrection of	0	27.0
	cost limit					
28.00	Recovery of excess depreciation resulting from pro	ovider termina	ation or a decrease in	program	0	28.0
	utilization					
	Other Adjustments (see instructions) Specify				0	
30. 00	Amounts applicable to prior cost reporting periods	s resulting fi	rom disposition of depr	eciable assets (0	30. C
	if minus, enter amount in parentheses)					
	Subtotal (Line 26 plus or minus lines 29, and 30,	minus lines	27 and 28)		0	
	Interim payments				0	
33.00	Balance due provider/program (Line 31 minus line 3	32) (indicate	overpayments in parent	heses) (see	0	33.0
	Instructions)					1

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315290	Period: From 01/01/2023 To 12/31/2023		epare
		Titl	e XVIII	Skilled Nursing Facility		<u>, p</u>
		I npati er	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero List separately each retroactive lump sum adjustment		3, 363, 6 172, 6		000	
	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)					
01	Program to Provider ADJUSTMENTS TO PROVIDER		1	0	0	3.
02 03 04	AUJUSTIMENTS TO PROVIDER			0 0 0 0) 3.) 3.) 3.
05	Provider to Program			0	0	<u> </u>
50 51 52	ADJUSTMENTS TO PROGRAM	06/15/2023	10, 7	0 0	000000000000000000000000000000000000000) 3.) 3.
53 54 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		-10, 7	0 0 28	000000000000000000000000000000000000000	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		3, 525, 5	29	0	4
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
01	Program to Provider TENTATIVE TO PROVIDER		1	0	0	5.
)2)3				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5
51 52 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0 0 0) 5) 5
00	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
01 02 00	PROGRAM TO PROVIDER PROVIDER TO PROGRAM Total Medicare program liability (see instructions)		10, 7 3, 514, 8		0 0 0	6.
			Contra	actor Name	Contractor Number 2.00	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der	No.: 315290	Period: From 01/01/2023 To 12/31/2023		epare D pm
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
	Assets CURRENT ASSETS					-
0	Cash on hand and in banks	287, 899		0 0		0 1
0	Temporary investments	207,077		0 0		
0	Notes receivable	0		0 0		
0	Accounts receivable	3, 303, 096		0 0		
0	Other receivables	-1, 898, 600		0 0		
0	Less: allowances for uncollectible notes and accounts	0		0 0) c	
	recei vabl e					
0	Inventory	0		0 0) C	7 0
0	Prepaid expenses	103, 679		0 0	C	
0	Other current assets	34, 442		0 0	C	
00	Due from other funds	0		0 0	-	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 830, 516		0 0	C	11
	FI XED_ASSETS	-	1	-	-	
00	Land	0		0 0		
00	Land improvements	0		0 0	-	
00	Less: Accumulated depreciation	0		0 0	-	
00	Buildings	0				
00 00	Less Accumulated depreciation Leasehold improvements	4, 359, 508				
00	Less: Accumulated Amortization	-3, 264, 290			-	
00	Fixed equipment	534, 944			-	
00	Less: Accumulated depreciation	034, 744				
00	Automobiles and trucks					
00	Less: Accumulated depreciation	0		0 0		
00	Major movable equipment	1, 489, 177		0 0		
00	Less: Accumulated depreciation	0		0 0		
00	Minor equipment - Depreciable	0		0 0		
00	Minor equipment nondepreciable	0		0 0		
00	Other fixed assets	0		0 0		
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	3, 119, 339		0 0		
	OTHER ASSETS	· · · ·		!	•	
00	Investments	0		0 0) C	29
00	Deposits on Leases	0		0 0) C	0 30
00	Due from owners/officers	0		0 0) C) 31
00	Other assets	3, 789, 982		0 0	C	
00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	3, 789, 982		0 0		
00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	8, 739, 837		0 0) C	34
	Liabilities and Fund Balances					_
~~	CURRENT LI ABI LI TI ES	2 507 000	I			
	Accounts payable	3, 597, 800				
00 00	Salaries, wages, and fees payable	344, 602			-	
	Payroll taxes payable (Short torm)	227, 404			-	
00 00	Notes & loans payable (Short term) Deferred income					
00	Accelerated payments					40
00	Due to other funds			0 0) c	
00	Other current liabilities	575, 830				
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4, 745, 636		0 0	-	
	LONG TERM LIABILITIES	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				1
00	Mortgage payable	0		0 0	C	5 44
00	Notes payable	0		0 0		
00	Unsecured Loans	0		0 0		
00	Loans from owners:	0		0 0	C	
00	Other long term liabilities	0		0 0	C	48
00	OTHER (SPECIFY)	0		0 0) C	49
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		0 0	-	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	4, 745, 636		0 0) C	51
	CAPI TAL ACCOUNTS	-				
00	General fund balance	3, 994, 201				52
00	Specific purpose fund			0		53
00	Donor created - endowment fund balance - restricted			C		54
00	Donor created - endowment fund balance - unrestricted			C		55
00	Governing body created - endowment fund balance			C		56
00	Plant fund balance - invested in plant				C	
00	Plant fund balance - reserve for plant improvement,				C	58
00	replacement, and expansion	0.004.001		_		
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	3, 994, 201 8, 739, 837		0 0		
00		1 0 7 20 0 27				11 60

STATEMENT OF CHANGES IN FUND BALANCES Provider No.: 315290 Period: From 01/01/2023 To 12/31/2023 Worksheet G-1 Date/Time Prepar 6/3/2024 2: 40 pm Image: Constraint of the state of t	40-10	254	u of Form CMS-	In Lieu			NORWOOD	BUCKI NGHAM A	Financial Systems	Heal th
Image: Non-Addition (sum of line 5 - 9) Image: Non-Addition (sum of line 3 plus line 10) <td>red:</td> <td>ı epai</td> <td>Worksheet G-1 Date/Time Pre</td> <td>eriod: com 01/01/2023</td> <td>Fr</td> <td>No.: 315290</td> <td>Provi der</td> <td></td> <td></td> <td></td>	red:	ı epai	Worksheet G-1 Date/Time Pre	eriod: com 01/01/2023	Fr	No.: 315290	Provi der			
1.00 Fund balances at beginning of period 5,911,633 0 1 2.00 Net income (loss) (from Wkst. G-3, line 31) -1,558,776 0 2 3.00 Total (sum of line 1 and line 2) 4,352,857 0 2 4.00 Additions (credit adjustments) 0 0 0 0 5.00 0 0 0 0 0 0 6.00 0 0 0 0 0 0 0 7.00 0		I	Endowment Fund	rpose Fund	Pur	Speci al	Fund	General		
1.00 Fund balances at beginning of period 5,911,633 0 1 2.00 Net income (loss) (from Wkst. G-3, line 31) -1,558,776 0 2 3.00 Total (sum of line 1 and line 2) 4,352,857 0 2 4.00 Additions (credit adjustments) 0 0 0 0 5.00 0 0 0 0 0 0 6.00 0 0 0 0 0 0 0 7.00 0										
2.00 Net income (loss) (from Wkst. G-3, line 31) -1,558,776 0 2 3.00 Total (sum of line 1 and line 2) 4,352,857 0 3 4.00 Additions (credit adjustments) 0 0 0 0 5.00 0 0 0 0 0 0 6.00 0 0 0 0 0 0 0 7.00 0 <t< td=""><td>1.00</td><td>+</td><td>5.00</td><td></td><td></td><td></td><td></td><td>1.00</td><td>Fund halances at beginning of period</td><td>1 00</td></t<>	1.00	+	5.00					1.00	Fund halances at beginning of period	1 00
6.00 0 0 0 0 0 7.00 0 0 0 0 0 0 8.00 0 0 0 0 0 0 0 0 9.00 10 <	2.00 3.00 4.00						-1, 558, 776		Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	2.00 3.00
7.00 0 0 0 0 0 8.00 0 0 0 0 0 0 0 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 10 0 10 0 10 0 10 0 10 <td>5.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	5.00									
8.00 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 4,352,857 0 11.10 12.00 Deductions (debit adjustments) 12.00	6.00 7.00							0		
10.00 Total additions (sum of line 5 - 9) 0 10 11.00 Subtotal (line 3 plus line 10) 4, 352, 857 0 11 12.00 Deductions (debit adjustments) 12	8.00		0		-			0		8.00
11.00 Subtotal (line 3 plus line 10) 4, 352, 857 0 11 12.00 Deductions (debit adjustments) 12	9.00 0.00		0	0	0		0	0	Total additions (sum of line 5 - 9)	
	1.00					,	4, 352, 857		, , ,	
	2.00		0					250 (5(
	3.00 4.00		-		-				DRAW	
15.00 0 15	5.00) 1			0			-		15.00
	6.00 7.00				0			0		
	8.00		0	0	Ŭ		358, 656	Ŭ	Total deductions (sum of lines 13 - 17)	
19.00Fund balance at end of period per balance3,994,201019sheet (Line 11 - Line 18)019	9.00	1		0			3, 994, 201			19.00
Endowment Fund Plant Fund				I		Fund	PI ant	Endowment Fund		
6.00 7.00 8.00						8.00	7.00	6.00		
	1.00	T			0	8.00	7.00		Fund balances at beginning of period	1.00
2.00 Net income (loss) (from Wkst. G-3, line 31) 2 3.00 Total (sum of line 1 and line 2) 0 0	2.00 3.00				0			0	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	3.00
	4.00 5.00						0		Additions (credit adjustments)	
	6.00						0			
	7.00						0			
	8.00 9.00						0			
	0.00							-		
	1.00 2.00				0			0		
13.00 DRAW 0 13	3.00	1					0			13.00
	4.00 5.00						0			
	5.00 6.00						0			
	7.00)	0			
	8.00 9.00									
sheet (Line 11 - Line 18)		.			-					

Heal th	Financial Systems	BUCKINGHAM AT NO	RWOOD			In Lie	u of Form CMS-	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	5	Provi der	No.: 315290	Peri From To	od: 1 01/01/2023 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 6/3/2024 2:40	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				
1.00	SKILLED NURSING FACILITY			23, 466, 12	25		23, 466, 125	1.00
2.00	NURSING FACILITY				0		0	2.00
3.00	ICF/IID				0		0	3.00
4.00	OTHER LONG TERM CARE				0		0	4.00
5.00	Total general inpatient care services (Sum of	ilines 1 - 4)		23, 466, 12	25		23, 466, 125	5.00
	All Other Care Services			1				
6.00	ANCI LLARY SERVI CES			2, 648, 3	25	0	2, 648, 325	6.00
7.00	CLINIC					0	0	
8.00	HOME HEALTH AGENCY COST					0	0	8.00
9.00	AMBULANCE					0	0	9.00
10.00	RURAL HEALTH CLINIC					0	0	10.00
10. 10	FQHC					0	0	10.10
	СМНС					0	0	11.00
	HOSPI CE				0	0	0	12.00
	OTHER (SPECIFY)				0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) Worksheet G-3, Line 1)	(Transfer column 3	to	26, 114, 4	50	0	26, 114, 450	14.00
	Cost Center Description							
	· .					1.00	2.00	
	PART II – OPERATING EXPENSES							
1.00	Operating Expenses (Per Worksheet A, Col. 3,	Line 100)					20, 753, 947	1.00
2.00	Add (Specify)					0		2.00
3.00						0		3.00
4.00						0		4.00
5.00						0		5.00
6.00						0		6.00
7.00						0		7.00
8.00	Total Additions (Sum of lines 2 - 7)						0	8.00
9.00	Deduct (Specify)					0		9.00
10.00						0		10.00
11.00						0		11.00
12.00						0		12.00
13.00						0		13.00
	Total Deductions (Sum of lines 9 - 13)						0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and	8, minus line 14)					20, 753, 947	15.00

Heal th	Financial Systems	BUCKINGHAM AT NO	RWOOD	In Lie	u of Form CMS-2	2540-10
STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider No.: 315290	Peri od:	Worksheet G-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 6/3/2024 2:40	
					0/0/2021 2.10	pin
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part	I, col. 3, line 1	4)		26, 114, 450	1.00
2.00	Less: contractual allowances and discounts on	patients accounts			6, 929, 741	2.00
3.00	Net patient revenues (Line 1 minus line 2)				19, 184, 709	3.00
4.00	Less: total operating expenses (From Worksheet	t G-2, Part II, li	ne 15)		20, 753, 947	4.00
5.00	Net income from service to patients (Line 3 mi	nus 4)	-		-1, 569, 238	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				1, 059	7.00
8.00	Revenues from communications (Telephone and I	nternet service)			0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	· · · · · · · · · · · · · · · · · · ·				0	13.00
	Revenue from meals sold to employees and guest	ts			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00			n patients		903	16.00
17.00					0	17.00
18.00	Revenue from sale of medical records and abstr				0	18.00
	Tuition (fees, sale of textbooks, uniforms, et	,			0	19.00
	Revenue from gifts, flower, coffee shops, cant	teen			0	20.00
	Rental of vending machines				0	21.00
22.00	Rental of skilled nursing space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	MISC INCOME				8, 500	24.00
24.50					0	24.50
25.00	Total other income (Sum of lines 6 - 24)				10, 462	25.00
26.00	Total (Line 5 plus line 25)				-1, 558, 776	26.00
27.00	Other expenses (specify)				0	27.00
28.00					0	28.00
29.00					0	29.00
	Total other expenses (Sum of lines 27 - 29)				0	30.00
31.00	Net income (or loss) for the period (Line 26 m	ninus line 30)			-1, 558, 776	31.00

THE BUCKINGHAM AT NORWOOD CARE AND REHAB CENTER LLC

Financial Statements

December 31, 2023

Financial Statements	
Balance Sheet	1
Statements of Income and Changes in Members' Equity	2

ASSETS

Current assets Fixed assets, net Other assets	\$	292,739 2,484,012 20,609,591
Total assets	\$_	23,386,342
LIABILITIES AND MEMBERS' EQUITY		
Current liabilities Other liabilities Members' equity	\$	12,416,125 6,331,165 4,639,052
Total liabilities and members' equity	\$	23,386,342

THE BUCKINGHAM AT NORWOOD CARE AND REHAB CENTER LLC

Statements of Income and Changes in Members' Equity For The Year Ended December 31, 2023

Revenue	\$	19,195,171
Expenses		
Operating expense		13,403,498
SG&A		2,884,643
Depreciation, amortization, and rent		2,201,195
Other		2,354,318
Total expenses	_	20,843,654
Net loss		(1,648,483)
Members' equity - beginning	_	6,287,535
Members' equity - ending	\$	4,639,052