	required by I aw (42 USC 1395g; 42 CFR 413.	3.20(b)). Failure to report can result in all int			
payments made :	since the beginning of the cost reporting p	eriod being o	deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315499	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 7/1/2022 1:51 pm
PART I - COST I	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost re	port		Date: 7/1/202	2 Time: 1:51 pm
use only	2. [] Manually prepared cost report				
•	3. [0] If this is an amended report en	ter the numbe	er of times the provide	er resubmitted th	is 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	
5	(2) Settled without audit		Cost Report for this		
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened				C 11
	(5) Amended		ine 4, column 1 is "4"		times reopened
		11.Contracto	r Vendor Code	4	
	5. Date Received:	12.[F] Medi	care Utilization. Ente	er "F" for full,	"L" for low, or "N"
		for	no utilization.		

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LLONS GATE (315499) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR			
		1	2	SI GNATURE STATEMENT	
1	David	d Thompson	T	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	David Thompson			2
3	Signatory Title	CHIEF EXECUTIVE OFFICER			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	5, 608	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	5, 608	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.

	D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA	TY HEALTH	H CARE	Provi der	No.: 315499	Period: From 01/01		Workshe Part I		
						To 12/31	/2021	Date/Ti 7/1/202		
	1.00		. 00		3.00					
00	Skilled Nursing Facility and Skilled Nursing Street: 1100 LAUREL OAK ROAD	<u>Facility</u> PO Box:	Complex Ad	ldress:						1. (
		State: N.	J	Zip Code	: 08043					2.0
00	5	CBSA Code		Urban/Ru						3.0
01		CBSA Code								3.0
			Compone	ent Name	Provi de		Payme	ent Syst		
					CCN	Certi fi ed	V	0, or N XVIII	<i>(</i>	-
			1	. 00	2.00	3.00	4.00	_	XI X 6. 00	
	SNF and SNF-Based Component Identification:			. 00	2.00	3.00	1 4.00	0.00	0.00	
00	SNF		LIONS GATE		315499	02/20/2007	N	Р	N	4.
00	Nursing Facility									5.
00	ICF/IID									6.
	SNF-Based HHA									7.
00	SNF-Based RHC									8.
00 00	SNF-Based FQHC SNF-Based CMHC									9.
	SNF-Based OLTC									11.
	SNF-Based HOSPICE									12.
	SNF-Based CORF									13.
						From	1:	То):	
						1.0	C	2. (00	
	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		14.
00	Type of Control (See Instructions)						2	CORPORA		15.
							-	Y/		-
	Type of Freestanding Skilled Nursing Facility	/						1. (00	
00	Is this a distinct part skilled nursing facili section 483.5?		meets the	requi reme	ents set for	th in 42 CFF	2	N	1	16.
00	Is this a composite distinct part skilled nur 42 CFR section 483.5?	sing fac	ility that	meets the	e requiremen	ts set forth	nin	N	I	17.
00	Are there any costs included in Worksheet A t organizations as defined in CMS Pub. 15–1, ch							N	I	18.
	Miscellaneous Cost Reporting Information									
00	If this is a low Medicare utilization cost re	eport, in	dicate with	a "Y", 1	for yes, or	"N" for no.		N	l	19.
	If line 19 is yes, does this cost report meet utilization cost report, indicate with a "Y",	for yes	, or "N" fo	r no.	0			N		19.
	Depreciation - Enter the amount of depreciati	on repor	ted in this	SNF for	the method	indicated o	n Lines			
	Straight Line							3,	137, 36	
	Declining Balance									0 21.
	Sum of the Year's Digits Sum of line 20 through 22							· ·		22.
	If depreciation is funded, enter the balance	as of t	he end of t	ha nari o	4			3,	137, 36 ⁻	0 24.
	Were there any disposal of capital assets dur							Ν		25.
	Was accelerated depreciation claimed on any a					reportina pe	ri od?	N		26.
	(Y/N)			• • • • • · · · j	p				-	
00	Did you cease to participate in the Medicare	program	at end of t	he perio	d to which t	his cost rep	ort	N	I	27.
	applies? (Y/N)									
00	Was there a substantial decrease in health ir reports? (Y/N)	isurance	proportion	of allowa	able cost fr	om prior cos		N		28.
								APart B		-
	If this facility contains a public or non-pub	lic prov	ider that o	ual i fi es	for an ever	ntion from		<u>2.00</u>		-
	the lower of the costs or charges enter "Y" f								511 01	
	exemption.			51.5						
	Skilled Nursing Facility						N	N		29.
	Nursing Facility								N	30.
										31.
	SNF-Based HHA						N	N		32.
	SNF-Based RHC SNF-Based FQHC							N		33.
	SNF-Based CMHC							N		35.
	SNF-Based OLTC									36.
						Y/N				
						1.0		2. (00	
00	Is the skilled nursing facility located in a				ovider as a	SNF N				37.
00	regardless of the level of care given for Tit			s? (Y/N)						0.7
	Are you legally-required to carry malpractice			o polici:		Y				38.
00	Is the malpractice a "claims-made" or "occurr "claims-made" enter 1. If the policy is "occu			e porrey	15	1				39.
	LAANDE WAVE ENTER L IT LIE DUITEVIS OCCU	i ence ,	GILCI Z.		Descritions	Daidia	5606 K	Self Ins	uranco	
					Premi lime	Paldio	2262			
					Premiums 1.00	Paid Lo 2.00		3.0		:

Health Financial Systems	LI ONS GATE		In Lie	u of Form CMS-:	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	G FACILITY HEALTH CARE	Provider No.: 315499		Worksheet S-2	
COMPLEX INDENTIFICATION DATA			From 01/01/2021 To 12/31/2021	Date/Time Pre	
				7/1/2022 1:51	pm
				Y/N	
				1.00	
42.00 Are malpractice premiums and paid los	ses reported in other thar	the Administrative a	ind General cost	N	42.00
center? Enter Y or N. If yes, check b	ox, and submit supporting	schedule listing cost	centers and		
amounts.					
43.00 Are there any home office costs as de	fined in CMS Pub. 15-1, Ch	apter 10?		N	43.00
44.00 If line 43 is yes, enter the home off	ice chain number and enter	the name and address	s 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 o	rganization, enter the nar	ne and address of the	home office on th	e lines	
bel ow.					
45.00 Name:	Contractor's Name:	Contrac	ctor's Number:		45.00
46.00 Street:	PO Box:				46.00
47.00 City:	State:	Zip Coo	de:		47.00
					•

	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 7/1/2022 1:5	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" fo	or 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)				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.			N	2.00	3.00	2. (
0	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home offic d to the provider c l, or members of th	es, drug r its e board	Ν			3. (
				Y/N 1.00	Type 2.00	Date 3.00	
_	Financial Data and Reports				2.00		
00	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 those on the filed financial statements? If	" for Audited, "C" te copy or enter da no, see instructic revenues different	for te ns. from	Y Y	A	05/26/2022	4. (
	reconciliation.	·			Y/N	Legal Oper.	
					1.00	2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch legal operator of the program? (Y/N)	ool? (Y/N) Column 2	: Is the	provider the	N	N	6.
00 00	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s	ng the cost reporti		for Nursing	N N		7. 8.
						Y/N 1.00	
00	Bad Debts Is the provider seeking reimbursement for ba	d debts? (Y/N) see	instructio	าทร		Y	9. (
00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	t collection policy	change du	uring this cos		Ν	10.
	If line 9 is "Y", are patient deductibles an Bed Complement					N	11.
00	Have total beds available changed from prior	cost reporting per	iod?lf"	γ", see instru Pa	uctions. rt A	N Part B	12.
		Descriptio O	n	Y/N 1.00	Date 2.00	Y/N 3.00	
00	PS&R Data Was the cost report prepared using the PS&R			Y	05/25/2022	Y	13.
	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.)				00/20/2022		
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.			Ν		Ν	14.0
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.			Ν		Ν	15.
00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report			Ν		Ν	16. (
00	information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			Ν		Ν	17.0
							1

Heal th	Financial Systems	LIONS	GATE			In Lieu	of Form CMS-	2540-10
÷··· ===	D NURSING FACILITY AND SKILLED NURSING FACILITY HEAL X REIMBURSEMENT QUESTIONNAIRE	TH CARE		Provi der No. : 315499	Fr	eriod: com 01/01/2021	Worksheet S-2 Part II	
					To	b 12/31/2021	Date/Time Pre 7/1/2022 1:51	pared:
		-						-
				1.00		2. (00	
	Cost Report Preparer Contact Information							
19.00	Enter the first name, last name and the title/positi		DEAND	DRA		FALLON		19.00
	held by the cost report preparer in columns 1, 2, ar respectively.	nd 3,						
20.00	Enter the employer/company name of the cost report		BAKER	R TILLY US, LLP				20.00
	preparer.							
21.00	Enter the telephone number and email address of the	cost	570-8	320-0301		DEANDRA. FALLON®	BAKERTI LLY. CO	21.00
	report preparer in columns 1 and 2, respectively.					M		

Heal th	Financial Systems	LIONS G	ATE	In Lieu	u of Form CMS-:	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der No.: 315499	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 7/1/2022 1:51	pared:
		Part B Date 4.00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	05/25/2022				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.		ENI OR MANAGER			19.00
20.00	Enter the employer/company name of the cost i preparer.	report				20.00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

	n Financial Systems ED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE			eriod: rom 01/01/2021	u of Form CMS-2 Worksheet S-3 Part I	
COMPL	EX STATI STI CAL DATA			To			
				l npa	ntient 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	110	40, 150	0	6, 328	10, 932	1.00
. 00	NURSING FACILITY	0	0	0		0	2.00
. 00	ICF/IID	0	0			0	3.00
. 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care		0	0	0	0	4.00 5.00
. 00	SNF-Based CMHC	0	0				6.00
. 00	HOSPI CE	0	o	0	0	o	7.00
. 00	Total (Sum of lines 1-7)	110	40, 150	0	6, 328	10, 932	8.00
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	1.00
1.00 2.00	SKILLED NURSING FACILITY NURSING FACILITY	15, 306	32, 566 0	0	344	15 0	1.00 2.00
. 00		0	0	0		0	3.00
. 00	HOME HEALTH AGENCY COST	0	0				4.00
. 00	Other Long Term Care	0	0				5.00
. 00	SNF-Based CMHC						6.00
. 00	HOSPI CE	0	0	0	0	-	7.00
. 00	Total (Sum of lines 1-7)	15, 306	32, 566	0	344 age Length of		8.00
		Di scha	irges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
. 00	SKILLED NURSING FACILITY	186	545	0.00	18.40		1.00
. 00	NURSING FACILITY	0	0	0.00		0.00	2.00
. 00 . 00	ICF/IID HOME HEALTH AGENCY COST	0	0			0.00	3.00 4.00
. 00	Other Long Term Care	0	0				5.00
b. 00	SNF-Based CMHC	3	0				6.00
. 00	HOSPI CE	0	0	0.00	0.00	0.00	7.00
00			545	0.00	18.40	728.80	8.00
8.00	Total (Sum of lines 1-7)	186					
5.00	lotal (Sum of lines 1-7)	Average		Admi s	sions		
. 00	lotai (Sum of lines I-7)	Average Length of	545	Admi s	si ons		
. 00	Component	Average	Title V	Admis Title XVIII	sions Title XIX	Other	
. 00	Component	Average Length of Stay Total 16.00		Title XVIII 18.00	Title XIX 19.00	20.00	
. 00	Component SKILLED NURSING FACILITY	Average Length of Stay Total 16.00 59.75	Title V 17.00 0	Title XVIII	<u>Title XIX</u> 19.00 5	20. 00 169	
. 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY	Average Length of Stay Total 16.00 59.75 0.00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00 5 0	20.00 169 0	2.00
. 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID	Average Length of Stay Total 16.00 59.75	Title V 17.00 0	Title XVIII 18.00	<u>Title XIX</u> 19.00 5	20. 00 169	2.00 3.00
. 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	Average Length of Stay Total 16.00 59.75 0.00 0.00	Title V 17.00 0	Title XVIII 18.00	Title XIX 19.00 5 0	20.00 169 0 0	2.0 3.0 4.0
. 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	Average Length of Stay Total 16.00 59.75 0.00	Title V 17.00 0	Title XVIII 18.00	Title XIX 19.00 5 0	20.00 169 0	2.00 3.00 4.00 5.00
. 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	Average Length of Stay Total 16.00 59.75 0.00 0.00	Title V 17.00 0	Title XVIII 18.00	Title XIX 19.00 5 0	20.00 169 0 0	2.00 3.00 4.00 5.00 6.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 0.00 59.75	Title V 17.00 0 0 0 0	Ti tl e XVI I I 18.00 379 0 379	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
. 00 2. 00 3. 00 5. 00 5. 00 5. 00 7. 00 8. 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00	Title V 17.00 0 0	Ti tl e XVI I I 18.00 379 0 379	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 0.00 59.75	Title V 17.00 0 0 0 Full Time I Employees on	Title XVIII 18.00 379 0 379 Equival ent Nonpaid	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 59.75 Admi ssi ons	Title V 17.00 0 0 0 0 5 0 7 0 0 0 0 7 0 0 0 0	<u>Ti tl e XVIII</u> <u>18.00</u> 379 0 379 Equi val ent	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 59.75 Admi ssi ons Total	Title V 17.00 0 0 Full Time I Employees on Payrol I	Title XVIII 18.00 379 0 379 Equival ent Nonpaid Workers	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 59.75 Admi ssi ons Total 21.00 553 0	Title V 17.00 0 0 0 0 0 Full Time I Employees on Payrol I 22.00 160.76 0.00	Ti tl e XVIII 18.00 379 0 379 Equi val ent Nonpai d Workers 23.00 0.00 0.00	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 59.75 Admi ssi ons Total 21.00 553	Title V 17.00 0 0 0 0 0 Full Time I Employees on Payrol I 22.00 160.76 0.00 0.00	Ti tl e XVIII 18.00 379 0 379 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 8.00 1.00 2.00 3.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 59.75 Admi ssi ons Total 21.00 0 0 0 0 0 0 0 0 0 0 0 0	Title V 17.00 0 0 0 0 0 0 0 0 0 0 0 0	Ti tl e XVIII 18.00 379 0 379 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 8.00 1.00 2.00 3.00 4.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 59.75 Admi ssi ons Total 21.00 553 0	Title V 17.00 0 0 0 0 0 0 0 0 0 0 0 0	Ti tl e XVIII 18.00 379 0 379 Equi val ent Nonpai d Workers 23.00 0.0	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 1.00 2.00 3.00 4.00 5.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	Average Length of Stay Total 16.00 59.75 0.00 0.00 0.00 0.00 59.75 Admi ssi ons Total 21.00 0 0 0 0 0 0 0 0 0 0 0 0	Title V 17.00 0 0 0 0 0 0 0 0 0 0 0 0	Ti tl e XVIII 18.00 379 0 379 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Title XIX 19.00 5 0 0	20.00 169 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00

Heal th	Financial Systems	LIONS	GATE		In Lie	u of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION				Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 7/1/2022 1:51	pared:
		Amount	Reclass. of	Adj usted	Paid Hours	Average	
		Reported	Salaries from	Sal ari es	Related to	Hourly Wage	
			Worksheet A-6	(col. 1 ±	Salary in	(col. 3 ÷	
				col. 2)	col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - DIRECT SALARIES						-
	SALARI ES				1		
1.00	Total salaries (See Instructions)	10, 273, 127	0	10, 273, 12			
2.00	Physician salaries-Part A	0	0		0 0.00		
3.00	Physician salaries-Part B	0	0		0 0.00		
4.00	Home office personnel	0	0		0 0.00		
5.00	Sum of lines 2 through 4	0	0		0 0.00		
6.00	Revised wages (line 1 minus line 5)	10, 273, 127	0	10, 273, 12			
7.00	Other Long Term Care	0	0		0 0.00		
8.00	HOME HEALTH AGENCY COST	0	0		0 0.00		
9.00	СМНС	0	0		0 0.00		
10.00	HOSPICE	0	0		0 0.00		
11.00	Other excluded areas	1, 694, 210		1, 694, 21			
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	1, 694, 210	0	1, 694, 21	10 59, 067. 00	28.68	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	8, 578, 917	0	8, 578, 91	275, 306. 00	31.16	13.00
	OTHER WAGES & RELATED COSTS	I		1		I	1
14.00	Contract Labor: Patient Related & Mgmt	686, 856	0	686, 85	20, 012. 00	34.32	14.00
15.00	Contract Labor: Physician services-Part A	30, 193	0	30, 19	168.00	179.72	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)	2, 076, 591	0	2, 076, 59	91		17.00
18.00	Wage-related costs other (See Part IV)	0	0		0		18.00
19.00	Wage related costs (excluded units)	342, 464	0	342, 46	54		19.00
20.00	Physician Part A - WRC	0	0		0		20.00
21.00	Physician Part B - WRC	0	0		0		21.00
22.00	Total Adjusted Wage Related cost (see	1, 734, 127	0	1, 734, 12	27		22.00
	instructions)						

Heal th	Financial Systems	LIONS	GATE		In Lie	u of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Peri od:	Worksheet S-3	
					From 01/01/2021	Part III	
					To 12/31/2021	Date/Time Pre 7/1/2022 1:51	pared:
		Amount	Reclass. of	Adjusted	Paid Hours	Average	
		Reported	Salaries from		Related to	Hourly Wage	
		noper teu	Worksheet A-6		Salary in	(col . 3 ÷	
				col. 2)	col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES				· · · · · · · · · · · · · · · · · · ·		
1.00	Employee Benefits	0	0		0.00	0.00	1.00
2.00	Administrative & General	1, 473, 431	0	1, 473, 43	1 36, 641. 00	40. 21	2.00
3.00	Plant Operation, Maintenance & Repairs	446, 808	0	446, 80	8 20, 108. 00	22. 22	3.00
4.00	Laundry & Linen Service	0	0		0.00	0.00	4.00
5.00	Housekeepi ng	0	0		0.00	0.00	5.00
6.00	Dietary	5, 628	0	5, 62	8 408.00	13.79	6.00
7.00	Nursing Administration	331, 775	0	331, 77	5 8, 994. 00	36.89	7.00
8.00	Central Services and Supply	0	0		0.00	0.00	8.00
9.00	Pharmacy	0	0	(0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	(0.00	0.00	10.00
11.00	Social Service	137, 536	0	137, 53	6 3, 891. 00	35.35	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	559, 225	0	559, 22	5 28, 812. 00	19. 41	13.00
14.00	Total (sum lines 1 thru 13)	2, 954, 403	0	2, 954, 40	3 98, 854. 00	29.89	14.00

Heal th	Financial Systems	LIONS GATE		In Lie	u of Form CMS-2	2540-10
SNF WA	GE RELATED COSTS		Provider No.: 315499	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Pre 7/1/2022 1:51	pared:
					Amount Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contributio	n			0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost				59, 946	3.00
4.00	Prior Year Pension Service Cost				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organ	ni zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan				0	6.00
7.00	Employee Managed Care Program Administration Fee	S			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)				966, 222	8.00
9.00	Prescription Drug Plan				0	9.00
10.00	Dental, Hearing and Vision Plan				8, 824	10.00
11.00	Life Insurance (If employee is owner or benefici	ary)			0	11.00
12.00	Accident Insurance (If employee is owner or bene	efi ci ary)			0	12.00
13.00	Disability Insurance (If employee is owner or be	eneficiary)			5, 939	13.00
	Long-Term Care Insurance (If employee is owner o	or beneficiary)			0	14.00
15.00	Workers' Compensation Insurance				267, 111	15.00
16.00	Retirement Health Care Cost (Only current year,	not the extraor	dinary accrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)					
	TAXES					
	FICA-Employers Portion Only				717, 804	
	Medicare Taxes - Employers Portion Only				0	18.00
	Unemployment Insurance				50, 745	
20.00	State or Federal Unemployment Taxes				0	20.00
	OTHER					
	Executive Deferred Compensation				0	21.00
	Day Care Cost and Allowances				0	22.00
	Tuition Reimbursement				0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)				2, 076, 591	24.00
					Amount	
					Reported 1.00	
	Part R Other than Core Delated Cost				1.00	
25 00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00
∠5.00	UTTER WAGE RELATED CUSTS (SPECIFY)				0	25.00

Heal th	Financial Systems	LI ONS (GATE		In Lie	u of Form CMS-2	2540-10
SNF RE	PORTING OF DIRECT CARE EXPENDITURES			No.: 315499	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Pre 7/1/2022 1:51	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adj usted Sal ari es (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 916, 869	387, 399				1.00
2.00	Licensed Practical Nurses (LPNs)	835, 063	168, 766	1, 003, 82			2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1, 890, 659	382, 102	2, 272, 76	83, 560. 00	27.20	3.00
4.00	Total Nursing (sum of lines 1 through 3)	4, 642, 591	938, 267	5, 580, 85	58 152, 196. 00	36.67	4.00
5.00	Physical Therapists	352, 314	71, 203	423, 51	8, 810. 00	48.07	5.00
6.00	Physical Therapy Assistants	149, 154	30, 144	179, 29	3, 773. 00	47.52	6.00
7.00	Physical Therapy Aides	0	0		0 0.00	0.00	7.00
8.00	Occupational Therapists	169, 480	34, 252	203, 73	4, 028. 00	50. 58	8.00
9.00	Occupational Therapy Assistants	161, 526	32, 644	194, 17	4, 286. 00	45.30	9.00
10.00	Occupational Therapy Aides	0	0		0 0.00	0.00	10.00
11.00	Speech Therapists	94, 952	19, 190	114, 14	1, 965. 00	58.09	11.00
12.00	Respi ratory Therapi sts	54, 497	11, 014	65, 5 ⁻	1, 397. 00	46.89	12.00
13.00	Other Medical Staff	0	0		0 0.00	0.00	13.00
	Contract Labor	· · ·		•	·		1
	Nursing Occupations						1
14.00	Registered Nurses (RNs)	56, 500		56, 50	1, 020. 00	55.39	14.00
15.00	Licensed Practical Nurses (LPNs)	244, 441		244, 44	5, 424. 00	45.07	15.00
16.00	Certified Nursing Assistant/Nursing	385, 915		385, 91	13, 568. 00	28.44	16.00
	Assi stants/Ai des						
17.00	Total Nursing (sum of lines 14 through 16)	686, 856		686, 85	20, 012. 00	34.32	17.00
18.00	Physical Therapists	0			0 0.00	0.00	18.00
19.00	Physical Therapy Assistants	0			0 0.00	0.00	19.00
20.00	Physical Therapy Aides	0			0 0.00	0.00	20.00
21.00	Occupational Therapists	0		1	0 0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0			0 0.00	0.00	22.00
23.00	Occupational Therapy Aides	0			0 0.00	0.00	23.00
24.00	Speech Therapists	0			0 0.00		
25.00	Respiratory Therapists	0			0 0.00	0.00	25.00
26.00	Other Medical Staff	0			0 0.00	0.00	26.00
		· ·				-	

ealth Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	LIONS GATE Provider No.: 315499	Peri od:	u of Form CMS Worksheet S-	
		From 01/01/2021 To 12/31/2021	Date/Time Pr	
		Group	7/1/2022 1:5 Days	51 pm
1.00		1.00 RUX	2.00	1.00
2.00		RUL		2.00
3.00		RVX		3.00
I. 00 5. 00		RVL		4.00 5.00
5. 00		RHX RHL		6.00
7.00		RMX		7.00
3. 00		RML		8.00
9. 00 10. 00		RLX RUC		9.00
1.00		RUB		11.00
2.00		RUA		12.00
13.00 14.00		RVC RVB		13.00
14.00		RVA		14.00
6.00		RHC		16.00
17.00		RHB		17.00
18.00 19.00		RHA RMC		18.00
20.00		RMB		20.00
21.00		RMA		21.00
22.00		RLB		22.00
23.00 24.00		RLA ES3		23.00
25.00		ES2		25.00
26.00		ES1		26.00
27.00		HE2		27.00
8. 00 9. 00		HE1 HD2		28.00
0.00		HD1		30.00
1.00		HC2		31.00
2.00 3.00		HC1 HB2		32.00
34.00		HB1		34.00
35. 00		LE2		35.00
36.00		LE1		36.00
37. 00 38. 00		LD2 LD1		37.00
39.00		LC2		39.00
0.00		LC1		40.00
11.00 12.00		LB2 LB1		41.00
3.00		CE2		43.00
4.00		CE1		44.00
5. 00		CD2		45.00
6. 00 7. 00		CD1 CC2		46.00 47.00
8.00		CC1		48.00
9.00		CB2		49.00
0.00		CB1 CA2		50.00 51.00
2.00		CA2 CA1		51.00
3. 00		SE3		53.0
4.00		SE2		54.00
5. 00 6. 00		SE1 SSC		55.00 56.00
7.00		SSB		57.00
3. 00		SSA		58.00
9. 00 0. 00		I B2 I B1		59.00 60.00
1.00		I A2		61.0
2.00		I A1		62.00
3. 00		BB2		63.0
4. 00 5. 00		BB1 BA2		64.00 65.00
5. 00		BA1		66.00
7.00		PE2		67.0
3. 00		PE1 PD2		68.0
9. 00 0. 00		PD2 PD1		69.00 70.00
1.00		PC2		71.00
2.00		PC1		72.00
3.00		PB2		73.00
4. 00 5. 00		PB1 PA2		74.0 75.0

Health Financial Systems LIONS GATE			In Lie	u of Form CMS-	2540-10			
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315499	Peri od:	Worksheet S-	7			
			From 01/01/2021 To 12/31/2021					
			Group	Days				
			1.00	2.00				
76.00 99.00			PA1		76.00 99.00			
100.00 TOTAL			AAA		100.00			
		Expenses	Percentage	Y/N				
		1.00	2.00	3.00				
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)								
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00			

	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	LIONS G		No.: 315499	In Lie Period:	u of Form CMS-2 Worksheet A	2540-10
REULAS	STECATION AND ADJUSTMENT OF TRIAL BALANCE U	F EAPENSES	Provider		From 01/01/2021 To 12/31/2021	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col 1	1 Reclassi fi cat	7/1/2022 1:51 Recl assi fi ed	pm
			other	+ col . 2)	i ons	Trial Balance	
					Increase/Decr	(col. 3 +-	
					ease (Fr Wkst	col. 4)	
		1.00	2.00	3.00	A-6) 4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		6, 695, 706	6, 695, 70	6 0	6, 695, 706	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0		0 0	0	2.00
3.00	00300 EMPLOYEE BENEFITS	0	2, 350, 881	2, 350, 88		2, 350, 881	
4.00	00400 ADMINI STRATI VE & GENERAL	1, 473, 431	1, 851, 624			3, 325, 055	
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	446, 808	2, 368, 170			2, 814, 978	
6.00	00600 LAUNDRY & LINEN SERVICE	0	258,075			258,075	
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY	0 E 439	1, 123, 693			1, 123, 693	
8.00 9.00	00900 NURSI NG ADMI NI STRATI ON	5, 628 331, 775	4, 262, 074 570			4, 267, 702 332, 345	
	01000 CENTRAL SERVICES & SUPPLY	331, 775	290, 747			290, 747	
	01100 PHARMACY	0	31, 291	31, 29		31, 291	
	01200 MEDICAL RECORDS & LIBRARY	0	51, 271		0 0	51, 271	
	01300 SOCI AL SERVI CE	137, 536	1, 151	138, 68		138, 687	
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
	01500 ACTI VI TI ES	559, 225	172, 468	731, 69	3 0	731, 693	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 SKILLED NURSING FACILITY	4, 642, 591	1, 025, 680	5, 668, 27	1 0	5, 668, 271	30.00
	03100 NURSING FACILITY	0	0		0 0	0	31.00
	03200 CF/I D	0	0		0 0	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS		22.20(22.20	(22.20(40.00
	04000 RADI OLOGY	0	32, 396			32, 396	
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	62, 283 0		0 0	62, 283 0	1
	04300 OXYGEN (INHALATION) THERAPY	0	1, 660			64, 831	
	04400 PHYSI CAL THERAPY	981, 923	156, 293			581, 287	
	04500 OCCUPATI ONAL THERAPY	0	0		0 383, 692	383, 692	
	04600 SPEECH PATHOLOGY	0	0		0 110,066	110, 066	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	350, 266	350, 26	6 0	350, 266	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	
	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS		0			0	1 (0.00
	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0 0 0	0	
	06200 FQHC	0	0		0 0	0	62.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u> </u>			02.00
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	0		0 0	0	
	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80.00
	08100 INTEREST EXPENSE		0		0 0	0	
	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	
	08300 HOSPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	8, 578, 917	21, 035, 028	29, 613, 94	5 0	29, 613, 945	89.00
00.00	NONREI MBURSABLE COST CENTERS		0				00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	1 02	0 0	0	
01 00	09100 BARBER AND BEAUTY SHOP	0	4,037	4, 03		4, 037 0	1
			0	1	0 0	0	1 72.00
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BECLASSIFICATION AND ADJUSTMET OF TRIAL BALANCE OF EXPINS: Provider No. : 315499 Percon (1/10/202) To 12/31/2021 Dercise To 10/10/2021 Dercise To 10/10/2021 <thdercise 10="" 2021<="" th="" to=""> Dercise To 10/2021</thdercise>	Heal th	Financial Systems	LI ONS	GATE		In Lieu	u of Form CMS-	2540-10
To 12/31/2021 Distor/Time Propared 7/12/2022 1:51 pr Cost Center Description Adjustments to Expenses (Fr Ws 18 A B) No. Espenses All coation (cut. 6 +- 0.00 Formation (cut. 6 +- 0.00 Formation (cut. 6 +- 0.00 1.00 001000 (An REL COST - ENTERS 0.000000 (An REL COST - ENTERS 0.0000000 (An REL COST - ENTERS 0.0000000 (An REL COST - ENTERS 0.000000 (An REL COST - ENTERS 0.00000 (An REL COST - ENTERS 0.00000 (An REL COST - ENTERS 0.00000 (An REL COST - ENTERS 0.000000 (Cost - IT AN CART - EDUCATION 0.00000 (Cost - IT AN CART - EDUCATION 0.000000 (Cost - IT AN CART - EDUCATION 0.000000 (Cost - IT AN CART - EDUCATION 0.0000000000 (IT REL COST - EDUCATERS 0.00000000 (IT REL COST - EDUCATER	RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315499		Worksheet A	
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44.00 04400 PHYSI CAL THERAPY 0 581,287 44.00 45.00 04500 0CUPATI ONAL THERAPY 0 383,692 45.00 45.00 04600 SPEECH PATHOLOGY 0 0 45.00 47.00 04700 ELECTROCARIO IOLOGY 0 0 47.00 48.00 ABOO MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 49.00 050.00 CLECTROCARIO IOLOGY 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 50.00 DSUDO DEVTAL CARE - TITLE XIX ONLY 0 0 0 50.00 000 DEVTAL CARE - TITLE XIX ONLY 0 0 0 60.00 0010 DUTPATIENT SERVICE COST CENTERS 0 0 0 60.00 0100 OTOOD (HWE HEALTH AGENCY COST 0 0 0 62.00 71.00 71.00 OTOOD (AWEAL HEALTH AGENCY COST 0 0 0 73.00 73.00 72.00 OSOOOD CLINC 0 0 0 82.00			0	-				
46.00 04000 SPEECH PATHOLOGY 0 110,066 46.00 47.00 04700 ELECTROCARDIOLOGY 0 0 47.00 48.00 04900 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 350,266 49.00 50.00 S000 DENTAL CARE - 1 TILE XIX ONLY 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 51.00 51.00 0000 CONTACT LET TS ERVICE COST CENTERS 0 0 0 60.00 00100 G100 RURAL HEALTH CLINIC 0 0 0 61.00 0100 G200 FOHC 0 0 0 61.00 0100 MURAL HEALTH AGENCY COST 0 0 70.00 70.00 71.00 OTOOL AMBULANCE 0 0 70.00 70.00 70.00 73.00 SPECI AL PURPOSE COST CENTERS 0 0 0 71.00 80.00 81.00 81.00 B300 OB300 INTERST ENDENSE 0 0 80.00 81.00 82.00 </td <td></td> <td></td> <td>0</td> <td>581, 287</td> <td></td> <td></td> <td></td> <td>44.00</td>			0	581, 287				44.00
47.00 64700 ELECTROCARDIOLOGY 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 48.00 59.00 04900 DRUCS CHARGED TO PATIENTS 0 350.266 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 60.00 06000 CLINIC 0 0 0 51.00 60.00 06000 CLINIC 0 0 0 60.00 61.00 61.00 06200 [F0HC 0 0 0 61.00 <td></td> <td></td> <td>0</td> <td></td> <td>1</td> <td></td> <td></td> <td>1</td>			0		1			1
48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 350, 266 49.00 50.00 DSOOD DENTAL CARE - TITLE XIX ONLY 0 0 51.00 50.00 0000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51.00 00100 ENTRE SUPPORT SURFACES 0 0 0 60.00 60.00 60.00 0000 OGOOD (LIN C 0 0 0 61.00 62.00 62.00 0100 PARE MBURSABLE COST CENTERS 0 0 0 62.00 62.00 07100 AMBULANCE 0 0 0 71.00 73.00 73.00 70.00 OTOOD HAURENEST EXPENSE 0 0 0 80.00 80.00 81.00 82.00 83.00 80.00 08200 UTILIZATION REVIEW - SNF 0 0 0 82.00 83.00 83.00 80.00 08300 HOSPICALS SUBTILS (SUBTICE CENTERS 0 0 0 83.00 <td< td=""><td></td><td></td><td>0</td><td></td><td>1</td><td></td><td></td><td>1</td></td<>			0		1			1
49.00 04900 DRUGS CHARGED TO PATIENTS 0 350, 266 49.00 50.00 DS000 DENTAL CARE - TI TLE XI X ONLY 0 0 50.00 50.00 51.00 DS100 SUPPORT SURFACCS 0 0 50.00 50.00 0UTPATI ENT SERVICE COST CENTERS 0 0 60.00 60000 CLINIC 0 60.00 60.00 06000 CLINIC 0 0 0 61.00 62			0	-				
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 50.00 50.00 51.00 51.00 51.00 51.00 51.00 60.00 70.00 70.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>				-				
51.00 05100 SUPPORT SURFACES 0 0 51.00 00 00000 CLINIC 0 0 60.00 60.00 60.00 06000 CLINIC 0 0 61.00 60.00 62.00 06200 FOHC 0 0 62.00 62.00 07000 FOME HEALTH AGENCY COST 0 0 0 62.00 0 071.00 O7000 FOME HEALTH AGENCY COST 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 71.00 73.00 C73000 CMHC 0 0 0 71.00 73.00 SPECIAL PURPOSE COST CENTERS 0 0 0 80.00 80.00 OBOOD MALPRACTI CE PREMI UMS & PAID LOSSES 0 0 80.00 81.00 81.00 08100 INTEREST EXPENSE 0 0 0 82.00 82.00 82.00 08200 UTI LIZATI ON REVIEW - SNF 0 0 0 82.00 83.00 89.00 82.00 83.00 </td <td></td> <td></td> <td>0</td> <td></td> <td>1</td> <td></td> <td></td> <td>1</td>			0		1			1
60.00 06000 CLINIC 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 61.00 62.00 06200 FOHC 62.00 62.00 62.00 62.00 01HER REIMBURSABLE COST CENTERS 0 0 70.00 70.00 70.00 70.00 07000 HOME HEALTH AGENCY COST 0 0 71.00 71.00 73.00 07300 CMC 0 0 71.00 73.00 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>51.00</td></td<>			0	0				51.00
61.00 06100 RURAL HEALTH CLINIC 0 0 61.00 62.00 0THER REI MBURSABLE COST CENTERS 0 0 62.00 62.00 0THO OTHOR HEALTH AGENCY COST 0 0 70.00 70.00 70.00 07000 HOME HEALTH AGENCY COST 0 0 71.00 71.00 73.00 07300 CMHC 0 0 71.00 73.00 SPECIAL PURPOSE COST CENTERS 0 0 73.00 80.00 80.00 80.00 08100 INTEREST EXPENSE 0 0 81.00 80.00 81.00 08100 INTEREST EXPENSE 0 0 81.00 82.00 83.00 08300 HOSPICE -1,902,772 27,711,173 89.00 89.00 SUBTOTALS (sum of lines 1-84) -1,902,772 27,711,173 89.00 90.00 09100 BARBER AND BEAUTY SHOP 0 4,037 91.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 92.00 92.00 09300 NONPAI D WORKER			1	1				
62.00 06200 FOHC 62.00 OTHER REI MBURSABLE COST CENTERS 70.00 O7000 HOME HEALTH AGENCY COST 0 0 71.00 O7100 AMBULANCE 0 0 71.00 73.00 73.00 O7300 CMHC 0 0 73.00 73.00 73.00 80.00 08100 IALPRACTI CE PREMI UMS & PAI D LOSSES 0 0 0 80.00 81.00 08100 INTEREST EXPENSE 0 0 81.00 82.00 82.00 08200 UTI LI ZATI ON REVIEW - SNF 0 0 82.00 83.00 08300 HOSPI CE 0 0 83.00 89.00 SUBTOTALS (sum of 1 i nes 1-84) -1, 902, 772 27, 711, 173 89.00 90.00 09000 GIFT, FLOWER, COFTER SHOPS & CANTEEN 0 0 91.00 91.00 09100 BARBER AND BEAUTY SHOP 0 4, 037 91.00 92.00 09300 NONPAI D WORKERS 0 0 93.00 93.00 93.00								1
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 70.00 70.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 73.00 71.00 73			0	0				
70.00 07000 HOME HEALTH AGENCY COST 0 0 70.00 71.00 07100 AMBULANCE 0 0 71.00 73.00 07300 CMHC 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 0 0 80.00 81.00 08100 INTEREST EXPENSE 0 0 81.00 82.00 08200 UTILIZATION REVIEW - SNF 0 0 82.00 83.00 08300 HOSPICE 0 0 83.00 89.00 SUBTOTALS (sum of Lines 1-84) -1,902,772 27,711,173 89.00 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 4,037 91.00 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 92.00 92.00 93.00 09300 NONPAI D WORKERS 0 0 92.00 93.00 94.00 94.00 95.00 <t< td=""><td>02.00</td><td></td><td></td><td></td><td> </td><td></td><td></td><td>02.00</td></t<>	02.00							02.00
73.00 OT300 CMHC 0 0 73.00 SPECIAL PURPOSE COST CENTERS 0 0 80.00 80.00 80.00 80.00 80.00 80.00 80.00 80.00 81.00 81.00 81.00 81.00 81.00 81.00 82.00 0.83.00 HSPECIAL S (sum of lines 1-84) -1,902,772 27,711,173 89.00 83.00 83.00 83.00 89.00 90.00 GUBTOTALS (sum of lines 1-84) -1,902,772 27,711,173 89.00 89.00 90.00	70.00		0	0				70.00
SPECIAL PURPOSE COST CENTERS 80.00 8000 MALPRACTICE PREMIUMS & PAID LOSSES 0 0 80.00 80.00 80.00 80.00 80.00 80.00 80.00 80.00 80.00 81.00 80.00 81.00 82.00 81.00 82.00 83.00 81.00 81.00 81.00 81.00 81.00 81.00 81.00 81.00 81.00 81.00 81.00 81.00	71.00	07100 AMBULANCE	0	0				71.00
80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 0 0 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) -1,902,772 27,711,173 89.00 NORREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 4,037 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 92.00 93.00 000 NONPAI D WORKERS 0 0 93.00 94.00 09400 PATI ENTS LAUNDRY 0 0 94.00 95.00 09500 ALU/I LU 0 2,465,037 95.00	73.00		0	0				73.00
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) -1,902,772 27,711,173 89.00 NONRET IMBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 4,037 91.00 92.00 092000 PHYSI CI ANS PRI VATE OFFI CES 0 0 92.00 93.00 09300 NONPAI D WORKERS 0 0 93.00 94.00 09400 PATI ENTS LAUNDRY 0 0 94.00 95.00 09500 ALU/I LU 0 2,465,037 95.00	00.00							00.00
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) -1,902,772 27,711,173 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 4,037 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 92.00 93.00 00000 NONPAI D WORKERS 0 0 93.00 93.00 94.00 09400 PATI ENTS LAUNDRY 0 0 94.00 95.00 2,465,037 95.00			0	-	1			
83.00 08300 HOSPI CE 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) -1,902,772 27,711,173 89.00 NONREL MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 4,037 91.00 92.00 09200 PHYSI CLANS PRI VATE OFFICES 0 0 92.00 93.00 09300 NONPAI D WORKERS 0 0 93.00 94.00 09400 PATI ENTS LAUNDRY 0 0 94.00 95.00 09500 ALU/I LU 0 2,465,037 95.00				-				1
89.00 SUBTOTALS (sum of lines 1-84) -1,902,772 27,711,173 89.00 NONREL MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 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 91.00 91.00 91.00 91.00 92.00 92.00 94.00 93.00 00NPAI D WORKERS 0 0 93.00 93.00 94.00 95.00 95.00 4LU/I LU 0 2,465,037 95.00 95.00			0	-				
90. 00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 93. 00 000 92. 00 93. 00 93. 00 93. 00 93. 00 93. 00 93. 00 93. 00 93. 00 93. 00 94. 00 95. 00 000 000 94. 00 95. 00			-1, 902, 772	27, 711, 173				
91.00 09100 BARBER AND BEAUTY SHOP 0 4,037 91.00 92.00 92.00 92.00 92.00 93.00 00300 NONPAI D WORKERS 0 0 93.00 93.00 94.00 94.00 95.00<		NONREIMBURSABLE COST CENTERS	1		1			
92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 92.00 93.00 94.00 95.00<			0	0				
93. 00 09300 NONPAI D WORKERS 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 94. 00 94. 00 94. 00 95. 00 95. 00 09500 ALU/I LU 0 2, 465, 037 95. 00 95. 00			0	4,037				
94. 00 09400 PATI ENTS LAUNDRY 0 0 94. 00 94. 00 95. 00 95. 00 0 2, 465, 037 95. 00<								
95.00 09500 ALU/I LU 0 2,465,037 95.00			0	0				
			0	2, 465, 037				
	100.00	TOTAL	-1, 902, 772					100.00

Health Financial Systems	LIONS GATE		In Lieu of Form CMS-2540-1			
RECLASSI FI CATI ONS	Provi der		Period: From 01/01/2021	Worksheet A-6		
			Го 12/31/2021	Date/Time Pre 7/1/2022 1:51	pared: _pm	
		Increases				
	Cost Center	Line #	Sal ary	Non Salary		
	2.00	3.00	4.00	5.00		
(1) A - TO RECLASS THERAPY		_				
1.00	OXYGEN (INHALATION) THERAPY	43.0	54, 497	8, 674	1.00	
2.00	OCCUPATI ONAL THERAPY	45.0	331, 006	52, 686	2.00	
3.00	SPEECH PATHOLOGY	46.0	94, 952	15, 114	3.00	
TOTALS						
100. 00	Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		480, 455	76, 474	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	LI ONS GATE			In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2021	Worksheet A-6	
				To 12/31/2021	Date/Time Pre 7/1/2022 1:51	
			Decreases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
(1) A - TO RECLASS THERAPY			_			
1.00	PHYSI CAL THERAPY		44. (480, 455	76, 474	1.00
2.00			0.0	0 0	0	2.00
3.00			0.0	0 0	0	3.00
TOTALS			•			
100.00				480, 455	76, 474	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.

	n Financial Systems	LIONS			In Lieu of Form CMS-2540			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315499	Period: From 01/01/2021	Worksheet A-7		
					To 12/31/2021		nared	
					10 12/31/202	7/1/2022 1:51	pm pm	
				Acqui si ti on	S			
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and		
		Bal ances				Retirements		
		1.00	2.00	3.00	4.00	5.00		
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALAN					1		
1.00	Land	6, 360, 288			0 0	0	1.00	
2.00	Land Improvements	1, 390, 910			0 38, 445		2.00	
3.00	Buildings and Fixtures	87, 445, 804	1, 028, 413		0 1, 028, 413		3.00	
4.00	Building Improvements	0	0		0 0	0 0	4.00	
5.00	Fixed Equipment	10, 016, 217	278, 019		0 278, 019		5.00	
6.00	Movable Equipment	1, 639, 751	4, 982		0 4, 982		6.00	
7.00	Subtotal (sum of lines 1-6)	106, 852, 970	1, 349, 859		0 1, 349, 859		7.00	
8.00	Reconciling Items	0	0		0 (0	8.00	
9.00	Total (line 7 minus line 8)	106, 852, 970			0 1, 349, 859	0	9.00	
	Description	Endi ng	Fully					
		Bal ance	Depreciated					
		6,00	Assets 7.00					
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALAN		7.00					
1.00	Land	6, 360, 288	0				1.00	
2.00	Land Improvements	1, 429, 355					2.00	
2.00	Buildings and Fixtures	88, 474, 217	0				3.00	
4.00	Building Improvements	00, 474, 217	0				4.00	
4.00 5.00	Fixed Equipment	10, 294, 236	0				5.00	
6.00	Movable Equipment	1, 644, 733	0				6.00	
7.00	Subtotal (sum of lines 1-6)	108, 202, 829					7.00	
8.00	Reconciling Items	00,202,029	0				8.00	
9.00	Total (line 7 minus line 8)	108, 202, 829	0				9.00	
7. 50		100,202,027	0	1			1 7.00	

	Financial Systems MENTS TO EXPENSES	LIONS G		No.: 315499	Period:	eu of Form CMS-2 Worksheet A-8	
5031	WENTS TO EXPENSES		FIOVICE	10515499	From 01/01/2021		
					To 12/31/2021	Date/Time Pre 7/1/2022 1:51	pare pm
					lassification on	Worksheet A	
				To/From Whic	ch the Amount is	to be Adjusted	
	Description (1)	(2) Basis	Amount	Cost	t Center	Line No.	
		For Adjustment					
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds	В	-1, 463, 199	CAP REL COST		1.00	1
00	(chapter 2) Trade, quantity, and time discounts (chapter		0	FIXTURES		0.00	2
50	8)		0			0.00	2
00	Refunds and rebates of expenses (chapter 8)		0			0.00	3
00	Rental of provider space by suppliers		0			0.00	4
00	(chapter 8) Telephone services (pay stations excluded)	В	-14 663	ADMI NI STRATI	VE & GENERAL	4.00	5
00	(chapter 21)	D	14,003		VE & GENERAE	4.00	
00	Television and radio service (chapter 21)	В	-17,047		ION, MAINT. &	5.00	6
00	Parking lot (chapter 21)		0	REPAI RS		0.00	7
00	Remuneration applicable to provider-based	A-8-2	0			0.00	8
	physician adjustment		-				
00	Home office cost (chapter 21)		0			0.00	
. 00 . 00	Sale of scrap, waste, etc. (chapter 23) Nonallowable costs related to certain		0			0.00	
. 00	Capital expenditures (chapter 24)		0			0.00	''
. 00	Adjustment resulting from transactions with	A-8-1	0				12
~~	related organizations (chapter 10)		0			0.00	
. 00 . 00	Laundry and linen service Revenue – Employee meals	В	-57 159	DI ETARY		0.00	
	Cost of meals - Guests	D	-37, 139			0.00	
00	Sale of medical supplies to other than		0			0.00	16
00	patients		0			0.00	17
00 00	Sale of drugs to other than patients Sale of medical records and abstracts		0			0.00	
00	Vendi ng machi nes		0			0.00	
. 00	Income from imposition of interest, finance		0			0.00	20
~~	or penalty charges (chapter 21)		0			0.00	
. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21
	overpayments						
. 00	Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	REVIEW - SNF	82.00	22
00	(chapter 21)		0			1 00	
. 00	Depreciationbuildings and fixtures			CAP REL COST FIXTURES	S - BLDGS &	1.00	23
. 00	Depreciationmovable equipment			CAP REL COST	S - MOVABLE	2.00	24
				EQUI PMENT			
00	NON-ALLOWABLE EXPENSES	A			VE & GENERAL	4.00	
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B			VE & GENERAL	4.00	
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B		EMPLOYEE BEN DIETARY		3.00	
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В		CAP REL COST	S - BLDGS &	1.00	
		-		FIXTURES	- 52550 u		_
	Total (sum of lines 1 through 99) (Transfer		-1, 902, 772	1		1	100

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

	Financial Systems	LIONS (GATE				u of Form CMS-2	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315499		eri od:	Worksheet B	
					TC	om 01/01/2021 12/31/2021	Part I Date/Time Pre	pared.
						, 12,01,2021	7/1/2022 1:51	pm
			CAPI TAL REL	_ATED COSTS				
			DI DOO					
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE		EMPLOYEE	Subtotal	
		for Cost Allocation	FI XTURES	EQUI PMENT		BENEFITS		
		(from Wkst A						
		col. 7)						
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	5, 220, 953	5, 220, 953					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0			0		l	2.00
3.00	00300 EMPLOYEE BENEFITS	2, 263, 992	0		0	2, 263, 992		3.00
4.00	00400 ADMINI STRATI VE & GENERAL	3, 058, 547	0		0	324, 715	3, 383, 262	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	2, 797, 931	0		0	98, 468	2, 896, 399	
6.00	00600 LAUNDRY & LINEN SERVICE	258, 075	0		0	0	258, 075	1
7.00	00700 HOUSEKEEPI NG	1, 123, 693	0		0	0	1, 123, 693	
8.00	00800 DI ETARY	4, 210, 127	0		0	1, 240	4, 211, 367	
9.00	00900 NURSI NG ADMI NI STRATI ON	332, 345	0		0	73, 117	405, 462	
10.00	01000 CENTRAL SERVICES & SUPPLY	290, 747	0		0	0	290, 747	
11.00	01100 PHARMACY	31, 291	0		0	0	31, 291	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	0	
13.00	01300 SOCIAL SERVICE	138, 687	0		0	30, 310	168, 997	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	
15.00	01500 ACTI VI TI ES	731, 693	0		0	123, 242	854, 935	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 SKILLED NURSING FACILITY	5, 668, 271	977, 493		0	1, 023, 133	7, 668, 897	
31.00	03100 NURSING FACILITY	0	0		0	0	0	
32.00	03200 CF/I D	0	0		0	0	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	0	33.00
	ANCILLARY SERVICE COST CENTERS							
40.00	04000 RADI OLOGY	32, 396	0		0	0	32, 396	
41.00	04100 LABORATORY	62, 283	0		0	0	62, 283	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	64, 831	0		0	12, 010		
44.00	04400 PHYSI CAL THERAPY	581, 287	0		0	110, 514	691, 801	
45.00	04500 OCCUPATI ONAL THERAPY	383, 692	0		0	72, 947	456, 639	
46.00	04600 SPEECH PATHOLOGY	110, 066	0		0	20, 926	130, 992	
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	1
49.00	04900 DRUGS CHARGED TO PATIENTS	350, 266	0		0	0	350, 266	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	1
51.00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	51.00
60.00	06000 CLINIC	0	0		0	0	0	60.00
60.00	06100 RURAL HEALTH CLINIC	0	0		0	0		1
61.00	06200 FQHC	0	0		U	0	0	62.00
02.00	OTHER REIMBURSABLE COST CENTERS							02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
71.00	07100 AMBULANCE	0	0		0	0	0	1
73.00	07300 CMHC	0	0		0	0	0	
73.00	SPECIAL PURPOSE COST CENTERS	0	0		U	0	0	/3.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	1						80.00
80.00								
	08100 I NTEREST 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
89.00	SUBTOTALS (sum of lines 1-84)	27, 711, 173	977, 493		0 0	1, 890, 622		
07.00	NONREIMBURSABLE COST CENTERS	27,711,173	777,473		U	1, 090, 022	23, 074, 343	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	4,037	0		0	0	0 4, 037	
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	4,037	0		0	0		1
92.00 93.00	09300 NONPALD WORKERS		0		0	0	0	1
	09400 PATIENTS LAUNDRY		0		0	0	0	
		0	0		0	0		1
94.00		2 4/5 007	1 212 1/0			וחדר רדר		
94.00 95.00	09500 ALU/I LU	2, 465, 037	4, 243, 460		0	373, 370		
94.00 95.00 98.00	09500 ALU/ILU Cross Foot Adjustments	2, 465, 037 0	4, 243, 460 0		0	373, 370 0	0	98.00
94.00 95.00	09500 ALU/ILU Cross Foot Adjustments Negative Cost Centers	2, 465, 037 0 0 30, 180, 247	4, 243, 460 0 0 5, 220, 953		0 0 0	373, 370 0 2, 263, 992	0 0	98.00 99.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	LIONS			Period:	u of Form CMS-2 Worksheet B	2040-10
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 7/1/2022 1:51	
	Cost Center Description	ADMI NI STRATI V E & 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	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAINT. & REPAIRS 00600 LAUNDRY & LI NEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	3, 383, 262 365, 685 32, 583 141, 872 531, 706 51, 192	3, 262, 084 0 0 0 0 0 0	290, 658 () ()	3 0 1, 265, 565 0 0 0 0	4, 743, 073 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	36, 708	0		0	0	1
12.00 13.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	3, 951 0 21, 337	0			0	11.00 12.00 13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15.00	01500 ACTIVITIES	107, 940	0	(0 0	0	15.00
30, 00	I NPATIENT ROUTINE SERVICE COST CENTERS	968, 244	610, 744	214, 50	384, 786	2, 707, 469	30.00
31.00	03100 NURSI NG FACI LI TY	0	010,711		0 0	0	31.00
32.00	03200 I CF/I I D	0	0		0 0	0	32.00
33.00	O3300 OTHER LONG TERM CARE	0	0	(0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	4,090	0		0 0	0	40.00
41.00	04100 LABORATORY	7, 864	0			0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	9, 702	0		0 0	0	
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	87, 343 57, 653	0			0	44.00 45.00
46.00	04600 SPEECH PATHOLOGY	16, 538	0			0	45.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	44, 223	0		0 0	0	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0			0	50.00 51.00
51.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	1	0	0	51.00
60.00	06000 CLINIC	0	0	(0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	(0 0	0	61.00
62.00	06200 FOHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	0		0 0		
73.00	07300 CMHC	0	0	(0 0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS	1		1			
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF						82.00
83.00	08300 HOSPI CE	0	0	(0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	2, 488, 631	610, 744	214, 50	5 384, 786	2, 707, 469	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP	510	0			0	
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0			0	
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	(0 0	0	94.00
95.00 98.00	09500 ALU/ILU Cross Foot Adjustments	894, 121 0	2,651,340	76, 15	2 880, 779 0 0	2, 035, 604 0	95.00 98.00
98.00 99.00	Negative Cost Centers	0				0	
100.00	S S	3, 383, 262	3, 262, 084	290, 65	1, 265, 565		
				-		· · · · · ·	-

Heal th	Financial Systems	LIONS	GATE		In Lie	u of Form CMS-	2540-10
	ALLOCATION - GENERAL SERVICE COSTS			No.: 315499	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 7/1/2022 1:51	epared:
	Cost Center Description	NURSING ADMINISTRATIO N	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 1		1			1 1 00
1.00 2.00 3.00 4.00 5.00 6.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						1.00 2.00 3.00 4.00 5.00 6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION	456, 654					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	327, 455				10.00
11.00	01100 PHARMACY	0	0	35, 2			11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0	0		0 0	100 224	12.00
13.00 14.00		0	0		0 0 0 0	190, 334 0	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	0		0 0 0 0	0	
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	1	0 0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	456, 654	327, 455	35, 2	42 0	190, 334	30.00
31.00	03100 NURSING FACILITY	0	027,100		0 0	0	
32.00	03200 CF/I D	0	0		0 0	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	
	ANCILLARY SERVICE COST CENTERS				L		
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	
44.00	04400 PHYSI CAL THERAPY	0	0		0 0	0	
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	0	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	
01.00	OUTPATI ENT SERVICE COST CENTERS						01.00
60.00	06000 CLINIC	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	0	1	0 0	0	
73.00	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS	1 1		1			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF	0	0		0	0	82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 456, 654	0 327, 455		0 0 42 0	0 190, 334	
69.00	NONREIMBURSABLE COST CENTERS	450, 054	527,400	J 35, Z	42 0	190, 334	09.00
90 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	
92.00		0	0		0 0	0	
93.00		0	0		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	0	1	0 0	0	
95.00		0	0		0 0	0	
98.00	Cross Foot Adjustments	0	0				98.00
99.00	Negative Cost Centers	0	0		0 0	0	
100.00	D TOTAL	456, 654	327, 455	35, 2	42 0	190, 334	100.00

Heal th	Financial Systems	LI ONS	GATE		In Lie	u of Form CMS-	2540-10
	LLOCATION - GENERAL SERVICE COSTS			No.: 315499	Period: From 01/01/2021	Worksheet B	
					To 12/31/2021		epared:
			OTHER GENERAL			17772022 1.31	
	Cost Center Description	NURSING AND	SERVICE ACTIVITIES	Subtotal	Post Stepdown	Total	
	cost center bescription	ALLI ED HEALTH		Subtotal	Adjustments	Total	
		EDUCATI ON	15.00	1(00	17.00	10.00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	18.00	
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
4.00	00400 ADMINI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						6.00 7.00
8.00	00800 DI ETARY						8.00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY						9.00 10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0					13.00 14.00
15.00	01500 ACTI VI TI ES	0	962, 875				15.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	528, 176	14, 092, 50	07 0	14, 092, 507	30.00
31.00	03100 NURSI NG FACI LI TY	0			0 0		1
32.00	03200 ICF/IID	0			0 0		
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	1	0 0	0	33.00
40.00	04000 RADI OLOGY	0					1
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	70, 14	47 O 0 O		1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	86, 54		, s	1
44.00	04400 PHYSI CAL THERAPY	0	0				1
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY						1
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0			0 0 39 0	0 394, 489	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			0 0		1
51.00	05100 SUPPORT SURFACES	0	C		0 0	0	51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	C	1	0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0			0 0		61.00
62.00	06200 FOHC OTHER REIMBURSABLE COST CENTERS						62.00
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0			0 0	-	71.00
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	1	0 0	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						81.00 82.00
83.00	08300 HOSPI CE	0	o		0 0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	0	528, 176	16, 121, 13	38 0	16, 121, 138	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	1	0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0		4, 54		4, 547	91.00
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		0 0	0	1
93.00 94.00	09400 PATIENTS LAUNDRY		0		0 0		1
95.00	09500 ALU/I LU	0	434, 699	14, 054, 50	52 0		
98.00 99.00	Cross Foot Adjustments Negative Cost Centers					0	1
100.00	5	0	962, 875	30, 180, 24	47 0		

Heal th	Financial Systems	LIONS	GATE			In Lie	u of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315499		eriod: com 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 7/1/2022 1:51	pared:
			CAPI TAL REL	ATED COSTS				
	Cost Center Description	Directly Assigned New Capital	BLDGS & FI XTURES	MOVABLE EQUI PMENT		Subtotal	EMPLOYEE BENEFI TS	
		Related Costs 0	1.00	2.00	-	2A	3.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES							1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0		~		0	2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	0	0		0	0	0 0	3.00 4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	0		0	0	0	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	0		0	0	0	6.00
7.00	00700 HOUSEKEEPING	0	0		0	0	0	7.00
8.00	00800 DI ETARY	0	0		0	0	0	8.00
9.00	00900 NURSING ADMINISTRATION	0	0		0	0	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	0	10.00
11.00	01100 PHARMACY	0	0		0	0	0	11.00
	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	0	12.00
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	0	13.00
	01500 ACTIVITIES	0	0		0	0	0	15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	<u> </u>	0	V	0	15.00
30.00	03000 SKILLED NURSING FACILITY	0	977, 493		0	977, 493	0	30.00
31.00	03100 NURSING FACILITY	0	0		0	0	0	31.00
	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
40.00	ANCI LLARY SERVICE COST CENTERS				0			1 40 00
	04000 RADI OLOGY 04100 LABORATORY	0	0		0 0	0	0	40.00
	04200 INTRAVENOUS THERAPY	0	0		0	0	0	41.00
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
	04600 SPEECH PATHOLOGY	0	0		0	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47.00
	04800 MEDICAL 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	0	49.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
011.00	OUTPATI ENT SERVICE COST CENTERS	<u> </u>						
60.00	06000 CLI NI C	0	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	0	61.00
62.00	06200 FQHC							62.00
70 00	OTHER REIMBURSABLE COST CENTERS		0		0	0	0	70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0 0		0 0	0	0	
	07300 CMHC	0	0		0	0	0	
/01/00	SPECIAL PURPOSE COST CENTERS	<u> </u>						1 101 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES				Т			80.00
	08100 INTEREST EXPENSE							81.00
	08200 UTILIZATION REVIEW - SNF							82.00
	08300 HOSPI CE	0	0		0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	977, 493		0	977, 493	0	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0		0	90.00
	09100 BARBER AND BEAUTY SHOP		0		0	0	0	90.00
	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0	0	0	
	09300 NONPAI D WORKERS	0	0		0	Ō	0	
	09400 PATIENTS LAUNDRY	0	0		0	0	0	
	09500 ALU/I LU	0	4, 243, 460		0	4, 243, 460	0	
98.00	Cross Foot Adjustments					0		98.00
99.00	Negative Cost Centers		0 E 000 050		0	E 220 052	0	
100.00	TOTAL	0	5, 220, 953	l	0	5, 220, 953	0	100.00

	Financial Systems	LIONS					u of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi	der	No.: 315499	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 7/1/2022 1:51	
	Cost Center Description	ADMI NI STRATI V E & GENERAL	PLANT OPERATI O MAI NT REPAI RS	N, &	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG E	DI ETARY	
		4.00	5.00		6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	r						
13.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0	9.00 10.00 11.00 12.00 13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0		0		0 0	0	
15.00	01500 ACTI VI TI ES	0		0		0 0	0	15.00
31.00 32.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0 0		0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0	31.00 32.00
40 00	ANCI LLARY SERVI CE COST CENTERS	0		0		0 0	0	40.00
41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 05000 DRUGS CHARGED TO PATI ENTS 05000 DENTAL CARE - TI TLE XI X ONLY 05100 SUPPORT SURFACES 0UTPATI ENT SERVI CE COST CENTERS							41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00
	06000 CLINIC	0		0		0 0	0	
	06100 RURAL HEALTH CLINIC 06200 FQHC OTHER REIMBURSABLE COST CENTERS	0		0		0 0	0	61.00 62.00
	07000 HOME HEALTH AGENCY COST	0		0		0 0	0	
	07100 AMBULANCE 07300 CMHC	0		0		0 0	0	
80. 00 81. 00 82. 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)	0		0		0 0 0 0 0 0	0	80.00 81.00 82.00 83.00
91.00 92.00 93.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CI ANS PRI VATE OFFI CES 09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY 09500 ALU/I LU Cross Foot Adj ustments Negati ve Cost Centers TOTAL			0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	91.00 92.00 93.00 94.00 95.00 98.00

	Financial Systems	LIONS		No 1215400		u of Form CMS-	2540-10
ALLOC.	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315499	Period: From 01/01/2021 To 12/31/2021		epared: 1_pm
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	1 1		1		1	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LI NEN SERVI CE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0				10.00
11.00	01100 PHARMACY	0	0		0		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0 0	_	12.00
13.00	01300 SOCIAL SERVICE	0	0		0 0	C	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0		
15.00	01500 ACTI VI TI ES I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	1	0 0	C	15.00
30.00	03000 SKILLED NURSING FACILITY	0	0	1	0 0	C	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	-	
32.00	03200 CF/I D	0	0		0 0		
33.00		0	0		0 0		
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0		0 0	C	40.00
41.00	04100 LABORATORY	0	0		0 0		
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	C	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	C	
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0		0 0		
45.00	04600 SPEECH PATHOLOGY	0	0				
47.00		0	0		0 0		
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ő		0 0		
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	C C	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	c c	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	C	51.00
	OUTPATIENT SERVICE COST CENTERS	1		1			
60.00	06000 CLINIC	0	0		0 0		
61.00	06100 RURAL HEALTH CLINIC 06200 F0HC	0	0		0 0	C	
62.00	OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	C	70.00
71.00	07100 AMBULANCE	0	0		0 0		
73.00	07300 CMHC	0	Ő		0 0		
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00							81.00
82.00							82.00
83.00		0	0		0 0		
89.00		0	0	1	0 0	C	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	1	0 0	C	90.00
90.00		0	0		0 0		1
92.00		0	0		0 0		
93.00		0	0		0 0		
94.00		0	0		0 0		
95.00		0	0		0 0	C	
98.00		0	0		0		98.00
99.00		0	0		0 0		
100.0	DITOTAL	0	0	1	0 0	I C	100.00

Heal th	Financial Systems	LIONS	GATE				In Lie	u of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS	_		Provi der	No.: 315499		riod: om 01/01/2021 12/31/2021	Worksheet B Part II Date/Time Pr 7/1/2022 1:5	
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	ACT	R GENERAL RVI CE I VI TI ES	Subtotal		Post Step-Down Adjustments	Total	
	GENERAL SERVICE COST CENTERS	14.00	1	5.00	16.00		17.00	18.00	_
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES								1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY								2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00 11.00 12.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0							8.00 9.00 10.00 11.00 12.00 13.00 14.00
15.00	01500 ACTI VI TI ES	0		0					15.00
	INPATIENT ROUTINE SERVICE COST CENTERS				077.4	00		077.40	
30.00 31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	1	0 0		93 0	0	977, 493	
32.00	03200 CF/I D	0		0		0	0	(
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0		0		0	0	(33.00
40.00	04000 RADI OLOGY	0		0		0	0	(40.00
41.00	04100 LABORATORY	0	0	0		0	0	(
42.00 43.00	04200 INTRAVENOUS THERAPY	0	2	0		0 0	0	(
43.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY			0		0	0	(
45.00	04500 OCCUPATI ONAL THERAPY	0		0		0	0	(
46.00	04600 SPEECH PATHOLOGY	0		0		0	0	(46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0		0	0	(
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2	0		0	0	(
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0		0 0		0 0	0	(
51.00	05100 SUPPORT SURFACES	0		0		0	0	(
	OUTPATIENT SERVICE COST CENTERS								
60.00	06000 CLINIC	0	•	0		0	0	(
61.00 62.00	06100 RURAL HEALTH CLINIC	0		0		0	0	(61.00
02.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS		1						02.00
70.00	07000 HOME HEALTH AGENCY COST	0)	0		0	0	(70.00
	07100 AMBULANCE	0		0		0	0		71.00
73.00	07300 CMHC	0		0		0	0	(73.00
00 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	1	1		1				80.00
81.00									81.00
	08200 UTILIZATION REVIEW - SNF								82.00
	08300 HOSPI CE	0	1	0		0	0		83.00
89.00	SUBTOTALS (sum of lines 1-84)	0		0	977, 4	93	0	977, 493	89.00
00 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0		0	0	(90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP	0		0		0	0		90.00
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0		0		0	0		92.00
93.00	09300 NONPAID WORKERS	0)	0		0	0	(
94.00	09400 PATIENTS LAUNDRY	0	2	0	4 040 4	0	0	4 242 444	
95.00 98.00	09500 ALU/ILU Cross Foot Adjustments	0		0	4, 243, 4	00	0	4, 243, 460) 95.00) 98.00
98.00 99.00	Negative Cost Centers			0		0	0		98.00
100.00		0		0		53	0	5, 220, 953	
			•				'		

	Financial Systems LLOCATION - STATISTICAL BASIS	LIONS			eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 7/1/2022 1:51	
		CAPI TAL RE	LATED COSTS				p
	Cost Center Description	BLDGS & FI XTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFI TS (GROSS SALARI ES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM COST)	
		1.00	2.00	3.00	4A	4.00	
1.00	GENERAL SERVICE COST CENTERS	400,000		1		1	1.00
2.00 3.00 4.00	00200 CAP REL COSTS - BEDGS & TEXTORES 00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFI TS 00400 ADMI NI STRATI VE & GENERAL	400,000	0	10, 273, 127 1, 473, 431	-3, 383, 262	26, 796, 985	2.00 3.00 4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	0	446, 808		2, 896, 399	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	0	0	0	258, 075	6.00
7.00	00700 HOUSEKEEPI NG	0	0	0	0	1, 123, 693	7.00
8.00	00800 DI ETARY	0	0	5, 628		4, 211, 367	8.00
9.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0		331, 775	0	405, 462	9.00
	01100 PHARMACY				0	290, 747 31, 291	10.00
	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
	01300 SOCI AL SERVI CE	0	0	137, 536	0	168, 997	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TI ES	0	0	559, 225	0	854, 935	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	74.000		4 (4 2 5 0 1	0	7 ((0 0 0 7	20.00
	03100 NURSING FACILITY	74, 890			0		30.00 31.00
	03200 CF/I D	0		-		-	32.00
	03300 OTHER LONG TERM CARE	0	-			-	33.00
	ANCILLARY SERVICE COST CENTERS	1	1	1	1	1	
	04000 RADI OLOGY	0	0	0	0	32, 396	40.00
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	62, 283	41.00
	04300 OXYGEN (INHALATION) THERAPY			54, 497		76, 841	42.00
	04400 PHYSI CAL THERAPY	0	0	501, 468	0	691,801	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	331,006	0	456, 639	45.00
	04600 SPEECH PATHOLOGY	0	0	94, 952	0	130, 992	46.00
	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00 49.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0		0	0	0 350, 266	48.00 49.00
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY			0	0	350, 200	50.00
51.00	05100 SUPPORT SURFACES	0	0			-	51.00
	OUTPATIENT SERVICE COST CENTERS		1				
	06000 CLINIC	0	-				60.00
	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100 AMBULANCE	0	0	0	0	0	
73.00	07300 CMHC	0	0	0	0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS	1	1	1	1	1	00.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
	08200 UTILIZATION REVIEW - SNF						82.00
	08300 HOSPI CE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	74, 890	0	8, 578, 917	-3, 383, 262	19, 711, 081	89.00
00.00	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		0		0	0 4, 037	
	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	
	09300 NONPAI D WORKERS	0	0	0	0	0	
	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
	09500 ALU/I LU	325, 110	0	1, 694, 210	0	7, 081, 867	95.00
98.00	Cross Foot Adjustments						98.00
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	5, 220, 953	0	2, 263, 992		3, 383, 262	99.00
102.00	Part I)	5, 220, 900		2,203,792		5, 505, 202	102.00
103.00		13. 052383	0. 000000	0. 220380		0. 126255	103.00
104.00	Cost to be allocated (per Wkst. B,			0			104.00
105 00	Part II)			0.000000		0.000000	105 00
105.00	Unit cost multiplier (Wkst. B, Part II)			0. 000000		0.000000	105.00
	1 1	I	I	1	I.	I	1

	Financial Systems	LIONS		N. 045400		u of Form CMS-2	
CUST A	LLOCATION - STATISTICAL BASIS		Provider	F	Period: From 01/01/2021 Fo 12/31/2021		pared:
	Cost Center Description	PLANT OPERATI ON, MAI NT. & REPAI RS (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (COSTED REQ UI S)	DI ETARY (MEALS SERVED)	7/1/2022 1:51 NURSI NG ADMI NI STRATI O N (DI RECT NRS G HRS)	pm
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	400,000 0 0 0 0 0 0 0 0 0 0	956, 300 0 0 0 0 0 0 0 0	900, 744 ((((((((4 0 171, 152 0 0 0 0 0 0 0 0 0 0 0 0	152, 196 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0 0	0	14.00
15.00	01500 ACTI VI TI ES	0	0		0 0	0	15.00
31.00 32.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	74, 890 0 0 0	705, 749 0 0 0	(152, 196 0 0 0	30.00 31.00 32.00 33.00
	ANCILLARY SERVICE COST CENTERS	1		1			
41.00 42.00 43.00 44.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0 0 0 0 0 0	0 0 0 0 0 0			0 0 0 0 0 0	40.00 41.00 42.00 43.00 44.00 45.00
47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0 0 0	46.00 47.00 48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY				-	0	49.00 50.00
	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	ט וי	0	51.00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC	0	0			0	60.00 61.00 62.00
	OTHER REIMBURSABLE COST CENTERS	1	1	1	11		
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	
73.00	07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	-	0 0 0 0	0	
80.00 81.00 82.00 83.00 89.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 74, 890	0 705, 749	(273, 865	0 0 5 97, 698	0 152, 196	
90.00	NONREI MBURSABLE COST CENTERS 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	(0	90.00 91.00
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0			0	92.00 93.00
	09400 PATIENTS LAUNDRY 09500 ALU/ILU Cross Foot Adjustments Negative Cost Centers	0 325, 110	0 250, 551	626, 879	0 0 9 73, 454	0	94.00 95.00 98.00 99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	3, 262, 084				456, 654	102.00
103. 00 104. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	8. 155210 0	0. 303940 0	1. 405022	2 27.712636 0 0	3. 000434 0	103. 00 104. 00
105.00		0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	105.00

	Financial Systems LLOCATION - STATISTICAL BASIS	LIONS		No.: 315499 F	In Lie Period:	u of Form CMS-2 Worksheet B-1	
CUST A	LLUUNIIUN - SIMIISIIUAL DASIS		FI OVI del'	F	From 01/01/2021 5 0 12/31/2021	Date/Time Pre	epared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQ UI S)	PHARMACY (COSTED REQ UIS)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCI AL SERVI CE (TI ME SPENT)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	290, 747 0 0 0 0 0	100 0 0 0 0	(3, 891	0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	<u> </u>	0	0	15.00
31.00	03000 SKI LLED NURSI NG FACI LI TY 03100 NURSI NG FACI LI TY 03200 I CF/I I D	290, 747 0 0	100 0 0			0 0 0	31.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	o	0		0 0	0	40.00
	04100 LABORATORY	0	0			-	
	04200 I NTRAVENOUS THERAPY	0	0	(-	0	
	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0	0			0	1
	04500 OCCUPATI ONAL THERAPY	Ō	0	0	0 0	0	
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0	(0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0			0	1
	OUTPATIENT SERVICE COST CENTERS	Q	0		<u> </u>	0	51.00
	06000 CLINIC	0		(
	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0	0	61.00 62.00
	OTHER REIMBURSABLE COST CENTERS					<u>.</u>	02.00
	07000 HOME HEALTH AGENCY COST	0	0				1
	07100 AMBULANCE 07300 CMHC	0	0			-	71.00
	SPECIAL PURPOSE COST CENTERS			1			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
	08200 UTILIZATION REVIEW - SNF						82.00
	08300 HOSPI CE	0	0	(0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	290, 747	100	[(3, 891	0	89.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0 0	0	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	1
	09300 NONPALD WORKERS	0	0			0	
	09400 PATIENTS LAUNDRY	0	0	(0 0	0	
95.00 98.00	09500 ALU/ILU Cross Foot Adjustments	0	0		0	0	95.00 98.00
99.00 99.00	Negative Cost Centers						99.00
102.00		327, 455	35, 242	0	190, 334	0	102.00
103.00 104.00		1. 126254 0	352. 420000 0	0. 000000	48. 916474 0 0		103.00 104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	105.00

	Financial Systems	LIONS GATE			u of Form CMS-	
COSTA	LLOCATION - STATISTICAL BASIS		Provider No.: 315499	Period: From 01/01/2021	Worksheet B-1	
				To 12/31/2021	Date/Time Pre 7/1/2022 1:51	
		OTHER GENERAL				
	Cost Center Description	SERVICE ACTIVITIES				
	cost center bescription	(TIME SPENT)				
		15.00				
1 00	GENERAL SERVICE COST CENTERS					1 1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT					1.00 2.00
3.00	00300 EMPLOYEE BENEFITS					3.00
4.00	00400 ADMI NI STRATI VE & GENERAL					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG					6.00 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 01200 MEDICAL RECORDS & LIBRARY					11.00
	01300 SOCIAL SERVICE					12.00
	01400 NURSING AND ALLIED HEALTH EDUCATION					14.00
15.00	01500 ACTI VI TI ES	28, 811				15.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	15 004				1 20 00
30.00	03100 NURSING FACILITY	15, 804 0				30.00 31.00
	03200 I CF/I I D	0				32.00
33.00	03300 OTHER LONG TERM CARE	0				33.00
10.00	ANCI LLARY SERVICE COST CENTERS					1 40 00
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY	0				40.00
	04200 I NTRAVENOUS THERAPY	0				42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0				43.00
	04400 PHYSI CAL THERAPY	0				44.00
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0				45.00 46.00
47.00	04700 ELECTROCARDI OLOGY	0				47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				48.00
	04900 DRUGS CHARGED TO PATIENTS	0				49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0				50.00 51.00
01100	OUTPATIENT SERVICE COST CENTERS					
	06000 CLINIC	0				60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0				61.00 62.00
02.00	OTHER REIMBURSABLE COST CENTERS					02.00
	07000 HOME HEALTH AGENCY COST	0				70.00
	07100 AMBULANCE	0				71.00
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	U				73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100 I NTEREST EXPENSE					81.00
82.00 83.00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	o				82.00 83.00
89.00	SUBTOTALS (sum of lines 1-84)	15, 804				89.00
	NONREI MBURSABLE COST CENTERS					
90.00	09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN	0				90.00
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0				91.00 92.00
93.00	09300 NONPAI D WORKERS	0				93.00
94.00	09400 PATIENTS LAUNDRY	0				94.00
95.00	09500 ALU/I LU	13, 007				95.00
98.00	Cross Foot Adjustments					98.00
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	962, 875				99.00 102.00
102.00	Part I)	,52,075				
103.00		33. 420395				103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	0				104.00
105.00		0. 000000				105.00

RATIO OF COST TO CHARGES FOR ANCI LLARY AND OUTPATI ENT COST CENT Period: For OI OI OI <tho< th=""><th>Health Financial Systems I</th><th>LIONS GATE</th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2540-10</th></tho<>	Health Financial Systems I	LIONS GATE		In Lie	u of Form CMS-2	2540-10
Cost Center Description Total (from Wkst. B, Pt I, col. 18) Total (charges Cost Center Description Ratio (col. 1 divided by col. 2 ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 ANCI LLARY SERVICE COST CENTERS 36,486 32,396 1.126250 40.00 04000 (ADD OLOGY 36,486 32,396 1.126250 40.00 44.00 04100 LABORATORY 70,147 126,314 0.555338 41.00 42.00 042000 INTRAVENOUS THERAPY 0 0 0.0000004 42.00 43.00 04400 PHYSI CAL THERAPY 514,292 729,822 0.704681 45.00 44.00 04600 SPECH PATHOLOGY 147,530 183,571 0.80366746.00 47.00 45.00 04500 BUPCH CARDIOLOGY 147,530 183,571 0.000000 47.00 47.00 04900 DRUGS CHARGED TO PATI ENTS 0 0 0 0.000000 47.00 48.00 04800 BUPCK CARE - TI TLE XI X ONLY 0 0 0 0.000000 47.00 0 0 0.0000000 50.00	RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST (CENTERS Provider			Worksheet C	
ANCI LLARY SERVICE COST CENTERS Total (from Wkst. B, Pt I, col. 18) Total Charges Vivide by col. 2 Ratio (col. 1 vivide by col. 2 40.00 04000 RADI OLOGY 36,486 32,396 1.126250 40.00 41.00 04000 INTRAVENOUS THERAPY 70,147 126,314 0.555338 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0.0000004 2.00 3.00 43.00 04300 OXYGEN (INHALATI ON) THERAPY 86,543 56,157 1.541090 43.00 44.00 044000 PHYSI CAL THERAPY 779,144 749,825 1.039101 44.00 45.00 04600 SPEECH PATHOLOGY 147,530 183,571 0.803667 46.00 46.00 04900 RUGS CHARGED TO PATI ENTS 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 394,489 292,652 1.34798 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0.000000 47.00 60.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00					Dato/Timo Pro	narod
Cost Center Description Total (from Wkst. B, Pt 1, col. 18) Total Charges (vided by col. 2 ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 40.00 04000 RADIOLOGY 36,486 32,396 1.126250 41.00 04100 LABORATORY 70,1147 126,314 0.555338 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 QXGEN (INHALATION) THERAPY 86,543 56,157 1.541090 43.00 44.00 04400 PHXIS CAL THERAPY 514,292 729,822 0.704681 45.00 45.00 04500 OCCUPATI ONAL THERAPY 514,292 729,822 0.704681 45.00 46.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 47.00 48.00 04900 DRUGS CHARGED TO PATIENTS 394,489 292,652 1.347980 49.00 49.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 5100 OSUPORT SURFACES 0 0 0.000000 51.00 5				0 12/31/2021	7/1/2022 1:51	pm
ANCILLARY SERVICE COST CENTERS col. 2 40.00 04000 RADIOLOGY 3.6,486 32,396 1.126250 40.00 41.00 04100 LABORATORY 70,147 126,314 0.555338 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 43.00 43.00 04300 OXYGEN (I NHALATI ON) THERAPY 86,543 56,157 1.53100 43.00 44.00 04400 PHYSI CAL THERAPY 779,144 749,825 1.03101 44.00 45.00 04500 OCCUPATI ONAL THERAPY 514,292 729,822 0.704681 45.00 46.00 04600 SPEECH PATHOLOGY 147,530 183,571 0.803067 46.00 47.00 04500 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 47.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 394,489 292,652 1.347980 49.00 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0 0 0 0	Cost Center Description			Total Charges	Ratio (col. 1	
I. 00 2. 00 3. 00 ANCILLARY SERVICE COST CENTERS			Wkst. B, Pt			
ANCI LLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 36, 486 32, 396 1. 126250 40.00 41.00 04100 LABORATORY 70, 147 126, 314 0. 55538 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 OXYGEN (INHALATI ON) THERAPY 86, 543 56, 157 1. 541090 43.00 44.00 04400 PHYSI CAL THERAPY 86, 543 56, 157 1. 039101 44.00 45.00 04500 OCCUPATI ONAL THERAPY 514, 292 729, 822 0. 704681 45.00 46.00 04500 SPEECH PATHOLOGY 147, 530 183, 571 0. 803667 46.00 47.00 04500 DELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 51.00						
40.00 04000 RADI OLOGY 36, 486 32, 396 1. 126250 40.00 41.00 04100 LABORATORY 70, 147 126, 314 0. 555338 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 0XYGEN (INHALATI ON) THERAPY 86, 543 56, 157 1. 541090 43.00 44.00 04400 PHYSI CAL THERAPY 779, 144 749, 825 1. 039101 44.00 45.00 04500 OCCUPATI ONAL THERAPY 514, 292 729, 822 0. 704681 45.00 46.00 04600 SPEECH PATHOLOGY 147, 530 183, 571 0. 803667 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 394, 489 292, 652 1. 347980 49.00 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 0 0 0.000000 51.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 51.00			1.00	2.00	3.00	
41. 00 04100 LABORATORY 70, 147 126, 314 0. 555338 41. 00 42. 00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42. 00 43. 00 04300 OXYGEN (1NHALATION) THERAPY 86, 543 56, 157 1. 541090 43. 00 44. 00 04400 PHYSI CAL THERAPY 86, 543 56, 157 1. 039101 44. 00 45. 00 04500 OCUPATI ONAL THERAPY 514, 292 729, 822 0. 704681 45. 00 46. 00 04600 SPECH PATHOLOGY 147, 530 183, 571 0. 803667 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0. 000000 47. 00 49. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 394, 489 292, 652 1. 347980 49. 00 50. 00 05000 DENTAL CARE - TI TLE XI X ONLY 0 0 0.000000 51. 00 010TPATI ENT SERVICE COST CENTERS 0 0 0.000000 50. 00 51. 00 51. 00 60. 00 60. 00 61. 00 61. 00 61. 00 61. 00						
42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 86,543 56,157 1.541090 43.00 44.00 04400 PHYSI CAL THERAPY 779,144 749,825 1.039101 44.00 45.00 04500 OCCUPATI ONAL THERAPY 514,292 729,822 0.704681 45.00 46.00 04600 SPEECH PATHOLOGY 147,530 183,571 0.803667 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 394, 489 292,652 1.347980 49.00 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 0 0 0.000000 51.00 0100 05100 SUPPORT SURFACES 0 0 0.000000 51.00 01000000 CLINI C 0 0 0.000000 61.00 61.00 61						
43.00 04300 0XYGEN (INHALATION) THERAPY 86,543 56,157 1.541090 43.00 44.00 04400 PHYSI CAL THERAPY 779,144 749,825 1.039101 44.00 45.00 04500 OCCUPATIONAL THERAPY 514,292 729,822 0.704681 45.00 46.00 04600 SPEECH PATHOLOGY 147,530 183,571 0.803667 46.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 394,489 292,652 1.347980 49.00 50.00 05000 DENTAL CARE - TITLE XI X ONLY 0 0 0.000000 51.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0 0 0 0 0.000000 51.00 0.000000 51.00 0 0 0 0 0 0.000000 51.00 0.000000 51.00 <td></td> <td></td> <td>70, 147</td> <td>126, 314</td> <td></td> <td></td>			70, 147	126, 314		
44.00 04400 PHYSI CAL THERAPY 779, 144 749, 825 1.039101 44.00 45.00 04500 OCCUPATI ONAL THERAPY 514, 292 729, 822 0.704681 45.00 46.00 04600 SPEECH PATHOLOGY 147, 530 183, 571 0.803667 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 394, 489 292, 652 1.347980 49.00 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 0 0 0.000000 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0 0 0 0 0 0.000000 51.00 51.00 0 0 0 0 0 0.000000 51.00 51.00 0 0 0 0 0 0.000000 51.00 61.00 60.00 <t< td=""><td></td><td></td><td>0</td><td>0 0</td><td></td><td></td></t<>			0	0 0		
45.00 04500 OCCUPATI ONAL THERAPY 514, 292 729, 822 0.704681 45.00 46.00 04600 SPEECH PATHOLOGY 147, 530 183, 571 0.803667 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 394, 489 292, 652 1.347980 49.00 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 0 0 0.000000 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0 06000 CLI NI C 0 0 0.000000 60.00 61.00 06100 RURAL HEALTH CLI NI C 61.00 61.00 62.00 61.00 62.00 71.00 07100 AMBULANCE 0 0 0.000000 71.00						
46.00 04600 SPEECH PATHOLOGY 147,530 183,571 0.803667 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 394,489 292,652 1.347980 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0.000000 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0 06000 CLINIC 0 0 0.000000 60.00 60.00 06100 RURAL HEALTH CLINIC 62.00 61.00 62.00 62.00 71.00 07100 AMBULANCE 0 0 0.000000 71.00			779, 144	749, 825		
47.00 04700 ELECTROCARDI OLOGY 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 394, 489 292, 652 1.347980 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0.000000 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 50.00 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 60.00 60.00 60.00 06100 RURAL HEALTH CLINIC 0 0 0.000000 61.00 62.00 00200 FOHC 0 0 0.000000 62.00 71.00 07100 AMBULANCE 0 0 0.000000 71.00						
48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 394,489 292,652 1.347980 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0.000000 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 51.00 60.00 06000 CLINIC 0 0.000000 60.00 61.00 06200 FOHC 0 0.000000 61.00 62.00 071.00 07100 AMBULANCE 0 0 0.000000 71.00			147, 530	183, 571		
49.00 04900 DRUGS CHARGED TO PATIENTS 394, 489 292, 652 1.347980 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0.000000 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 60.00 61.00 62.00 61.00 62.00 62.00 71.00 07100 AMBULANCE 0 0 0.000000 71.00 </td <td></td> <td></td> <td>(</td> <td>0 0</td> <td></td> <td></td>			(0 0		
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0.000000 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 51.00 50.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 51.00 50.00 50.00 50.00 51.00 50.0			(0 0		
51.00 05100 SUPPORT SURFACES 0 0.000000 51.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 61.00 62.00 61.00 62.00 62.00 62.00 71.00 07100 AMBULANCE 0 0 0.000000 71.00			394, 489	292, 652		
OUTPATI ENT_SERVICE_COST_CENTERS 60.00 06000 CLINIC 0 0.00000 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 61.00 62.00 61.00 62.00 62.00 62.00 71.00 07100 AMBULANCE 0 0 0.000000 71.00			(0 0		
60.00 06000 CLINIC 0 0.00000 60.00 61.00 06100 RURAL HEALTH CLINIC 61.00 61.00 62.00 62.00 6200 FOHC 62.00 60.00 61.00 71.00 07100 AMBULANCE 0 0 0.000000 71.00			(0 0	0.00000	51.00
61.00 06100 RURAL HEALTH CLINIC 61.00 62.00 06200 FOHC 62.00 71.00 07100 AMBULANCE 0 0.000000 71.00						
62.00 06200 FOHC 62.00 71.00 07100 AMBULANCE 0 0.000000 71.00			0	0 0	0.00000	
71.00 07100 AMBULANCE 0 0.000000 71.00						
100.00 Total 2,028,631 2,170,737 100.00			(0	0.00000	
	100.00 Total		2, 028, 631	2, 170, 737		100.00

Health Financial Systems	LIONS				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2021	Worksheet D Part I	
				To 12/31/2021	Date/Time Pre 7/1/2022 1:51	
		Title	XVIII (1)	Skilled Nursing		
			. ,	Facility		
		Health Care Pr	rogram Charge	s Heal th Care	Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col.	Part B (col.	
cost center bescription	to Charges	Tart A		$1 \times col. 2$	$1 \times col.$ 3)	
	(Fr. Wkst. C			1 // 0011 2)	1 / 0011 0)	
	Column 3)					
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	LIENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	1. 126250			0 21, 859		
41. 00 04100 LABORATORY	0. 555338	117, 179		0 65, 074	0	
42.00 04200 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 541090			0 0	0	1 101 00
44. 00 04400 PHYSI CAL THERAPY	1. 039101	474, 423		0 492, 973		1
45. 00 04500 OCCUPATI ONAL THERAPY	0. 704681	526, 434		0 370, 968	0	45.00
46.00 04600 SPEECH PATHOLOGY	0. 803667	132, 381		0 106, 390	0	1 101 00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	1
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	1 101 00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 347980			0 390, 306	0	1 17.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			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	
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of Lines 40 - 71)		1, 559, 375		0 1, 447, 570	0	100.00

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

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

Health Financial Systems	LIONS	GATE		In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315499	Period: From 01/01/2021 To 12/31/2021	7/1/2022 1:51	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description				Facility		
					1.00	
PART II - APPORTIONMENT OF VACCINE COST						
1.00 Drugs charged to patients - ratio of c	ost to charges	(From Workshee	t C, column 3	3, line 49)	1. 347980	1.00
2.00 Program vaccine charges (From your rec					0	
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	oviders, transf	er this amour	nt to Worksheet	0	3.00
E, Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part	Part A	
	(From Wkst. B. Part L.	Allied Health (From Wkst.	Nursing & Allied Healt	A Cost (From	Nursing & Allied Health	
	Col. 18	B, Part I,	Costs to	I, Col. 4)	Costs for	
	COI. 10	Col. 14)	Total Costs		Pass Through	
			Part A (Col.		(Col. 3 x	
			2 / Col. 1)		Col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
ANCI LLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	36, 486		0.00000			40.00
41.00 04100 LABORATORY	70, 147		0.0000			41.00
42.00 04200 I NTRAVENOUS THERAPY	0	-	0.0000		0	42.00
43.00 O4300 OXYGEN (INHALATION) THERAPY	86, 543		0.0000		0	43.00
44.00 04400 PHYSI CAL THERAPY	779, 144		0.0000			44.00
45. 00 04500 OCCUPATI ONAL THERAPY	514, 292		0.0000			45.00 46.00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	147, 530	0	0.0000		0	46.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000		0	47.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	394, 489		0.00000		-	48.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	374,407		0.00000		0	50.00
51. 00 05100 SUPPORT SURFACES		0	0. 00000		0	
100.00 Total (Sum of Lines 40 - 52)	2, 028, 631	0		1, 447, 570	-	100.00
					•	•

OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315499	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 7/1/2022 1:51	pare	
	Title XVIII Skilled Nursing Facility					
				1.00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS					
	I NPATI ENT DAYS					
. 00	Inpatient days including private room days			32, 566	1.	
. 00	Private room days			0	2.	
. 00	Inpatient days including private room days applicable to the F			6, 328	3.	
. 00	Medically necessary private room days applicable to the Progra	am		0	4.	
. 00	Total general inpatient routine service cost			14, 092, 507	5.	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
. 00	General inpatient routine service charges			18, 856, 666		
. 00	General inpatient routine service cost/charge ratio (Line 5 d	divided by line 6)		0.747349		
. 00	Enter private room charges from your records			0	8	
. 00	Average private room per diem charge (Private room charges lir 2)	0.00	9			
0. 00					10	
1.00	Average semi-private room per diem charge (Semi-private room	charges line 10, divid	ed by	18, 856, 666 579. 03		
2.00	semi-private room days) Average per diem private room charge differential (Line 9 minu	ic line 11)		0.00	12	
	Average per diem private room cost differential (Line 7 times			0.00		
	Private room cost differential adjustment (Line 2 times line 7			0.00	14	
	General inpatient routine service cost net of private room cost		minus line 14)	14, 092, 507		
5.00	PROGRAM INPATIENT ROUTINE SERVICE COST HET OF DITVATE FOOM COS		minus inne 14)	14,072,307	1 13	
6.00	Adjusted general inpatient service cost per diem (Line 15 div	/ided by line 1)		432.74	16	
	Program routine service cost (Line 3 times line 16)			2, 738, 379		
	Medically necessary private room cost applicable to program	(line 4 times line 13)		2, ,00,0,7	18	
9.00	Total program general inpatient routine service cost (Line 17			2, 738, 379		
0.00	Capital related cost allocated to inpatient routine service co		rt II column 18.	977, 493		
0.00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20	
1.00				30. 02	21	
	Program capital related cost (Line 3 times line 21)			189, 967	22	
3.00	Inpatient routine service cost (Line 19 minus line 22)			2, 548, 412		
4.00		ovider records)		2,010,112	24	
5.00			inus line 24)	2, 548, 412		
6.00				2, 515, 112	26	
7.00		er diem limitation line	26) (1)		27	
8.00					28	
0.00	(Transfer to Worksheet E, Part II, line 4) (See instructions)	.5 . 555561 01 11110 20 01			1 20	

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	32, 566	1.00
2.00	Program inpatient days (see instructions)	6, 328	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. 194313	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Heal th	Financial Systems LIONS GAT	E	In Lie	u of Form CMS-2	2540-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provi der No.: 315499	Period: From 01/01/2021	Worksheet E Part I	
			To 12/31/2021	Date/Time Pre 7/1/2022 1:51	
		Title XVIII	Skilled Nursing	PPS	piii
			Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBUR	DSEMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	SEMENT		4, 237, 890	1.00
2.00	Nursing and Allied Health Education Activities (pass through p	payments)		4,237,070	2.00
3.00	Subtotal (Sum of Lines 1 and 2)		4, 237, 890	3.00	
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			271, 201	5.00
6.00	Allowable bad debts (From your records)			8, 628	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instr	ructions)		3, 411	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			5, 608	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)	3, 972, 297	11.00		
	Interim payments (See instructions)			3, 966, 689	12.00
	Tentative adjustment			0	13.00
	OTHER adjustment (See instructions)	0	14.00		
14.50	Demonstration payment adjustment amount before sequestration			0	14.50
	Demonstration payment adjustment amount after sequestration			0	14.55
	Sequestration for non-claims based amounts (see instructions)			0	14.75
	Sequestration amount (see instructions)			0	14.99
	Balance due provider/program (see Instructions)			5, 608	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER			0	16.00
17 00	Ancillary services Part B	COF CUST OR CHARGES -	TITLE AVITE UNLY	0	17.00
	Vaccine cost (From Wkst D, Part II, line 3)			0	17.00
	Total reasonable costs (Sum of Lines 17 and 18)			0	19.00
	Medicare Part B ancillary charges (See instructions)			0	20.00
	Cost of covered services (Lesser of Line 19 or Line 20)			0	21.00
	Primary payor amounts			0	22.00
	Coinsurance and deductibles			Ő	23.00
	Allowable bad debts (From your records)			0	24.00
	Allowable Bad debts for dual eligible beneficiaries (see instr	ructions)		0	24.01
	Adjusted reimbursable bad debts (see instructions)	,		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.00
26.00	Interim payments (See instructions)			0	26.00
27.00	Tentative adjustment			0	27.00
	Other Adjustments (See instructions) Specify			0	28.00
	Demonstration payment adjustment amount before sequestration			0	28.50
	Demonstration payment adjustment amount after sequestration			0	28.55
	Sequestration amount (see instructions)			0	28.99
	Balance due provider/program (see instructions)			0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordar	nce with CMS Pub. 15-2, s	section 115.2	0	30.00

NALYS	ALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		No.: 315499	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Pre 7/1/2022 1:51	pared
		Titl	e XVIII	Skilled Nursing Facility		
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Tatal interim neuments usid to approxide	1.00	2.00	3.00	4.00	1.0
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, 966, 6	0	0	
	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)					
0.1	Program to Provider			0	0	
01 02 03 04 05	ADJUSTMENTS TO PROVIDER			0 0 0 0		3. 0 3. 0 3. 0
	Provider to Program					
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0	0 0 0 0	3. ! 3. ! 3. ! 3. ! 3. !
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)			0	0	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) TO BE COMPLETED BY CONTRACTOR		3, 966, 6	89	0	4.
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01 02 03	TENTATI VE TO PROVI DER			0 0 0	0 0 0	
50 51 52	Provider to Program TENTATIVE TO PROGRAM			0 0 0	0 0 0	5. 5. 5.
99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1) PROGRAM TO PROVIDER			08	0	6.
01 02 00	PROGRAM TO PROVIDER PROVIDER TO PROGRAM Total Medicare program liability (see instructions)		5, 6 3, 972, 2	0	0	
				actor Name	Contractor Number	

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

	HEET (If you are nonproprietary and do not maintain accounting records, complete the "General Fund" column	ר	Fr To	rom 01/01/2021 12/31/2021	Date/Time Pre
)		General Fund	Speci fi c	Endowment	7/1/2022 1:51 Plant Fund
		1.00	Purpose Fund 2.00	Fund 3.00	4.00
	sets		2.000	0.00	
	RRENT ASSETS	0.000.005			
	sh on hand and in banks	8, 998, 985		0	0
	mporary investments tes receivable	26, 748	0	0	0
	counts receivable	1, 544, 066	-	0	0
	her receivables	421, 369		0	0
Les	ss: allowances for uncollectible notes and accounts	0	0	0	0
	cei vabl e				
	ventory	0	0	0	0
	epaid expenses her current assets	62, 770 183, 926		0	0
	e from other funds	103, 920	0	0	0
	TAL CURRENT ASSETS (Sum of lines 1 - 10)	11, 237, 864	-	0	0
	KED ASSETS	1 1 1 1 1 1 1	1 -1	- 1	
) Lar	nd	6, 360, 288	0	0	0
	nd improvements	1, 429, 355		0	0
	ss: Accumulated depreciation	0 474 017	0	0	0
	ildings ss Accumulated depreciation	88, 474, 217 -42, 551, 978	0	0	0
	asehold improvements	-42, 551, 976	0	0	0
	ss: Accumulated Amortization	0	0	0	0
	xed equipment	10, 294, 236	0	0	0
) Les	ss: Accumulated depreciation	0	0	0	0
	tomobiles and trucks	252, 008	0	0	0
	ss: Accumulated depreciation	0	0	0	0
	jor movable equipment ss: Accumulated depreciation	1, 392, 725	0	0	0
	nor equipment - Depreciable		0	0	0
	nor equipment nondepreciable	0	0	0	0
	her fixed assets	51, 522	0	0	0
о то	TAL FIXED ASSETS (Sum of lines 12 - 27)	65, 702, 373	0	0	0
	IER ASSETS		,	1	
	vestments	20, 619, 435		0	0
	posits on leases e from owners/officers	0	0	0	0
	her assets	7, 765, 004	-	0	0
	TAL OTHER ASSETS (Sum of lines 29 - 32)	28, 384, 439		0	0
о то	TAL ASSETS (Sum of lines 11, 28, and 33)	105, 324, 676	0	0	0
	abilities and Fund Balances				
	RRENT LI ABI LI TI ES	1 444 715	0	0	0
	counts payable Laries, wages, and fees payable	1, 444, 715 2, 482, 571	0	0	0
	yroll taxes payable	2,402,371		0	0
	tes & loans payable (Short term)	1, 245, 000	0	0	0
	ferred income	0	0	0	0
	celerated payments	0			
	e to other funds	0	0	0	0
	her current liabilities	0 E 172 204	0	0	0
	TAL CURRENT LIABILITIES (Sum of lines 35 - 42) IG TERM LIABILITIES	5, 172, 286	0	0	0
	rtgage payable	51, 726, 289	0	0	0
	tes payable	0	0	0	0
	secured Loans	0	0	0	0
) Loa	ans from owners:	0	0	0	0
	her long term liabilities	42,031,327	0	0	0
	HER (SPECIFY)	00 757 (1)	0	0	0
	TAL LONG TERM LIABILITIES (Sum of lines 44 - 49	93, 757, 616 98, 929, 902		0	0
	TAL LIABILITIES (Sum of lines 43 and 50) PITAL ACCOUNTS	90, 929, 902	0	0	0
	neral fund balance	6, 394, 774			
	ecific purpose fund		0		
	nor created - endowment fund balance - restricted			0	
	nor created - endowment fund balance - unrestricted			О	
	verning body created - endowment fund balance			0	- 1
	ant fund balance - invested in plant				0
	ant fund balance - reserve for plant improvement,				0
	placement, and expansion TAL FUND BALANCES (Sum of lines 52 thru 58)	6, 394, 774	0	0	0
	THE FORD DRENNOLS (SUIL OF FILES SZ LILU SO)	0, 374, 774	0	0	0

	Financial Systems IENT OF CHANGES IN FUND BALANCES	LIONS GAT		No.: 315499	Do	ri od:	u of Form CMS Worksheet G		540-TC
STATE	IENT OF CHANGES IN FUND DALANCES		Provider	10313499		om 01/01/2021	Date/Time P		pared.
						12/01/2021	7/1/2022 1:		
		General F	und	Speci al	Pur	pose Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5, 00	-	
1.00	Fund balances at beginning of period	1.00	-3,053,912	3.00		0	3.00		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		9, 276, 004						2.00
3.00	Total (sum of line 1 and line 2)		6, 222, 092			0			3.00
4.00	Additions (credit adjustments)								4.00
5.00	INCREASE IN FOUNDATION INTEREST	526, 630			0			0	5.00
6.00	INCREASE IN FOUNDATION INTEREST	149, 244			0			0	6.00
7.00	OTHER	12, 298			0			0	7.00
8.00		0			0			0	8.00
9.00 10.00	Total additions (sum of line 5 - 9)	0	688, 172		0	0			9.00 10.00
11.00	Subtotal (line 3 plus line 10)		6, 910, 264			0			11.00
12.00	Deductions (debit adjustments)		0, 910, 204			0			12.00
12.00	NET ASSETS RELEASED FROM RESTRICTION	515, 490			0			o	13.00
14.00		0			0			o	14.00
15.00		0			0			0	15.00
16.00		0			0			0	16.00
17.00		0			0			0	17.00
18.00	Total deductions (sum of lines 13 - 17)		515, 490			0			18.00
19.00	Fund balance at end of period per balance		6, 394, 774			0			19.00
	sheet (Line 11 - line 18)	Endowment	Diant	Fund				_	
		Fund	PI ant	Fund					
		- Turiu							
		6.00	7.00	8.00	_				
1.00	Fund balances at beginning of period	0			0				1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	0			0				2.00 3.00
3.00 4.00	Additions (credit adjustments)	0			0				4.00
5.00	INCREASE IN FOUNDATION INTEREST		0						5.00
6.00	INCREASE IN FOUNDATION INTEREST		0						6.00
7.00	OTHER		0						7.00
8.00			0						8.00
9.00			0						9.00
10.00	Total additions (sum of line 5 - 9)	0			0				10.00
11.00	Subtotal (line 3 plus line 10)	0			0				11.00
12.00	Deductions (debit adjustments)								12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION		0						13.00
14.00			0						14.00
15 00			0						15.00
15.00			0						16.00
16.00									17.00
16. 00 17. 00	Total deductions (our -f. Lizza 10, 17)		0						
16. 00 17. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	0	0		0				18.00 19.00

Heal th	Financial Systems	LI ONS GATE				In Lie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315499		eriod: com 01/01/2021 0 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 7/1/2022 1:51	pared:
	Cost Center Description			Inpati ent		Outpati ent	Total	
				1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Care Services							
1.00	SKILLED NURSING FACILITY			18, 856, 6	66		18, 856, 666	1.00
	NURSING FACILITY			10,000,0	0		0,000,000	2.00
	ICF/IID				0		0	3.00
4.00	OTHER LONG TERM CARE				0		0	4.00
4.00 5.00	Total general inpatient care services (Sum of line	$0 \in (1 + 1)$		18, 856, 6	~		18, 856, 666	5.00
	All Other Care Services	es i - 4)		10,000,00	00		10, 000, 000	5.00
6.00	ANCI LLARY SERVICES			2, 102, 6	27	0	2, 102, 637	6.00
	CLINIC			2, 102, 0	57	0	2, 102, 037	7.00
	HOME HEALTH AGENCY COST					0	0	8.00
8.00 9.00	AMBULANCE					0	0	9.00
	RURAL HEALTH CLINIC					0	0	9.00 10.00
	FORC					0	0	10.00
	CMHC					0	-	
						0	0	11.00
	HOSPICE			10.0(0.7)	20	0	0	12.00
	OTHER PATIENT REVENUES			12, 863, 73		0	12, 863, 738	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Trai Worksheet G-3, Line 1)	nster corulin 3	10	33, 823, 04	41	0	33, 823, 041	14.00
	Cost Center Description				-			
	cost center bescription				ŀ	1.00	2.00	
	PART II - OPERATING EXPENSES					1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line	100)					32, 083, 019	1.00
2.00	Add (Specify)	100)				0	52,005,017	2.00
3.00	Add (Specify)					0		3.00
4.00						0		4.00
4.00 5.00						0		4.00 5.00
5.00 6.00						0		5.00 6.00
						0		
7.00						0	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, m	inus line 14)					32, 083, 019	15.00

Heal th	Financial Systems	LIONS GATE			In Lie	u of Form CMS-2	2540-10
	STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315499	Peri od:	Worksheet G-3	
					From 01/01/2021		
					To 12/31/2021	Date/Time Pre	
						7/1/2022 1:51	pm
						1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,	col 3 line 1	4)			33, 823, 041	1.00
2.00	Less: contractual allowances and discounts on pat					6, 613, 359	2.00
3.00	Net patient revenues (Line 1 minus line 2)					27, 209, 682	3.00
4.00	Less: total operating expenses (From Worksheet G-	2. Part II. li	ne 15)			32,083,019	4.00
5.00	Net income from service to patients (Line 3 minus					-4, 873, 337	5.00
	Other income:						
6.00	Contributions, donations, bequests, etc					10, 856, 860	6.00
7.00	Income from investments					1, 350, 165	7.00
8.00	Revenues from communications (Telephone and Inte	rnet service)				14, 663	8.00
9.00	Revenue from television and radio service					17, 047	9.00
10.00	Purchase di scounts					0	10.00
11.00	Rebates and refunds of expenses					0	11.00
	Parking lot receipts					0	12.00
	Revenue from Laundry and Linen service					0	13.00
	Revenue from meals sold to employees and guests					57, 159	14.00
	Revenue from rental of living quarters					0	15.00
	Revenue from sale of medical and surgical supplies	s to other tha	n patients	5		0	16.00
	Revenue from sale of drugs to other than patients					0	17.00
18.00	Revenue from sale of medical records and abstract	S				0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)					0	19.00
	Revenue from gifts, flower, coffee shops, canteen					0	20.00
	Rental of vending machines					0	21.00
22.00	Rental of skilled nursing space					0	22.00
	Governmental appropriations					0	23.00
	MISC REVENUE					188, 470	
24.01	AL IL REVENUE					1, 387, 623	
	BARBER REVENUE					6, 114	24.02 24.03
	G&A OTHER REVENUE					78, 247	
24.50 25.00	COVID-19 PHE Funding Total other income (Sum of lines 6 - 24)					192, 993 14, 149, 341	24.50 25.00
25.00	Total (Line 5 plus line 25)					9, 276, 004	
26.00	Other expenses (specify)					9, 278, 004	26.00
27.00	CUTEL EXPENSES (SPECITY)					0	27.00
28.00						0	28.00 29.00
	Total other expenses (Sum of lines 27 - 29)					0	30.00
	Net income (or loss) for the period (Line 26 minu:	s line 30)				9, 276, 004	
01.00	instantion (or ross) for the period (Erric 20 minu				I	7, 2, 8, 884	51.00