Heal th Financia		LIONS GATE			J of Form CMS-2540-10
	required by law (42 USC 1395g; 42 CFR 413. since the beginning of the cost reporting p				FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315499	Period: From 01/01/2023 To 12/31/2023	
PART I - COST I	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost re	port		Date: 6/24/20	24 Time: 5:07 pm
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report en	ter the numbe	r of times the provide	er resubmitted thi	is cost report
	3.01 [] No Medicare Utilization. Enter	"Y" for yes o	r leave blank for no.		
Contractor	4.[1]Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN	
	Settled without audit	8.[N]Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened	10 [0] f	ine 4, column 1 is "4"	· Enter number of	^c times reopened
	(5) Amended		r Vendor Code		trines respense
	C Data Datainad				
	5. Date Received:		care Utilization. Ente	er F For Tull,	L FOF TOW, OF "N"
		TOP	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 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	ANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	K	yle Smith	Y	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	Kyle Smith			2
3	Signatory Title	DIRECTOR OF FINANCE			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	0	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	0	0	0	100.00

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

	Financial Systems		IONS GATE					n Lieu	ı of Form		
	D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA	TY HEALTH	H CARE	Provi der	No.: 3154	F	Period: From 01/01. Fo 12/31.		Workshee Part I Date/Tir 6/24/202	ne Pre	pared:
	1.00		. 00		3.	00			0/24/202	24 0.0	
1.00	Skilled Nursing Facility and Skilled Nursing Street: 1100 LAUREL OAK ROAD	Facility PO Box:	Complex A	ddress:							1.00
2.00		State: NJ	J	Zip Code	: 08043						2.00
3.00		CBSA Code		Urban/Ru							3.00
3. 01		CBSA Code			D		Data	D		(D	3.01
			Compor	nent Name	Prov		Date Certified	Payme	ent Syste O, or N)		
							ocrititicu	V		XIX	
			1	. 00	2.	00	3.00	4.00	5.00	6.00	
	SNF and SNF-Based Component Identification:				045	100	00 /00 /0007				1 00
4.00 5.00	SNF Nursing Facility		LIONS GATE		315	499 0	02/20/2007	N	P	Ν	4.00
5.00	ICF/IID										6.00
7.00	SNF-Based HHA										7.00
3.00	SNF-Based RHC										8.00
9.00	SNF-Based FQHC SNF-Based CMHC										9.00
10.00 11.00	SNF-Based OLTC										11.00
	SNF-Based HOSPICE										12.00
	SNF-Based CORF										13.00
							From		To:		
14 00	Cost Doporting Doried (mm/dd/(0000)						1.00		2.00		14.00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (See Enstructions)						01/01/2		CORPORAT		15.00
									Y/N		10100
									1.00	0	
16.00	Type of Freestanding Skilled Nursing Facility Is this a distinct part skilled nursing facil section 483.5?		meets the	requi reme	ents set	forth	in 42 CFR		N		16.00
17.00	Is this a composite distinct part skilled nur 42 CFR section 483.5?	sing faci	ility that	meets the	e require	ments	set forth	in	Ν		17.00
18.00	Are there any costs included in Worksheet A t organizations as defined in CMS Pub. 15-1, ch								N		18.00
19.00	Miscellaneous Cost Reporting Information If this is a low Medicare utilization cost re	nort in	dicate with	ם. איז איז איז איז איז איז איז איז איז איז	for ves	or "N	" for no		N		19.00
	If line 19 is yes, does this cost report meet utilization cost report, indicate with a "Y",	your co	ntractor's	cri teri a				re	N		19.01
	Depreciation - Enter the amount of depreciati	on repor	ted in thi	s SNF for	the meth	nod in	dicated or	Line			
	Straight Line								3, 3		20.00
	Declining Balance Sum of the Year's Digits									(21.00
	Sum of line 20 through 22								3, 3	86. 320	23.00
24.00	If depreciation is funded, enter the balance	as of t	he end of	the period	d.				-, -	(24.00
	Were there any disposal of capital assets dur								N		25.00
	Was accelerated depreciation claimed on any a (Y/N)			5	•				N		26.00
	Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in	1 3							N		27.00
20.00	reports? (Y/N)	Surance							APart B	Other	20.00
									2.00		
	If this facility contains a public or non-pub the lower of the costs or charges enter "Y" f exemption.									n of	
29.00	Skilled Nursing Facility							N	N		29.00
	Nursing Facility									Ν	30.00
31.00	ICF/IID										31.00
	SNF-Based HHA							N	N		32.00
	SNF-Based RHC SNF-Based FQHC										33.00 34.00
	SNF-Based CMHC								N		34.00
	SNF-Based OLTC										36.00
							Y/N			_	
7 00	Le the skilled pursing fasility leasted in a	ctoto th	at contifi	ac the are	nul dan sa	0.01	1.00)	2.00	0	27.00
07.00	Is the skilled nursing facility located in a regardless of the level of care given for Tit				ovi der as	a SN	F N				37.00
8. 00	Are you legally-required to carry malpractice			(1/N)			Y				38.00
9.00	Is the malpractice a "claims-made" or "occurr	ence" po	licy? If th	ne policy	is		1				39.00
	"claims-made" enter 1. If the policy is "occu	rrence",	enter 2.		Dur			2005	ੇਗਵਾ	100	
					Premi 1.0		Paid Los 2.00		Self Insu 3.00		
41.00	List malpractice premiums and paid losses:				470, 4		0		0	,	41.00
								1	Ũ		

Health Finan	cial Systems	LIONS GATE			In Lieu	u of Form CM	S-2540-10
	SING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3		Period:	Worksheet S	5-2
COMPLEX INDE	ENTIFICATION DATA				From 01/01/2023 To 12/31/2023		Prepared:
						6/24/2024 5	5:07 pm
						Y/N	
						1.00	
42.00 Are ma	alpractice premiums and paid loss	es reported in other than	the Administra	tive and	d General cost	N	42.00
center	r? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listing	g cost o	centers and		
amount	ts.						
	here any home office costs as def					N	43.00
44.00 If lir	ne 43 is yes, enter the home offi	ce chain number and enter	the name and a	ddress (of the home		44.00
offi ce	e on lines 45, 46 and 47.						
	1.00	2.00			3.00		
lf thi	is facility is part of a chain or	ganization, enter the nam	ne and address o	of the h	ome office on th	e lines	
bel ow.							
45.00 Name:		Contractor's Name:	C	Contract	or's Number:		45.00
46.00 Street	t:	PO Box:					46.00
47.00 City:		State:	Z	ip Code	:		47.00

	EX REIMBURSEMENT QUESTI ONNAI RE	TY HEALTH CARE	Provi der		Period: From 01/01/2023 To 12/31/2023		epared
					Y/N	Date	
	General Instruction: For all column 1 respon responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	n 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)	ly prior to the be the date of the ch	ginning of ange in col	lumn 2. (see	N		1.
				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			N			2.
00	3, "V" for voluntary or "I" for involuntary. 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 office d to the provider of 1, or members of the	ces, drug or its he board	N			3.
				Y/N	Туре	Date	
	Financial Data and Reports			1.00	2.00	3.00	
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	" for Audited, "C" te copy or enter da no, see instruction revenues differen	for ate ons. t from	Y	A	05/24/2024	4.
	those on the filed financial statements? If reconciliation.	column 1 is "Y", s	ubmi t				
					Y/N 1.00	Legal Oper. 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	ng the cost report		for Nursing	N N		7. 8.
	School and/or Allied Health Program? (Y/N) s					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb	d debts? (Y/N) see			st reporting		
00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	d debts? (Y/N) see t collection polic d/or coinsurance w	y change di aived? If	uring this cos "Y", see instr	ructions.	1.00 N	10.
00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an	d debts? (Y/N) see t collection polic d/or coinsurance w	y change di aived? If	uring this cos "Y", see instr Y", see instru	ructions.	1.00 N N N	10. 11.
00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	d debts? (Y/N) see t collection polic d/or coinsurance w cost reporting pe Descriptic	y change du aived? If ' riod? If "'	uring this cos "Y", see instr Y", see instru Pa Y/N	ructions. uctions. urt A Date	1.00 N N Part B Y/N	10. 11.
00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data	d debts? (Y/N) see t collection polic d/or coinsurance w cost reporting pe	y change du aived? If ' riod? If "'	uring this cos "Y", see instru Y", see instru Pa Y/N 1.00	ructions.	1.00 N N Part B Y/N 3.00	10. 11. 12.
00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior	d debts? (Y/N) see t collection polic d/or coinsurance w cost reporting pe Descriptic	y change du aived? If ' riod? If "'	uring this cos "Y", see instr Y", see instru Pa Y/N	ructions. uctions. urt A Date	1.00 N N Part B Y/N	9. 10. 11. 12. 13.
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and	d debts? (Y/N) see t collection polic d/or coinsurance w cost reporting per Descriptic 0	y change du aived? If ' riod? If "'	uring this cos "Y", see instru Y", see instru Pa Y/N 1.00	ructions.	1.00 N N Part B Y/N 3.00	10. 11. 12.
00 00 00 00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used	d debts? (Y/N) see t collection polic d/or coinsurance w cost reporting per Descriptic 0	y change du aived? If ' riod? If "'	uring this cos "Y", see instru Y", see instru Pa Y/N 1.00 Y	ructions.	1.00 N N Part B Y/N 3.00	10. 11. 12.
	Bad Debts Is the provider seeking reimbursement for ballf line 9 is "Y", did the provider's bad debperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	d debts? (Y/N) see t collection polic d/or coinsurance w cost reporting per Descriptic 0	y change du aived? If ' riod? If "'	uring this cos "Y", see instru Y", see instru Pa Y/N 1.00 Y	ructions.	1.00 N N Part B Y/N 3.00	10. 11. 12. 13.
00 00 00 00 00 00 00 00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	d debts? (Y/N) see t collection polic d/or coinsurance w cost reporting per Descriptic 0	y change du aived? If ' riod? If "'	uring this cos "Y", see instr Y", see instru- Pa Y/N 1.00 Y N	ructions.	1.00 N N N Part B Y/N 3.00 Y N N N N N N N N	10. 11. 12. 13. 13.

Heal th	Financial Systems LION	S GATE		In Lie	u of Form CMS-	2540-10
) NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CA	RE	Provider No.: 315499	Period:	Worksheet S-2	
COMPLEX	K REIMBURSEMENT QUESTIONNAIRE			From 01/01/2023 To 12/31/2023		pared:
				10 12/01/2020	6/24/2024 5:0	7 pm
			1.00	2.	00	
C	Cost Report Preparer Contact Information					
	Enter the first name, last name and the title/position	DEAN	IDRA	FALLON		19.00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
20.00	Enter the employer/company name of the cost report	BAKE	R TILLY			20.00
	preparer.					
	Enter the telephone number and email address of the cost	570-	820-0301	DEANDRA. FALLON	BAKERTI LLY. CO	21.00
	report preparer in columns 1 and 2, respectively.			M		

Heal th	Financial Systems	LIONS GAT	E	In Lieu	of Form CMS-2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provider No.: 315499	From 01/01/2023 F To 12/31/2023 D	lorksheet S-2 Part II Date/Time Prepared: 5/24/2024 <u>5:07 pm</u>
		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	02/27/2024			13.00
	prepare this cost report in cols. 2 and				
	4. (see Instructions.)				
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and				14.00
45 00	4.				15 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		0.00		
	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		ECTOR		19.00
20.00	Enter the employer/company name of the cost preparer.	report			20.00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv				21.00

	Financial Systems	LI ONS	GATE		In Lie	u of Form CMS-2	2540-10
	ED NURSING FACILITY AND SKILLED NURSING EX STATISTICAL DATA	FACILITY HEALTH CARE	Provi der		eriod: rom 01/01/2023 0 12/31/2023	Worksheet S-3 Part I Date/Time Prep	
						6/24/2024 5:0	7 pm
				Inpa	ntient Days/Vis	SETS	
	Component	Number of Beds	Bed Days Avai I abl e	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	110	40, 150 0	0	7, 363	13, 158 0	1.00 2.00
. 00		0	0	0		0	3.00
. 00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
. 00	Other Long Term Care	0	0	-	-	-	5.00
. 00	SNF-Based CMHC						6.00
. 00	HOSPICE	0	0	0	0	0	7.00
. 00	Total (Sum of lines 1-7)	110	40, 150	0	7, 363	13, 158	8.00
		Inpatient [ays/visits		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
. 00	SKILLED NURSING FACILITY	14, 498	35, 019	0	408	37 0	1.00
. 00 . 00	NURSING FACILITY		0	0		0	2.00 3.00
. 00	HOME HEALTH AGENCY COST	0	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	0	7.00
. 00	Total (Sum of lines 1-7)	14, 498	35, 019	0	408	37	8.00
		Di sch	arges	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	253	698	0.00	18.05	355.62	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
. 00	SNF-Based CMHC		Ū.				6.00
. 00	HOSPI CE	0	0	0.00	0.00	0.00	7.00
. 00	Total (Sum of lines 1-7)	253	698	0.00	18.05	355.62	8.00
		Average Length of		Admi s	sions		
		Stay					
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
. 00 . 00	SKILLED NURSING FACILITY	50. 17 0. 00	0	470	15	205	1.00
	NURSING FACILITY				0	0	2.0
			0		0		
00	ICF/IID HOME HEALTH AGENCY COST	0.00	0		0	0	
00 00	HOME HEALTH AGENCY COST	0.00	0		0		4.0
00 00 00					O	0	4.0 5.0
. 00 . 00 . 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	0.00 0.00 0.00	0	O	0	0	4.00 5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	0.00 0.00 0.00 50.17	0	470	Ĵ	0	4.00 5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	0.00 0.00 0.00 50.17 Admi ssi ons	0 O Full Time	470 Equi val ent	0	0	4.00 5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	0.00 0.00 0.00 50.17	0	470	0	0	4.00 5.00 6.00 7.00
. 00 . 00 . 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component	0.00 0.00 0.00 50.17 Admi ssi ons Total 21.00	0 0 Full Time Employees on Payroll 22.00	470 Equi val ent Nonpai d Workers 23.00	0	0	4.00 5.00 6.00 7.00 8.00
. 00 . 00 . 00 . 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component	0.00 0.00 0.00 50.17 Admi ssi ons Total 21.00 690	0 0 Full Time Employees on Payroll 22.00 174.07	470 Equi val ent Nonpai d Workers 23.00 0.00	0	0	4.00 5.00 6.00 7.00 8.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY	0.00 0.00 0.00 50.17 Admissions Total 21.00 690 0	0 0 Full Time Employees on Payroll 22.00 174.07 0.00	470 Equi val ent <u>Workers</u> 23.00 0.00 0.00	0	0	4.00 5.00 6.00 7.00 8.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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	0.00 0.00 0.00 50.17 Admi ssi ons Total 21.00 690	0 Full Time Employees on Payroll 22.00 174.07 0.00 0.00	470 Equi val ent <u>Workers</u> 23.00 0.00 0.00 0.00	0	0	4.00 5.00 6.00 7.00 8.00 1.00 2.00 3.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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	0.00 0.00 50.17 Admissions Total 21.00 0 0	0 Full Time Employees on Payroll 22.00 174.07 0.00 0.00 0.00	470 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00	0	0	4.00 5.00 6.00 7.00 8.00 1.00 2.00 3.00 4.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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	0.00 0.00 0.00 50.17 Admissions Total 21.00 690 0	0 0 Full Time Employees on Payrol I 22. 00 174. 07 0. 00 0. 00 0. 00 0. 00	470 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00	0	0	4.00 5.00 6.00 7.00 8.00 1.00 2.00 3.00 4.00 5.00
. 00 . 00	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	0.00 0.00 50.17 Admissions Total 21.00 0 0	0 Full Time Employees on Payroll 22.00 174.07 0.00 0.00 0.00	470 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00	0	0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00

Heal th	Financial Systems	LI ONS	GATE		In Lie	u of Form CMS-:	2540-10
SNF W	AGE INDEX INFORMATION				Period: From 01/01/2023 To 12/31/2023		pared:
		Amount	Reclass. of	Adj usted	Paid Hours	Average	
			Salaries from		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)	12, 536, 306	0	12, 536, 30			1.00
2.00	Physician salaries-Part A	0	0		0 0.00		2.00
3.00	Physician salaries-Part B	0	0		0 0.00		3.00
4.00	Home office personnel	0	0		0 0.00		4.00
5.00	Sum of lines 2 through 4	0	0		0 0.00		5.00
6.00	Revised wages (line 1 minus line 5)	12, 536, 306	0	12, 536, 30			6.00
7.00	Other Long Term Care	0	0		0 0.00		7.00
8.00	HOME HEALTH AGENCY COST	0	0		0 0.00		
9.00	СМНС	0	0		0 0.00		9.00
10.00	HOSPICE	0	0		0 0.00		10.00
11.00	Other excluded areas	1, 582, 283		1, 582, 28			11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	1, 582, 283	0	1, 582, 28	46, 125. 00	34.30	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	10, 954, 023	C	10, 954, 02	3 315, 938. 00	34.67	13.00
	OTHER WAGES & RELATED COSTS	I	I	1			
14.00	Contract Labor: Patient Related & Mgmt	653, 280	0	653, 28	16, 871. 00	38. 72	14.00
15.00	Contract Labor: Physician services-Part A	30, 193		30, 19			15.00
16.00	Home office salaries & wage related costs	0			0 0.00	0.00	16.00
	WAGE-RELATED COSTS		· · · ·				
17.00	Wage-related costs core (See Part IV)	2, 831, 229	0	2, 831, 22	9		17.00
	Wage-related costs other (See Part IV)	0	0		0		18.00
	Wage related costs (excluded units)	357, 347	0	357, 34	7		19.00
	Physician Part A - WRC	0	l o		0		20.00
		0	0		0		21.00
	Total Adjusted Wage Related cost (see	2, 473, 882	0	2, 473, 88	2		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		Period:	Worksheet S-3	
					From 01/01/2023 To 12/31/2023		narod
					10 12/31/2023	6/24/2024 5:0	
		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 III - OVERHEAD COST - DIRECT SALARIES	1		1			
1.00	Employee Benefits	0	0		0.00	0.00	1.00
2.00	Administrative & General	1, 622, 734	0	1, 622, 73	4 36, 858. 00	44.03	2.00
3.00	Plant Operation, Maintenance & Repairs	476, 400	0	476, 40	0 19, 327. 00	24.65	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	105, 648	0	105, 64	5, 349. 00	19.75	6.00
7.00	Nursing Administration	639, 773	0	639, 77	3 14, 338. 00	44.62	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	162, 454	0	162, 45	4, 628. 00	35.10	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	693, 502	0	693, 50	2 31, 048. 00	22.34	13.00
14.00	Total (sum lines 1 thru 13)	3, 700, 511	0	3, 700, 51	1 111, 548. 00	33. 17	14.00

	Financial Systems	LIONS GATE		In Lie	u of Form CMS-2	2540-1
SNF WA	GE RELATED COSTS	P	rovider No.: 315499	Period: From 01/01/2023 To 12/31/2023		
				10 12/01/2020	6/24/2024 5:0	
					Amount	
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					-
	Part A - Core List					-
1 00	RETIREMENT COST					1 1 0
1.00	401K Employer Contributions				0	1.00
2.00 3.00	Tax Sheltered Annuity (TSA) Employer Contribution Qualified and Non-Qualified Pension Plan Cost	on			93, 110	2.00 3.00
4.00	Prior Year Pension Service Cost				93, 110	4.00
+. 00	PLAN ADMINISTRATIVE COSTS (Paid to External Orga	anizati on)			0	4.00
5.00	401K/TSA Plan Administration fees				0	5.00
5.00	Legal /Accounting/Management Fees-Pension Plan				0	6.0
7.00	Employee Managed Care Program Administration Fee	es			0	7.0
	HEALTH AND INSURANCE COST					/.0
3. 00	Health Insurance (Purchased or Self Funded)				1, 252, 124	8.0
9.00	Prescription Drug Plan				0	9.0
10.00	Dental, Hearing and Vision Plan				56, 640	10.0
11.00	Life Insurance (If employee is owner or benefici	iary)			0	11.0
12.00	Accident Insurance (If employee is owner or bene	eficiary)			0	12.0
3.00	Disability Insurance (If employee is owner or be	enefi ci ary)			21, 507	13.0
	Long-Term Care Insurance (If employee is owner of	or beneficiary)			0	14.C
	Workers' Compensation Insurance				336, 468	
6.00	Retirement Health Care Cost (Only current year,	not the extraordi	nary accrual requir	ed by FASB 106.	0	16. C
	Non cumulative portion)					
	TAXES				000 1/5	
	FICA-Employers Portion Only				982, 165	
	Medicare Taxes - Employers Portion Only Unemployment Insurance				0 89, 215	
	State or Federal Unemployment Taxes				89,215	
20.00	OTHER				0	20.0
21 00	Executive Deferred Compensation				0	21.0
	Day Care Cost and Allowances				0	
	Tuition Reimbursement				0	22.0
	Total Wage Related cost (Sum of lines 1 - 23)				2, 831, 229	
					Amount	20
					Reported	
					1.00	
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00

Heal th	Financial Systems	LIONS O	ATE		In Lie	u of Form CMS-2	2540-10
SNF RE	EPORTING OF DIRECT CARE EXPENDITURES		Provi der		Period:	Worksheet S-3	
					From 01/01/2023 To 12/31/2023	Part V Date/Time Pre	pared:
						6/24/2024 5:0	
	Occupational Category	Amount	Fringe	Adj usted	Paid Hours	Average	
		Reported	Benefits	Sal ari es	Related to	Hourly Wage	
				(col. 1 + col. 2)	Salaryin col. 3	(col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4,00	5,00	
	Direct Salaries	1.00	2.00	5.00	4.00	3.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 645, 045	371, 451	2, 016, 49	32, 595. 00	61.87	1.00
2.00	Licensed Practical Nurses (LPNs)	1, 758, 253	397, 014	2, 155, 26	45, 622. 00	47.24	2.00
3.00	Certified Nursing Assistant/Nursing	2, 475, 521	558, 973	3, 034, 49	94, 967. 00	31.95	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	5, 878, 819	1, 327, 438			41.61	4.00
5.00	Physi cal Therapi sts	428, 217	96, 691	524, 90			5.00
6.00	Physical Therapy Assistants	274, 664	62, 019	336, 68			6.00
7.00	Physical Therapy Aides	0	0		0 0.00		7.00
8.00	Occupational Therapists	315, 492	71, 238	386, 73			8.00
9.00	Occupational Therapy Assistants	150, 941	34, 082	185, 02			9.00
10.00	Occupational Therapy Aides	0	0		0 0.00	0.00	
11.00	Speech Therapists	115, 887	26, 167	142, 05			11.00
12.00	Respiratory Therapists	89, 493	20, 208	109, 70			12.00
13.00	Other Medical Staff	0	0		0 0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations	01.000		01.07		(0.00	
14.00	Registered Nurses (RNs)	31, 229		31, 22			14.00
15.00	Licensed Practical Nurses (LPNs)	148, 131		148, 13			15.00
16.00		473, 920		473, 92	13, 631. 00	34.77	16.00
17.00	Assistants/Aides Total Nursing (sum of lines 14 through 16)	653, 280		653, 28	16, 871. 00	38.72	17.00
17.00	Physical Therapists	055, 260		000, 20	0 0.00	0.00	
18.00	Physical Therapy Assistants	0			0 0.00	0.00	
20.00	Physical Therapy Aides	0			0 0.00	0.00	
20.00	Occupational Therapists	0			0 0.00	0.00	
21.00	Occupational Therapy Assistants	0			0 0.00		
22.00	Occupational Therapy Aides	0			0 0.00		
23.00	Speech Therapi sts				0 0.00	0.00	
24.00	Respiratory Therapists	0			0 0.00		
26.00	Other Medical Staff	0			0 0.00		26.00
20.00		, vi			5.00	5.00	

Health Financial Systems LIC PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	NS GATE Provider No.: 315499	Peri od:	u of Form CMS- Worksheet S-	
		From 01/01/2023 To 12/31/2023		
		Group	Days	
PROSPECTI VE PAYMENT FOR SNF STATI STI CAL DATA		Period: From 01/01/2023 To 12/31/2023 Image: Complement of the second secon	Worksheet S- Date/Time Pro 6/24/2024 5:0	7 07 pm 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 11.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 40.00 41.00 42.00 43.00 44.00
64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00		BB1 BA2 BA1 PE2 PE1 PD2 PD1 PC2 PC1 PB2 PB1 PA2		64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00

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 01/01/2023 To 12/31/2023		
				Group	Days	
				1.00	2.00	
76.00				PA1		76.00
99.00				AAA		99.00
100. 00 TOTAL						100.00
			Expenses	Percentage	Y/N	
			1.00	2.00	3.00	
A notice published in the Federal Register Vo payments beginning 10/01/2003. Congress expect expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for 1, column 3. Indicate in column 3 "Y" for yes direct patient care and related expenses for instructions)	ted this increase column 1 the amou each category to or "N" for no if	to be used nt of the total SNF the spendi	d for direct expense for revenue from ng reflects	patient care and each category. E Worksheet G-2, increases associ	l related Enter in Part I, line ated with	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY)						101.00 102.00 103.00 104.00 105.00

^{106.00}Total SNF revenue (Worksheet G-2, Part I, Line 1, column 3)106.00

Heal th	Financial Systems	LIONS G	ATE		In Lie	u of Form CMS-2	2540-10
	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF				Period:	Worksheet A	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 6/24/2024 5:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons	Reclassified Trial Balance	
				+ COL 2)	Increase/Decr	(col. 3 +-	
					ease (Fr Wkst	col. 4)	
		1.00	2.00	2.00	A-6)	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		6, 835, 340	6, 835, 340) 0	6, 835, 340	1.00
	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0	c c	-	0	2.00
3.00	00300 EMPLOYEE BENEFITS	0	2,831,229			2, 831, 229	3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	1, 622, 734 476, 400	2, 452, 557 2, 487, 490			4, 075, 291 2, 963, 890	4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	470,400	2, 467, 470			2, 903, 090	6.00
7.00	00700 HOUSEKEEPI NG	0	1, 364, 232			1, 364, 232	
8.00	00800 DI ETARY	105, 648	6, 543, 790			6, 649, 438	
	00900 NURSI NG ADMI NI STRATI ON	639, 773	0	639, 773		639, 773	
	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	397, 832 56, 845			397, 832 56, 845	10.00 11.00
	01200 MEDICAL RECORDS & LIBRARY	0	0,049	00,040		0	12.00
	01300 SOCIAL SERVICE	162, 454	4, 114	166, 568	0	166, 568	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	-	0	14.00
15.00		693, 502	205, 196	898, 698	0	898, 698	15.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	5, 878, 819	829, 501	6, 708, 320	0	6, 708, 320	30.00
	03100 NURSING FACILITY	5, 676, 617	027, 301			0,700,320	31.00
32.00	03200 CF/I D	0	0	C	-	0	32.00
	03300 OTHER LONG TERM CARE	0	0	C	0	0	33.00
	ANCI LLARY SERVICE COST CENTERS		22 707	20.707		22.707	40.00
	04000 RADI OLOGY 04100 LABORATORY	0	32, 787 40, 399			32, 787 40, 399	40.00
	04200 I NTRAVENOUS THERAPY	0	40, 377			40, 377	
	04300 OXYGEN (INHALATION) THERAPY	0	3, 714	3, 714	100, 064	103, 778	
	04400 PHYSI CAL THERAPY	1, 374, 693	162, 387	1, 537, 080		785, 909	44.00
	04500 OCCUPATI ONAL THERAPY	0	0	C C	02.,00.	521, 531	45.00
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0		129, 576	129, 576 0	46.00 47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	307, 396	307, 396	0	307, 396	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	-	0	50.00
	05100 SUPPORT SURFACES	0	0	C	0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0			0	61.00
	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0				70.00 71.00
	07300 CMHC	0	0		-		73.00
	SPECIAL PURPOSE COST CENTERS						/0/00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		-	0	80.00
	08100 INTEREST EXPENSE		0	C	0	0	
82.00 83.00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0			0	82.00 83.00
89.00	SUBTOTALS (sum of lines 1-84)	10, 954, 023	24, 811, 290	35, 765, 313	-	35, 765, 313	89.00
	NONREI MBURSABLE COST CENTERS		, ,				
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	-	0	
	09100 BARBER AND BEAUTY SHOP	0	10, 467	10, 467	0	10, 467	
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0			0	92.00 93.00
	09300 NUNPATE WORKERS 09400 PATIENTS LAUNDRY	0	0			0	
	09500 ALU/I LU	1, 582, 283	791, 745	2, 374, 028	0	2, 374, 028	
100.00	TOTAL	12, 536, 306	25, 613, 502	38, 149, 808	0	38, 149, 808	

	Financial Systems	LIONS				u of Form CMS-	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	F EXPENSES	Provi der	No.: 315499	Period:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
						6/24/2024 5:0	
	Cost Center Description	Adjustments	Net Expenses				
		to Expenses	For				
		(Fr Wkst A-8)	Allocation				
			(col. 5 +- col. 6)				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-850, 841	5, 984, 499				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	0				2.00
3.00	00300 EMPLOYEE BENEFITS	-53, 231	2, 777, 998				3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	-398, 720	3, 676, 571				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	-7,088	2, 956, 802				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	256, 481				6.00
7.00	00700 HOUSEKEEPI NG	0	1, 364, 232				7.00
8.00	00800 DI ETARY	-46, 596	6, 602, 842				8.00
9.00	00900 NURSING ADMINISTRATION	0	639, 773				9.00
	01000 CENTRAL SERVICES & SUPPLY	0	397, 832				10.00
	01100 PHARMACY	0	56, 845				11.00
	01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
	01300 SOCIAL SERVICE	0	166, 568				13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0				14.00
15.00	01500 ACTIVITIES	0	898, 698				15.00
30, 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	-26, 818	6, 681, 502				30.00
	03100 NURSING FACILITY	-20, 818	0,001,002				31.00
	03200 CF/I D	0	0				32.00
	03300 OTHER LONG TERM CARE	0	0				33.00
00.00	ANCI LLARY SERVICE COST CENTERS						00.00
40.00	04000 RADI OLOGY	0	32, 787				40.00
	04100 LABORATORY	0	40, 399				41.00
	04200 I NTRAVENOUS THERAPY	0	0				42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	103, 778				43.00
44.00	04400 PHYSI CAL THERAPY	0	785, 909				44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	521, 531				45.00
	04600 SPEECH PATHOLOGY	0	129, 576				46.00
	04700 ELECTROCARDI OLOGY	0	0				47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				48.00
	04900 DRUGS CHARGED TO PATIENTS	0	307, 396				49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0				50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVI CE COST CENTERS	0	0				51.00
40.00	06000 CLINIC	0	0				60.00
	06100 RURAL HEALTH CLINIC	0	0				61.00
	06200 FQHC	0					62.00
02.00	OTHER REIMBURSABLE COST CENTERS		I	1			- 02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0				70.00
	07100 AMBULANCE	0					71.00
	07300 CMHC	0					73.00
	SPECIAL PURPOSE COST CENTERS						1
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0				80.00
	08100 INTEREST EXPENSE	0	0				81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	0				82.00
	08300 HOSPI CE	0	0				83.00
89.00	SUBTOTALS (sum of lines 1-84)	-1, 383, 294	34, 382, 019				89.00
	NONREI MBURSABLE COST CENTERS	1	r	I			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90.00
	09100 BARBER AND BEAUTY SHOP	0	10, 467				91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0				92.00
	09300 NONPALD WORKERS	0	0				93.00
	09400 PATI ENTS LAUNDRY 09500 ALU/I LU	0					94.00
		1 202 204	2, 374, 028				95.00
100.00	TOTAL	-1, 383, 294	36, 766, 514	I			100.00

Health Financial Systems	LIONS GATE		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Provi der		Period: From 01/01/2023	Worksheet A-6	
			To 12/31/2023		
		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	89, 493	10, 571	1.00
2.00	OCCUPATI ONAL THERAPY	45.0	466, 433	55, 098	2.00
3.00	SPEECH PATHOLOGY	46.0	00 115, 887	13, 689	3.00
TOTALS					
100.00	Total Reclassifications (Su	m	671, 813	79, 358	100.00
	of columns 4 and 5 must				
	equal sum of columns 8 and				
	9)	1			

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	LIONS GATE			In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Period:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 6/24/2024 5:0	pared: 7 pm
			Decreases			
	Cost Center	-	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
(1) A - TO RECLASS THERAPY						
1.00	PHYSI CAL THERAPY		44. (00 671, 813	79, 358	1.00
2.00			0. (0 00	0	2.00
3.00			0. (0 00	0	3.00
TOTALS						
100. 00				671, 813	79, 358	100.00

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

Heal th	n Financial Systems	LIONS	GATE		In Lie	eu of Form CMS-2	2540-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315499	Period:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		pared [.]
					10 12/01/2020	6/24/2024 5:0	
				Acquisition			
	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 BALA						
1.00	Land	6, 316, 248	0		0 0	0 0	1.00
2.00	Land Improvements	1, 619, 293	74, 285		0 74, 285		2.00
3.00	Buildings and Fixtures	89, 852, 362	1, 617, 079		0 1, 617, 079	0	3.00
4.00	Building Improvements	0	0		0 0	0 0	4.00
5.00	Fixed Equipment	10, 430, 949	262, 666		0 262, 666	0	5.00
6.00	Movable Equipment	1, 656, 424	16, 059		0 16, 059	0	6.00
7.00	Subtotal (sum of lines 1-6)	109, 875, 276	1, 970, 089		0 1, 970, 089	0	7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	109, 875, 276	1, 970, 089		0 1, 970, 089	0	9.00
	Description	Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALA						
1.00	Land	6, 316, 248	0				1.00
2.00	Land Improvements	1, 693, 578	0				2.00
3.00	Buildings and Fixtures	91, 469, 441	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	10, 693, 615	0				5.00
6.00	Movable Equipment	1, 672, 483	0				6.00
7.00	Subtotal (sum of lines 1-6)	111, 845, 365	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	111, 845, 365	0				9.00

IIICT*	Financial Systems	LIONS C		No 1 21E400		eu of Form CMS-2	
JUSI	IENTS TO EXPENSES		Provi der	No.: 315499	Period: From 01/01/2023	Worksheet A-8	5
					To 12/31/2023		
					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	B		CAP REL COST		1.00	1
	(chapter 2)			FIXTURES		0.00	
	Trade, quantity, and time discounts (chapter 8)		0			0.00	2
	o) Refunds and rebates of expenses (chapter 8)		0			0.00	3
	Rental of provider space by suppliers		0			0.00	
	(chapter 8)						_
00	Telephone services (pay stations excluded) (chapter 21)	В	-5, 236	ADMINISTRATI	VE & GENERAL	4.00	5
00	Television and radio service (chapter 21)	В	-7,088	PLANT OPERAT	ION, MAINT. &	5.00	6
				REPAI RS			
	Parking lot (chapter 21)		0			0.00	
	Remuneration applicable to provider-based physician adjustment	A-8-2	0				8
	Home office cost (chapter 21)		0			0.00	9
	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
. 00	Nonallowable costs related to certain		0			0.00	11
00	Capital expenditures (chapter 24)	101	0				1.10
	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	0				12
	Laundry and Linen service		0			0.00	13
	Revenue – Employee meals	В	-46, 596	DI ETARY		8.00	
	Cost of meals - Guests		0			0.00	
	Sale of medical supplies to other than patients		0			0.00	16
	Sale of drugs to other than patients		0			0.00	17
00	Sale of medical records and abstracts		0			0.00	
	Vending machines		0			0.00	
	Income from imposition of interest, finance		0			0.00	20
	or penalty charges (chapter 21) Interest expense on Medicare overpayments		0			0.00	21
	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) Depresention buildings and fixtures		0			1 00	1 22
00	Depreciationbuildings and fixtures		0	CAP REL COST FIXTURES	S - DLDGS &	1.00	23
00	Depreciationmovable equipment		0	CAP REL COST	S - MOVABLE	2.00	24
				EQUI PMENT			0
	MISCELLANEOUS INCOME	B			VE & GENERAL	4.00	
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		EMPLOYEE BEN CAP REL COST		3.00 1.00	
UZ	WIT SOLLEAINEOUS I INCOMIL	ט	-10,142	FIXTURES	5 - ΟΕΡΟΟ α	1.00	20
. 03	PHYSICIAN PROFESSIONAL FEES	A	-26, 818		ING FACILITY	30.00	25
	NON-ALLOWABLE EXPENSES	A	-345, 367	ADMI NI STRATI	VE & GENERAL	4.00	25
	Total (sum of lines 1 through 99) (Transfer						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.

Cost Center Description Not Expenses For Cost Allocation RUCES & FIXTURES MOVABLE EWILPMENT EWPLOPEE BINEFITS Subtotal 1.00 00100 (AP REL COST - ENDES A FIXTURES - 00100 (AP REL COST - BLOS A FIXTURES - 000000 (BE REPAIN - 0000000 (BE REPAIN - 0000000000 (BE REPAIN - 000000000000000000000000000000000000		Financial Systems	LIONS (u of Form CMS-2	2540-10
Cost Center Description Net Expenses For Cost All cost on (real with) CAP TAL RELATE ODSTS FOUNDER EVENUES FOUNDER EVENUES FOUNDER Subtotal First Durks 1.00 General. SERVICE COST CENTERS 0.00 1.00 2.00 3.00 34. 1.00 GENERAL.SERVICE COST CENTERS 0.00 1.00 2.00 3.00 34. 1.00 GENERAL SERVICE COST CENTERS 0.00 0.100 2.00 3.00 34. 1.00 GENERAL SERVICE COST CENTERS 0.00 0.010 2.777.99 0.2777.99 4.036.06 1.00 GENERAL SERVICE COST CENTERS 0.00 0.0000 0.0105.68 3.00.277 37.00 2.00 GOSCOP LANT OPERATION. MAINT: A LEPARS 0.00 2.596.802 0 0.0105.68 3.00.277 3.00 DETERM MINISTRATION 6.60.2422 0 0.23.91.16 6.66.25.02 3.00 DICOM DETERM MINISTRATION 6.645.660 0 0.05.99 2.26.641 3.00 DICOM DETERM MINISTRATION 6.645.566 0 0 1.05.271 3.00 DICOM DETERM MINISTRATIVE SENDER S.991.4.03.772 </td <td>COST A</td> <td>LLOCATION - GENERAL SERVICE COSTS</td> <td></td> <td>Provi der</td> <td>No.: 315499</td> <td>Pe</td> <td>eriod:</td> <td>Worksheet B</td> <td></td>	COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315499	Pe	eriod:	Worksheet B	
Loc Cost Center Description Not Expenses Al location (from kers A EDDS A rout of the texpenses al location (from kers A EDDS A EVENS A MOVABLE EULIPMENT EMPLOYEE Subtotal 0 00100 CAP FEL COSTS - BLIDS A 00000 CAP FEL COSTS - BLIDS A 1.00 1.00 2.00 3.00 3A 1.00 00100 CAP FEL COSTS - BLIDS A 00000 CAP FEL COSTS - BLIDS A 1.00 5.984.499 0 2.777.998 0 2.777.998 4.056.51 3.00									pared:
Cost Center Description Net Expenses for Cost (tron Witt) 4 BLDGS / FixTURES MOVABLE Four Net FixTURES EXPLOYE Four Net FixTURES EMPLOYE Four Net FixTURES Subtotal 1.00 Cost Conternes 0 1.00 2.00 3.00 3A 1.00 D00000 CAP REL COSTS - NOVABLE ECUI PRENT 2.00 5.984.499 0 2.777.999 4.055.56 0.00000 CAP REL COSTS - NOVABLE ECUI PRENT 2.00 2.777.999 4.055.56 3.00 3A 5.00 000500 PLANT OPENTION, MAINT & PEPAIRS 2.777.999 4.055.56 3.00 3.00 3.00 5.00 000500 PLANT OPENTION, MAINT & PEPAIRS 2.976.481 0 0 1.364.232 0 0 1.364.232 0.000000 NURSING AUMIN STRATION 6.602.642 0 0 1.364.232 0 0 1.364.233 0 0 1.364.237 0 0 1.365.26 1.364.233 0 0 0 0 0 0.077.78 0 1.362.37 1.00 010000 NURSING AUMINISTRATION 6.691.902 1.120.448 0 1								6/24/2024 5:0	
Prof Cost (From West A) FIXTURES (From West A) EQUIPMENT BENEFITS 1.00 00000 2.00 3.00 3.0 2.00 00000 CAP REL COSTS - BLOGS & FIXURES 0 5.984.499 0 2.00 0.00000 CAP REL COSTS - MOVABLE FOULPHENT 0 5.984.499 0 2.00 3.00 3.00 0.00000 CARD OPERTON NAIT OFERATON 6.05,571 0 0 3.625,571 0 3.62,673 0.00000 CARD OPERTON NAIT OFERATON 6.02,942 0 0 1.25,420 0.00000 CARD OPERATON NAIT OPERATON 6.02,942 0 0 1.25,420 0.00000 CARD OPERATON 6.02,942 0 0 1.25,420 0 0 3.97,832 0.00000 CORDS ALIBRARY 56,645 0 0 0 3.97,832 0 0 1.11,771 781,54 10.000 CORDS ALIBRARY 56,645 0 0 0 0 1.05,277 10.000				CAPI TAL REL	LATED COSTS				
Prof Dost (From Wists A) FIXTURES (From Wists A) EQUIPMENT BENEFITS 1.00 00000 LASERVICE COST CENTERS 0 0 1.00 2.00 3.00 34 1.00 00000 LAP REL COSTS - BLOSS & FITURES 0.00000 LAWENT BREINTS 5.984.499 0 2.00		Cost Center Description	Net Expenses	BLDGS &	MOVABLE			Subtotal	
All location All location All location 00 1.00 2.00 3.00 3.4 1.00 00100 (AP RL COST - BUDS A LIXTURES 5.984.499 0 2.777,998 0 2.777,998 0 0.2777,998 0 2.777,998 0 0.2874 0 0.2874 0 0.2874 0 0.2874 0 0.2874 0 0.2874 0 0.2874 0.2874 0.2874 0.2874 0.2874 0.2874 0.2874 0.2874 0.2874 0.2874 <		cost center bescription						Subtotal	
Col. 7) Col. 7) <t< td=""><td></td><td></td><td></td><td>TTATORES</td><td>Egottimenti</td><td></td><td>DENEITIO</td><td></td><td></td></t<>				TTATORES	Egottimenti		DENEITIO		
Definition 0 1.00 2.00 3.00 3A 1.00 00100 CAP REL COSTS - BLOSS & FIXTURES 5.984,499 0 2 2.777,998 0 0 2.777,998 0 0 2.777,998 0 0 2.777,998 0 0 2.777,998 0 0 2.777,998 0 0 2.777,998 0 0 2.777,998 0 0 2.777,998 0 0 2.777,998 0 0 2.956,632 0 0 0.0020 (PLANT OPERATION, MAN STRATTON ESERVICE 2.566,632 0 0 0 0 0 2.777,978 0 0 1.666,537 771,593 0			(from Wkst A						
ENDERAL SERVICE COST CENTERS 5 964.49 0 100 000100 CAP REL COSTS - BURSA & INTURES 0 0 2.777.96 0 0 2.777.96 0 0 2.777.96 0 0 2.00 0.00000 CAP REL COSTS - BURSA & INTURES 2.777.96 0 0 2.777.96 0 0 2.777.96 0 0 2.00 0.00000 CAP REL COSTS - BURSA & INTURES 2.776.571 0 0 0.005.566 0.00000 CAUNT OPEANTON, MAINT & REPAIRS 2.966.002 0 0 0 0.55.66 0 0 2.56.481 0 0 2.777.966 0 2.777.966 0 2.86.43 0 0 2.56.442 0 0 2.56.445 0 0 2.777.966 0 2.87.472 7.85.645 0 0 0 0 0.77.716.666.525 0 0 0 0.77.716.666 0 0 2.97.83 0 0 0.66.666 0 0 0 0 0 0 0 0 0 0.0									
1.00 00100 CAP REL COSTS - BLORS & FIXTURES 5,984,499 5,984,499 0 2.00 00200 CAP REL COSTS - MOVABLE EDINENT 2,777,998 0 0 2,777,998 3.00 00300 EMPLOYEE BENEFITS CUPTOP FARTION, MAINT & REPAIRS 2,956,602 0 0 0,62,37 5.00 00500 PLANT OPERATION, MAINT & REPAIRS 2,956,602 0 0 0 2,66,63 0,62,37 6.00 00600 DLTARY 6.002,443 0 0 2,34,11 6,42,23 0 0 1,64,23 9.00 00000 CENTRAL SERVICES 6,598 0 0 0 1,64,23 0 0 1,64,23 10.00 01000 CENTRAL SERVICES 6,581 0 0 0 0 0 0 0,697,937,83 12.00 01000 CENTRAL SERVICE 6,581,949 0 0 1,5,77 1,652,37 1,622,37 13.00 01300 OTALSERVICE 898,698 0 0 1,32,777 1,652,37 1,122,438 0 1,32,777 <td< td=""><td></td><td></td><td>0</td><td>1.00</td><td>2.00</td><td></td><td>3.00</td><td>3A</td><td></td></td<>			0	1.00	2.00		3.00	3A	
2 00 00200 (CAP REL COSTS - MOVABLE EQUIPMENT 0 0 0.0 00300 (DHUYCE EDENLITIS 2,777,996 0 2,777,996 4.00 00400 ADMI MISTATTIVE & GENERAL 3,676,571 0 0 3359,591 4,036,16 0.0 00500 (LAUNDER X LINEN SERVICE 2,556,481 0 0 105,563 3,062,37 0.0 00500 (LAUNDER X LINEN SERVICE 2,566,481 0 0 1,364,232 0 0 1,364,232 0 0 1,364,232 0 0 1,364,232 0 0 1,364,232 0 0 1,364,232 0 0 1,364,232 0 0 1,364,232 0 0 1,364,232 0 0 1,364,332 0 0 1,364,332 0 0 1,364,332 0 0 1,364,332 0 0 1,364,332 0 0 1,364,332 0 0 1,364,332 0 0 1,364,332 0 0 0,374,833 0 0,300,336,306,334 0			5 984 499	5 984 499		- T			1.00
3.00 00300 EMPLOYEE EENEFITS 2.777,998 0 0 2.777,998 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 2.956,802 0 0 105,568 3.662,37 6.00 00600 LUMPRY & LINN SERVICE 1.344,232 0 0 0 1.344,232 9.00 00900 NURSIN ADMIN STRATION 6.39,773 0 0 1.41,6262,52 9.00 00900 NURSIN ADMIN STRATION 6.39,773 0 0 1.41,771 1781,54 10.00 01000 ENTRAL SERVICE & SUPPLY 397,832 0 <td></td> <td></td> <td></td> <td>0, 701, 177</td> <td></td> <td>0</td> <td></td> <td></td> <td>2.00</td>				0, 701, 177		0			2.00
5.00 00500 PLANT OPERATION, MAINT, & REPAIRS 2, 956, 802 0 0 105.568 3, 062, 37 6.00 00600 LANDRY & LINEN SERVICE 1, 364, 232 0 0 1, 364, 232 9.00 00700 HOUSEKEPI NG 1, 364, 232 0 0 23, 411 6, 622, 55 9.00 00900 HURSING ADMINISTRATION 639, 773 0 0 141, 771 781, 54 9.00 00900 HURSING ADMINISTRATION 639, 773 0 0 141, 771 781, 54 9.00 01000 PHARAMACY 56, 645 0 0 0 0 0 0 141, 771 781, 54 13.00 01300 SOCIAL SERVICE 166, 568 0 <td></td> <td></td> <td>2, 777, 998</td> <td>0</td> <td></td> <td>0</td> <td>2, 777, 998</td> <td></td> <td>3.00</td>			2, 777, 998	0		0	2, 777, 998		3.00
6.00 00600 LAUNDRY & LINEN SERVICE 256.481 0 0 256.481 7.00 00700 NURSING ADMINISTRATION 6.302,432 0 0 23,411 6.622,542 8.00 00800 DIETARY 6.602,842 0 0 141,771 781,54 10.00 01000 CENTRAY 56,645 0 0 0 56,644 12.00 01200 MEDICAL RECORDS & LIBRARY 0<	4.00	00400 ADMI NI STRATI VE & GENERAL	3, 676, 571	0		0	359, 591	4, 036, 162	4.00
7.00 00700 [HOUSEKEPPING 1, 364, 232 0 0 0 1, 364, 232 8.00 00800 [LTRAY 6, 602, 624 0 0, 23, 411 6, 622, 25 9.00 00900 [LTRAY SEN (CES & SUPPLY 397, 733 0 0 141, 771 781, 54 10.00 01000 [PHARMACY 56, 845 0 0 0 56, 84 12.00 01200 [PHCAL CRECORDS & LIBRAY 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td>0</td> <td>105, 568</td> <td></td> <td>5.00</td>				-		0	105, 568		5.00
8.00 008000 DI ETARY 6, 602, 842 0 23, 411 6, 6, 626, 523 9.00 00900 UNRSI KG ADMI NI STRATION 6339, 773 0 0 141, 771 781, 54 10.00 01000 CENTRAL SERVICES 56, 844 0 0 6, 645 12.00 01200 MEDI CAL RECORDS & LI BRARY 0 0 0 6, 661 12.00 01300 OLICH KENK GAD ALLIED HEALTH EDUCATION 0				-		-	-		
9.00 00900 NURSI NG ADMINISTRATION 6.39,77.3 0 0 141,771 781.54. 10.00 01000 (CHITRAL SERVICES & SUPPLY 397,832 0 0 0 56.84. 10.00 01000 PHARMACY 56.84.5 0 0 0 56.84. 10.00 01000 PHARMACY 56.84.5 0 0 0 0 56.84. 10.00 01000 NURSI NG ADA LLIED HEALTH EDUCATION 0 0 0 0 0 57. 11.00 01000 NURSI NG ADA LLIED HEALTH EDUCATION 898.698 0 0 153.677 1, 1052.37 11.00 03000 SKI LLED NURSI NG FACILITY 6.6.681.502 1, 120,448 0 1, 302,727 9, 104,67 10.00 03000 SKI LLED NURSI NG FACILITY 6.6.681.502 1, 120,448 0 0 1, 302,727 9, 104,67 32.00 03200 ICF/ I D 0 0 0 0 0 0 0 332.00 ICF/ I D 0 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 03200 ICF/ I D 0 0 0 0 0 0 32.00 0400 UHER LONG TERM CARE 0 0 0 0 0 0 0 32.00 0400 UHER LONG TERM CARE 0 0 0 0 0 0 0 32.00 04300 DYIEC COST CENTERS 30.00 05100 INTRAVENUOS THERAPY 703,778 0 0 19,831 123.60 43.00 04500 DYIEC (NHALATION) THERAPY 703,778 0 0 19,831 123.60 44.00 04400 DYISI CAL THERAPY 781.55,509 0 0 155,755 941.66 45.00 04500 DEVEL 9 PATIENTS 0 0 0 0 0 55,755 941.66 45.00 04500 DEVEL 9 PATIENTS 0 0 0 0 0 0 0 307.39 0 00 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 307.39 0 000 DUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 307.39 0 0000 OUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0 0 300 0300 OUTAL CARE - TTUE XIX ONLY 0 0 0 0 0 0				-			-	.,	
10. 00 01000 CENTRAL SERVICES & SUPPLY 397, 832 0 0 0 397, 832 11. 00 01100 PHARMACY 56, 645 0 0 0 56, 644 12. 00 01200 MEDICAL, RECORDS & LIBRARY 0 0 0 0 66 13. 00 01300 CHALS SERVICE 166, 568 0 0 0 0 14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 10. 00 0300 CTIVITIES 898, 698 0 0 1, 302, 727 9, 104, 67 10. 00 03100 NURSING FACILITY 6, 681, 502 1, 120, 448 0 1, 302, 727 9, 104, 67 20. 00 03300 CIF, 71 ID 0 0 0 0 0 0 30. 00 03300 CIF, 71 ID 0 0 0 0 0 0 30. 00 04000 RADIOLOGY 32, 787 0 0 0 32, 787 0 0 32, 787 0 0 32, 787 0 0 32, 787 0 0 0 32, 787 0 0 0 32, 787 0 0 0 32, 787 0 0 0 32, 785 0 0				-					
11.00 01100[PHARMACY 56,845 0 0 56,845 12.00 012000 MEDICAL RECORDS & LIBRARY 0 0 0 0 13.00 01300 SOCIAL SERVICE 166,568 0 35,999 202,56 15.00 01500 ACTI VIT IES 898,698 0 153,677 1,052,377 IMPAT ENT ROUTINE SERVICE COST CENTERS 9 0 0 0 0 0 30.00 03000 SKILLED NURSING ACTI LITY 6,681,502 1,120,448 0 1,302,727 9,104,67 31.00 03000 CIF/ ID 0				-		-			9.00 10.00
12:00 01200 MEDICAL RECORDS & LIBRARY 0				-			-		11.00
13. 00 01300 SOCIAL SERVICE 166, 568 0 0 35, 999 202, 56 14. 00 01400 MRSING AND ALLIED HEALTH EDUCATION 898, 698 0 0 153, 677 1, 052, 37 INPART INF NOTTINE SERVICE COST CENTERS 0				-		-	0	0	12.00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 <th< td=""><td></td><td></td><td>166, 568</td><td>0</td><td></td><td></td><td>35, 999</td><td></td><td>13.00</td></th<>			166, 568	0			35, 999		13.00
INPATIENT ROUTINE SERVICE COST CENTERS 100 03000 SKILLED NURSING FACILITY 6, 681, 502 1, 120, 448 0 1, 302, 727 9, 104, 67 31.00 03300 NURSING FACILITY 6, 681, 502 1, 120, 448 0 1, 302, 727 9, 104, 67 33.00 03300 OTF/LID 0				0		0		0	14.00
30. 00 03000 SK1LLED NURSING FACILITY 6, 681, 502 1, 120, 448 0 1, 302, 727 9, 104, 67 31. 00 03300 NURSING FACILITY 0 <td>15.00</td> <td></td> <td>898, 698</td> <td>0</td> <td></td> <td>0</td> <td>153, 677</td> <td>1, 052, 375</td> <td>15.00</td>	15.00		898, 698	0		0	153, 677	1, 052, 375	15.00
31.00 03100 NURSI NG FACILITY 0 0 0 0 32.00 03200 ICFAI ID 0 0 0 0 0 33.00 03300 ITHER LONG TERM CARE 0			1 1						
32.00 03300 0THE LONG TERM CARE 0 0 0 0 33.00 03300 OTHER LONG TERM CARE 0								9, 104, 677	30.00
33.00 00 00 0 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>-</td> <td></td> <td>31.00</td>				-			-		31.00
ANCILLARY SERVICE COST CENTERS 40.00 04000 RADIOLOGY 32,787 0 0 0 32,787 41.00 04100 LABORATORY 40,399 0 0 0 40,39 42.00 04200 INTRAVENOUS THERAPY 0 0 0 0 40,39 43.00 04300 OXYGEN (INHALATION) THERAPY 103,778 0 0 19,831 123,607 44.00 04400 PHYSI CAL THERAPY 785,909 0 0 103,360,6624,897 45.00 04600 OCUPATI CNAL THERAPY 129,576 0 0 103,360,6624,897 46.00 04600 KEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0								0	32.00 33.00
40.00 04000 RADIOLOGY 32,787 0 0 02,78 41.00 04100 LABORATORY 40,399 0 0 0 40,09 42.00 04200 INTRAVENOUS THERAPY 0	33.00		0	0	<u> </u>	0	0	0	33.00
41.00 \Delta ABORATORY 40, 399 0	40 00		32 787	0		0	0	32 787	40.00
42.00 04200 INTRAVENUST THERAPY 0 0 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 103, 778 0 0 19, 831 123, 60 44.00 04400 PHYSI CAL THERAPY 785, 909 0 0 155, 755 941, 66 45.00 04500 SPECIAL THERAPY 521, 531 0 0 103, 360 624, 89 46.00 46000 SPECIAL THERAPY 521, 531 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>-</td> <td></td> <td></td>				-			-		
44.00 04400 PHYSI CAL THERAPY 785,909 0 0 155,755 941,66 45.00 04500 0CCUPATI ONAL THERAPY 521,531 0 0 103,360 624,89 46.00 04600 SPEECH PATHOLOGY 129,576 0				0		0	0	0	42.00
45.00 04500 OCCUPATIONAL THERAPY 521,531 0 0 103,360 624,89 46.00 04600 SPECH PATHOLOGY 129,576 0 0 25,680 155,257 47.00 04700 ELECTROCARDI OLOGY 0 <td< td=""><td>43.00</td><td>04300 OXYGEN (INHALATION) THERAPY</td><td>103, 778</td><td>0</td><td></td><td>0</td><td>19, 831</td><td>123, 609</td><td>43.00</td></td<>	43.00	04300 OXYGEN (INHALATION) THERAPY	103, 778	0		0	19, 831	123, 609	43.00
46.00 04600 SPEECH PATHOLOGY 129, 576 0 0 25, 680 155, 250 47.00 04700 ELECTROCARDIOLOGY 0				-					44.00
47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 307,396 0 0 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 <td< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td>45.00</td></td<>				-					45.00
48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 <				-					46.00
49.00 04900 DRUGS CHARGED TO PATIENTS 307,396 0 0 0 307,396 50.00 DENTAL CARE - TITLE XIX ONLY 0			-	0		-	-	0	47.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0			-	0			-		49.00
51.00 OSTOO SUPPORT SURFACES O <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>-</td> <td></td> <td>50.00</td>				-			-		50.00
60.00 06000 CLINIC 0	51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 62.00 06200 FOHC 0 0 0 0 0 0100 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0100 O7000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0100 07100 AMBULANCE 0			1 1						
62.00 06200 FQHC Image: construction of the state of the stat									60.00
OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY OST O			0	0		0	0	0	61.00
70.00 07000 HOME HEALTH AGENCY COST 0									62.00
71.00 07100 AMBULANCE 0			0	0		0	0	0	70.00
73.00 07300 CMHC 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td></t<>							-		
80.00 08000 MALPRACTICE PREMI UMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE 0 0 0 82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 83.00 08300 HOSPICE 0									
81.00 08100 INTEREST EXPENSE INTEREST EXPENSE 82.00 08200 UTI LI ZATI ON REVIEW - SNF 0 0 0 83.00 08300 HOSPI CE 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 34, 382, 019 1, 120, 448 0 2, 427, 370 29, 167, 340 NONREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0<		SPECIAL PURPOSE COST CENTERS							
82.00 08200 UTILIZATION REVIEW - SNF 0 <									80.00
83.00 08300 HOSPICE 0									81.00
89.00 SUBTOTALS (sum of lines 1-84) 34,382,019 1,120,448 0 2,427,370 29,167,340 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0						~			82.00
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0				-			-		83.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 <td></td> <td></td> <td>34, 382, 019</td> <td>1, 120, 448</td> <td></td> <td>0</td> <td>2,427,370</td> <td>29, 167, 340</td> <td>89.00</td>			34, 382, 019	1, 120, 448		0	2,427,370	29, 167, 340	89.00
91.00 09100 BARBER AND BEAUTY SHOP 10,467 0 0 10,466 92.00 09200 PHYSICIANS PRIVATE OFFICES 0			0	0		0	0	0	90.00
92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0								10, 467	91.00
93.00 09300 NONPAI D WORKERS 0 0 0 0 94.00 09400 PATI ENTS LAUNDRY 0				-			0	0	92.00
95. 00 09500 ALU/I LU 2, 374, 028 4, 864, 051 0 350, 628 7, 588, 70			0	0		0	0	0	93.00
			0	0			0	0	94.00
98.00 L LCross Foot Adjustments L OL OL OL OL O			1			-	-		95.00
	98.00	Cross Foot Adjustments	0	0		0	0	0	98.00
		0	-	0			-	0	99.00
100. 00 TOTAL 36, 766, 514 5, 984, 499 0 2, 777, 998 36, 766, 514	100.00	IUIAL	36, 766, 514	5, 984, 499	l	U	2, 777, 998	36, 766, 514	1100.00

	Financial Systems	LI ONS (u of Form CMS-2	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 01/01/2023 Fo 12/31/2023	Worksheet B Part I Date/Time Pre 6/24/2024 5:0	epared:)7 pm
	Cost Center Description	ADMI NI STRATI V E & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE		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			1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	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 SERVI CE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE 01400 NURSI NG AND ALLI ED HEALTH EDUCATI ON 01500 ACTI VI TI ES	4, 036, 162 377, 639 31, 628 168, 232 817, 123 96, 377 49, 059 7, 010 0 24, 980 0 129, 775	3, 440, 009 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			7, 443, 376 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 100 707	(4 4 . 05 (212 (2)	402 444	2 246 204	1 20 00
30.00 31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	1, 122, 737 0	644, 056 0		5 483, 466 0 0	3, 246, 394 0	1
32.00	03200 I CF/I I D	0	0		0 0	0	1
33.00	03300 OTHER LONG TERM CARE	0	0	(0 0	0	33.00
10.00	ANCI LLARY SERVICE COST CENTERS	4.042		1		0	1 40 00
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY	4, 043 4, 982	0			0	1
42.00	04200 I NTRAVENOUS THERAPY	4, 702	0			0	
43.00	04300 OXYGEN (INHALATION) THERAPY	15, 243	0		0 0	0	1
44.00	04400 PHYSI CAL THERAPY	116, 122	0	(0 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	77, 059	0	(0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	19, 146	0	(0 0	0	
47.00	04700 ELECTROCARDI OLOGY	0	0	(0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	37, 907 0	0			0	
50.00	05100 SUPPORT SURFACES	0	0			0	
51.00	OUTPATIENT SERVICE COST CENTERS	0	0	1	0	0	1 51.00
60.00	06000 CLINIC	0	0	(0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	T T		1			
	07000 HOME HEALTH AGENCY COST	0	0	1	0 0	0	
	07100 AMBULANCE 07300 CMHC	0	0			0	71.00
73.00	SPECIAL PURPOSE COST CENTERS	0	0	<u>ı</u> (0	0	/3.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	(0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	3, 099, 062	644, 056	212, 62	5 483, 466	3, 246, 394	89.00
	NONREI MBURSABLE COST CENTERS	,		1	-		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	
91.00	09100 BARBER AND BEAUTY SHOP	1, 291	0		0	0	
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES	0	0			0	1
93.00 94.00	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0	0			0	1
94.00 95.00	09500 ALU/ILU	935, 809	2, 795, 953	75, 484	1,048,998	4, 196, 982	1
98.00	Cross Foot Adjustments	935, 809	2,775,755 N	, 3, 40) 1,040,990	4, 190, 982	
99.00	Negative Cost Centers	0	0		0 0	0	
100.00	U U	4, 036, 162	3, 440, 009	288, 104	1, 532, 464	7, 443, 376	

	Financial Systems	LIONS		No.: 315499	Period: From 01/01/2023	u of Form CMS- Worksheet B Part I	2010 10
					To 12/31/2023	Date/Time Pre 6/24/2024 5:0	
	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						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	877, 921					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	446, 891				10.00
11.00	01100 PHARMACY	0	0	63, 8			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	227, 547	
14.00	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
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKI LLED NURSI NG FACI LI TY	877, 921	446, 891	63, 8		227, 547	
31.00	03100 NURSING FACILITY	0	0		0 0	0	
32.00		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			1			10.00
40.00	04000 RADI OLOGY	0	0		0 0	0	
41.00		0	0		0 0	0	
42.00	04200 INTRAVENOUS THERAPY	0	0		0 0	0	
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0		0 0	0	
44.00	04400 PHYSICAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	
46.00	04600 SPEECH PATHOLOGY	0	0			0	
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	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	
51.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0 0	0	51.00
60.00	06000 CLINIC	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	
62.00	06200 FQHC	0	0		ů ů	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	
73.00	07300 CMHC	0	0		0 0	0	
/01/00	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	877, 921	446, 891	63, 8		227, 547	
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00		0	0		0 0	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	
95.00	09500 ALU/I LU	0	0		0 0	0	
98.00	Cross Foot Adjustments	0	0				98.00
	3	0	0		0 0	0	99.00
99.00	Negative Cost Centers	0	0		0	0	/ //.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	LIONS		No.: 315499	Peri od:	u of Form CMS- Worksheet B	
					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 6/24/2024 5:0	epared: 07 pm
			OTHER GENERAL				
	Cost Center Description	NURSING AND ALLIED HEALTH	SERVICE ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATION 14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	10.00	17.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00 11.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY						10.00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
	01300 SOCI AL SERVI CE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTI VI TI ES	0	1, 182, 150				15.00
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
	03000 SKILLED NURSING FACILITY	0				17, 135, 979	
31.00 32.00	03100 NURSING FACILITY 03200 ICF/IID	0			0 0 0 0	C	
33.00	03300 OTHER LONG TERM CARE	0			0 0	C	
00.00	ANCI LLARY SERVICE COST CENTERS						00.00
40.00	04000 RADI OLOGY	0	0	36, 8	30 0	36, 830	40.00
41.00	04100 LABORATORY	0	0	45, 3	81 0	45, 381	
	04200 I NTRAVENOUS THERAPY	0	-	100.0	0 0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0			138, 852	
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0	.,,		1, 057, 786 701, 950	
46.00	04600 SPEECH PATHOLOGY	0	0			174, 402	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	C	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	C	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	0	345, 30		345, 303	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			0 0	C	
51.00	05100 SUPPORT_SURFACES OUTPATIENT_SERVICE_COST_CENTERS	0	0		0 0	C	51.00
60.00	06000 CLINIC	0	0		0 0	C	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	C	61.00
62.00	06200 FQHC						62.00
70 00	OTHER REIMBURSABLE COST CENTERS						70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0			0 0 0 0	C) 70.00) 71.00
	07300 CMHC	0	-		0 0	C	
, 0, 00	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0			0 0 33 0	C 19, 636, 483	
07.00	NONREI MBURSABLE COST CENTERS		703,010	19,030,40	55 0	19,030,403	5 09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	C	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	11, 7	58 0	11, 758	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	C	
93.00	09300 NONPALD WORKERS	0	0		0 0	C	
94.00 95.00	09400 PATIENTS LAUNDRY 09500 ALU/ILU	0	174 240	17, 118, 2	0 0	C 17 118 273	
95.00 98.00	Cross Foot Adjustments		476, 340	17, 118, 2	73 0 0 0	17, 118, 273 C	
,			0		0 0		
99.00	Negative Cost Centers	0	0		0 0	C	77.00

Heal th	Financial Systems	LI ONS (GATE			In Lie	u of Form CMS-2	2540-10
	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315499		riod: om 01/01/2023	Worksheet B Part II	
					To		Date/Time Pre	
			CAPI TAL REL	ATED COSTS			6/24/2024 5:0	7 pm
				LATED COSTS				
	Cost Center Description	Di rectl y	BLDGS &	MOVABLE		Subtotal	EMPLOYEE	
		Assigned New Capital	FI XTURES	EQUI PMENT			BENEFI TS	
		Related Costs						
		0	1.00	2.00		2A	3.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES				_			1.00
2.00	00200 CAP REL COSTS - BEDGS & FIXTORES							2.00
3.00	00300 EMPLOYEE BENEFITS	0	0		0	0	0	3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	0	0		0	0	0	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	0		0	0	0	5.00
6.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	0	0		0	0	0	6.00
7.00 8.00	00800 DI ETARY	0	0		0	0	0	7.00 8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0	0	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	0	10.00
11.00	01100 PHARMACY	0	0		0	0	0	11.00
	01200 MEDI CAL RECORDS & LI BRARY	0	0		0	0	0	12.00
	01300 SOCIAL SERVICE	0	0		0	0	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	0		0 0	0	0	14.00 15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		U	0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	0	1, 120, 448		0	1, 120, 448	0	30.00
31.00	03100 NURSING FACILITY	0	0		0	0	0	31.00
	03200 I CF/I 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	0		0	0	0	40.00
	04100 LABORATORY	0	0		0	0	0	40.00
	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43.00
	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 48.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	47.00 48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
(0.00	OUTPATIENT SERVICE COST CENTERS				0		0	1 (0.00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0	0	0	60.00 61.00
62.00	06200 FQHC	0	0		0	0	0	62.00
	OTHER REIMBURSABLE COST CENTERS	11						02100
	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
	07100 AMBULANCE	0	0		0	0	0	1
73.00	07300 CMHC	0	0		0	0	0	73.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00
	08100 I NTEREST EXPENSE							81.00
82.00	08200 UTILIZATION REVIEW - SNF							82.00
	08300 HOSPI CE	0	0		0	0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	0	1, 120, 448		0	1, 120, 448	0	89.00
00.00	NONREI MBURSABLE COST CENTERS				~		-	00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	1
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRIVATE OFFICES	0	0		0	0	0	
	09300 NONPALD WORKERS	0	0		0	0	0	1
	09400 PATI ENTS LAUNDRY	0	0		0	0	0	
	09500 ALU/I LU	0	4, 864, 051		0	4, 864, 051	0	95.00
98.00	Cross Foot Adjustments					0		98.00
99.00	Negative Cost Centers		0		0	0		99.00
100.00	TOTAL	0	5, 984, 499	I	0	5, 984, 499	0	100.00

	Financial Systems	LIONS				u of Form CMS-	2540-10
ALLOCA	TTION OF CAPITAL RELATED COSTS		Provi der	- No.: 315499	Period: From 01/01/2023 To 12/31/2023		
	Cost Center Description	ADMI NI STRATI V E & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVIO	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	TT					
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 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	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
	01500 ACTIVITIES	0		0	0 0	0	
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		9	0 0	0	10.00
31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	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	04000 RADI OLOGY	0		0	0 0	0	40.00
41.00 42.00 43.00 44.00 45.00 46.00 47.00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDIOLOGY 04700 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY						41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVI CE COST CENTERS	0		<u>v</u>	0 0	0	51.00
60.00 61.00 62.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0		0	0 0 0 0	0 0	
71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0		0 0 0	0 0 0 0 0 0	0 0 0	71.00
80. 00 81. 00 82. 00 83. 00 89. 00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0		0	0 0 0 0	0	
93.00	09500 ALU/ILU Cross Foot Adjustments Negative Cost Centers					0 0 0 0 0 0 0 0 0 0 0 0	91.00 92.00 93.00 94.00 95.00 98.00

	TION OF CAPITAL RELATED COSTS		GATE Provider	No.: 315499	Peri od:	Worksheet B	2540-10
					From 01/01/2023 To 12/31/2023	Part II Date/Time Pro 6/24/2024 5:0	
	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	т т		1		Γ	_
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS						4.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0				10.00
11.00	01100 PHARMACY	0	0		0		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0		12.00
13.00	01300 SOCIAL SERVICE	0	0		0 0	(C	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15.00	01500 ACTI VI TI ES	0	0		0 0		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·		1			
30.00	03000 SKILLED NURSING FACILITY	0	0		0 0		
31.00	03100 NURSING FACILITY	0	0		0 0		
32.00	03200 I CF/I I D	0	0		0 0		
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	(33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	(40.00
40.00	04000 RADI OLOGI 04100 LABORATORY	0	0		0 0		
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0		
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0		
44.00	04400 PHYSI CAL THERAPY	0	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	(47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	C	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	(49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0		
51.00	05100 SUPPORT SURFACES	0	0		0 0	(51.00
(0.00	OUTPATIENT SERVICE COST CENTERS						
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0		
	06200 FQHC	0	0		0 0		62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	(70.00
71.00	07100 AMBULANCE	0	0		0 0		
73.00	07300 CMHC	0	0		0 0		
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0		0 0		
89.00	SUBTOTALS (sum of lines 1-84)	0	0		0 0	(89.00
00.00	NONREI MBURSABLE COST CENTERS		0	1	0		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0		
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0		
	09200 PHYSICIANS PRIVATE OFFICES	0	0				
93.00 94.00	09400 PATIENTS LAUNDRY	0	0		0 0		
	09500 ALU/I LU	0	0		0 0		
98.00	Cross Foot Adjustments	0	0		0		98.00
99.00	Negative Cost Centers	0	0		0 0		99.00

	Financial Systems TION OF CAPITAL RELATED COSTS	LIONS		Provi der	No.: 315499	Pe	eri od:	Worksheet B	-2540-10
	TON OF ONT THE REATED COSTS						om 01/01/2023	Part II Date/Time Pr 6/24/2024 5:	
				GENERAL					
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	ACT	ERVICE I VITIES	Subtotal		Post Step-Down Adjustments	Total	
		14.00	1	5.00	16.00		17.00	18.00	
	GENERAL SERVICE COST CENTERS	1	1		1				
2.00	00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT								1.00 2.00
	00300 EMPLOYEE BENEFITS								3.00
1	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS								4.00
	00600 LAUNDRY & LINEN SERVICE								6.00
	00700 HOUSEKEEPI NG								7.00
	00800 DI ETARY								8.00
	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY								9.00
	01100 PHARMACY								11.00
	01200 MEDICAL RECORDS & LIBRARY								12.00
	01300 SOCIAL SERVICE								13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0							14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0		0					15.00
30.00	03000 SKILLED NURSING FACILITY	0		0	1, 120, 4	48	0	1, 120, 44	8 30.00
	03100 NURSING FACILITY	0		0		0	0		0 31.00
	03200 CF/I D	0	•	0		0	0		0 32.00
	03300 OTHER LONG TERM CARE	0		0		0	0		0 33.00
	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	1	0		0	0		0 40.00
	04100 LABORATORY	0		0		0	0		0 41.00
1	04200 I NTRAVENOUS THERAPY	0		0		0	0		0 42.00
	04300 OXYGEN (INHALATION) THERAPY	0		0		0	0		0 43.00
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0		0		0 0	0		0 44.00 0 45.00
	04600 SPEECH PATHOLOGY	0		0		0	0		0 46.00
	04700 ELECTROCARDI OLOGY	0		0		0	0		0 47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	0		0 48.00
	04900 DRUGS CHARGED TO PATIENTS	0		0		0	0		0 49.00
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	•	0		0 0	0		0 50.00 0 51.00
	OUTPATIENT SERVICE COST CENTERS		1						0 01.00
	06000 CLI NI C	0		0		0	0		0 60.00
	06100 RURAL HEALTH CLINIC	0		0		0	0		0 61.00
	06200 FQHC OTHER REIMBURSABLE COST CENTERS								62.00
	07000 HOME HEALTH AGENCY COST	0		0		0	0		0 70.00
	07100 AMBULANCE	0		0		0	0		0 71.00
	07300 CMHC	0		0		0	0		0 73.00
	SPECIAL PURPOSE COST CENTERS	1	1		1				
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE								80.00
	08200 UTILIZATION REVIEW - SNF								82.00
	08300 HOSPI CE	0		0		0	о		0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	0		0	1, 120, 4	48	0	1, 120, 44	8 89.00
	NONREI MBURSABLE COST CENTERS		J		1	_			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	•	0		0 0	0		0 90.00 0 91.00
	09200 PHYSI CLANS PRI VATE OFFI CES	0		0		0	0		0 91.00
	09300 NONPAI D WORKERS	0		0		0	0		0 93.00
93.00	09400 PATIENTS LAUNDRY	0		0		0	0		0 94.00
94.00									
94.00 95.00	09500 ALU/I LU	0		0	4, 864, 0		0	4, 864, 05	
94.00		000000000000000000000000000000000000000		0 0 0		051 0 0	0 0 0		1 95.00 0 98.00 0 99.00

	Financial Systems LLOCATION - STATISTICAL BASIS	LIONS			No.: 315499	In Lie Period:	u of Form CMS-2 Worksheet B-1	
CUST P	ALLOCATION - STATISTICAL BASIS		PI	oviuei		From 01/01/2023		
						To 12/31/2023	Date/Time Pre 6/24/2024 5:0	
		CAPI TAL RE	LATED CO	DSTS				
	Cost Center Description	BLDGS &	MOVA	ABLE	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
		FIXTURES	EQUIF		BENEFITS	n	E & GENERAL	
		(SQUARE FEET)	(SQUARE	E FEET)	(GROSS		(ACCUM COST)	
		1.00	2.	00	SALARIES) 3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	1.00		00	0.00		1.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	400, 000	D					1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0		0	12, 536, 30	6		2.00 3.00
4.00	00400 ADMINI STRATI VE & GENERAL			0	1, 622, 73		32, 730, 352	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	D C	0	476, 40		3, 062, 370	
6.00	00600 LAUNDRY & LINEN SERVICE	0		0		0 0	256, 481	6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY			0	105, 64	8 0	1, 364, 232 6, 626, 253	7.00 8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	5	0	639, 77		781, 544	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	D D	0		0 0	397, 832	
11.00 12.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY			0			56, 845	11.00 12.00
	01300 SOCI AL SERVI CE	0	Ď	0	162, 45	4 0	202, 567	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	D	0		0 0	0	14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	ון	0	693, 50	2 0	1, 052, 375	15.00
30.00	03000 SKILLED NURSING FACILITY	74, 890	D	0	5, 878, 81	9 0	9, 104, 677	30.00
31.00	03100 NURSING FACILITY	0	-	0		0 0	0	31.00
	03200 ICF/IID 03300 OTHER LONG TERM CARE	0	-	0		0 0 0 0	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS		<u>л</u>	0		0 0	0	33.00
40.00	04000 RADI OLOGY	0	כ	0		0 0	32, 787	40.00
41.00	04100 LABORATORY	0	D D	0		0 0	40, 399	41.00
42.00 43.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY			0	89, 49	U U 3 0	0 123, 609	42.00 43.00
	04400 PHYSI CAL THERAPY	0		0	702, 88		941, 664	
45.00	04500 OCCUPATI ONAL THERAPY	0	D	0	466, 43		624, 891	45.00
46.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0		0	115, 88	7 0	155, 256	
47.00 48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			0		0 0	0	47.00 48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	D	0		0 0	307, 396	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	D D	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	<u></u>	0		0 0	0	51.00
60.00	06000 CLINIC	0		0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	D	0		0 0	0	61.00
62.00	06200 FOHC OTHER REIMBURSABLE COST CENTERS							62.00
70.00	07000 HOME HEALTH AGENCY COST	0	D	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	D C	0		0 0	0	71.00
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0		0		0 0	0	73.00
80, 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00
	08100 INTEREST EXPENSE							81.00
82.00	08200 UTILIZATION REVIEW - SNF							82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 74, 890		0		0	0 25, 131, 178	83.00 89.00
07.00	NONREI MBURSABLE COST CENTERS	74,070	<u>л</u>	0	10, 754, 02	5 -4,050,102	23, 131, 170	09.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	D	0		0 0	0	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0		0		0 0	10, 467	
	09300 NONPALD WORKERS			0		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	D	0		0 0	0	94.00
95.00	09500 ALU/I LU	325, 110	D	0	1, 582, 28	3 0	7, 588, 707	95.00
98.00 99.00	Cross Foot Adjustments Negative Cost Centers							98.00 99.00
102.00		5, 984, 499	7	0	2, 777, 99	8	4, 036, 162	
	Part I)							
103.00 104.00		14. 961248	3 O	. 000000	0. 22159	6	0. 123316	103.00 104.00
104.00	Part II)							104.00
105.00	Unit cost multiplier (Wkst. B, Part				0. 00000	0	0. 000000	105.00
	1)		I		I	I	l	I

Health Financial Systems	LIONS		N 015 100		u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2023	Worksheet B-1	
			-	To 12/31/2023	Date/Time Pre 6/24/2024 5:0	
Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DIETARY	NURSI NG	
	OPERATION, MAINT. &	LINEN SERVICE (POUNDS OF	(COSTED REQ UIS)	(MEALS SERVED)	ADMI NI STRATI O N	
	REPAI RS	LAUNDRY)		02.0020)	(DIRECT NRS G	
	(SQUARE FEET)	(00	7.00	8.00	HRS)	
GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00 00300 EMPLOYEE BENEFITS 4. 00 00400 ADMINI STRATIVE & GENERAL						3.00 4.00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	400, 000					5.00
6.00 00600 LAUNDRY & LINEN SERVICE	0					6.00
7. 00 00700 HOUSEKEEPI NG 8. 00 00800 DI ETARY	0	0		234, 525		7.00 8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	173, 183	9.00
10. 00 01000 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	10.00
11.00 01100 PHARMACY 12.00 01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	11.00 12.00
13. 00 01300 SOCIAL SERVICE	0				0	12.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15. 00 01500 ACTIVITIES	0	0	(0 0	0	15.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 SKI LLED NURSI NG FACI LI TY	74, 890	724, 605	409, 02	3 102, 287	173, 183	30.00
31. 00 03100 NURSING FACILITY	0			0 0	0	31.00
32. 00 03200 I CF/I I D	0			0 0	0	32.00
33. 00 03300 OTHER LONG TERM CARE	0	0	(0 0	0	33.00
40. 00 04000 RADI OLOGY	0	0		0 0	0	40.00
41. 00 04100 LABORATORY	0			0 0		41.00
42.00 04200 I NTRAVENOUS THERAPY	0	0	(0 0	0	42.00
43. 00 04300 0XYGEN (I NHALATI ON) THERAPY 44. 00 04400 PHYSI CAL THERAPY	0	0			0	43.00
45. 00 04400 OCCUPATI ONAL THERAPY	0	0		0 0	0	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	(0 0	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0			0	47.00
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS	0				0	48.00 49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00 05100 SUPPORT SURFACES	0	0	(0 0	0	51.00
60.00 06000 CLINIC	0	0			0	60,00
61.00 06100 RURAL HEALTH CLINIC	0			0 0		61.00
62.00 06200 FQHC						62.00
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71. 00 07100 AMBULANCE	0			0 0		
73. 00 07300 CMHC	0	0	(0 0	0	
SPECIAL PURPOSE COST CENTERS	1	1	1		[
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE						80.00 81.00
82. 00 08200 UTI LI ZATI ON REVIEW - SNF						82.00
83. 00 08300 HOSPI CE	0	0		0 0	0	
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	74, 890	724, 605	409, 02	3 102, 287	173, 183	89.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	(0 0	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00 93.00
93. 00 09300 NONPALD WORKERS 94. 00 09400 PATLENTS LAUNDRY	0				0	93.00
95. 00 09500 ALU/I LU	325, 110	257, 244	887, 47	5 132, 238	-	95.00
98.00 Cross Foot Adjustments						98.00
99.00Negative Cost Centers102.00Cost to be allocated (per Wkst. B,	2 110 000	200 100	1 500 14	אדר כאא ד	001	99.00
102.00 Cost to be allocated (per Wkst. B, Part I)	3, 440, 009	288, 109	1, 532, 46	4 7, 443, 376	877, 921	102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	8. 600023	0. 293435	1. 182003	2 31. 738092		
104.00 Cost to be allocated (per Wkst. B,	0	0	(0 0	0	104.00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0.00000	0. 000000	0.000000	105.00

Heal th Fi	inancial Systems	LIONS	GATE		In Lie	u of Form CMS-2	2540-10
	OCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2023	Worksheet B-1	
					o 12/31/2023	Date/Time Pre	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQ	PHARMACY (COSTED REQ UIS)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCI AL SERVI CE (TI ME SPENT)	6/24/2024 5: 0 NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED TI ME)	
		UI S) 10. 00	11.00	12.00	13.00	14.00	
	ENERAL SERVICE COST CENTERS			I		I	
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	D100 CAP REL COSTS - BLDGS & FIXTURES D200 CAP REL COSTS - MOVABLE EQUIPMENT D300 EMPLOYEE BENEFITS D400 ADMI NI STRATI VE & GENERAL D500 PLANT OPERATION, MAINT. & REPAIRS D600 LAUNDRY & LI NEN SERVI CE D700 HOUSEKEEPING D800 DI ETARY D900 NURSI NG ADMI NI STRATI ON 1000 CENTRAL SERVI CES & SUPPLY 1100 PHARMACY 1200 MEDI CAL RECORDS & LI BRARY 1300 SOCI AL SERVI CE	397, 832 0 0 0	100 0 0	C	4, 628		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
	1400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C			1
		0	0	C	0 0	0	15.00
30.00 03	NPATIENT ROUTINE SERVICE COST CENTERS 3000 SKILLED NURSING FACILITY	397, 832	100	C	4, 628	0	30.00
	3100 NURSING FACILITY	0	0			-	
	3200 I CF/I I D 3300 OTHER LONG TERM CARE	0	0				
	NCILLARY SERVICE COST CENTERS					· ·	
	4000 RADI OLOGY	0	0				
	4100 LABORATORY 4200 I NTRAVENOUS THERAPY	0	0			0	
	4300 OXYGEN (INHALATION) THERAPY	Ō	0	C	0	0	1
	4400 PHYSI CAL THERAPY	0	0	C	0	0	
	4500 OCCUPATI ONAL THERAPY 4600 SPEECH PATHOLOGY	0	0			0	
	4700 ELECTROCARDI OLOGY	0	0		0 0	0	1
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	c c	0 0	0	
	4900 DRUGS CHARGED TO PATIENTS 5000 DENTAL CARE - TITLE XIX ONLY	0	0		-	0	
	5100 SUPPORT SURFACES	0	0				
OL	JTPATIENT SERVICE COST CENTERS						
	5000 CLINIC	0		C			1
	5100 RURAL HEALTH CLINIC 5200 FOHC	0	0	C	0	0	61.00 62.00
	THER REIMBURSABLE COST CENTERS	I		1	<u>I</u>	1	02.00
70.00 07	7000 HOME HEALTH AGENCY COST	0	0				70.00
	7100 AMBULANCE	0	0	-	-	-	1
	7300 CMHC PECIAL PURPOSE COST CENTERS	0	0		<u>ı</u> 0	0	73.00
80.00 08	BOOO MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	3100 INTEREST EXPENSE						81.00
	3200 UTI LI ZATI ON REVI EW – SNF 3300 HOSPI CE	0	0	C	0	0	82.00 83.00
89.00	SUBTOTALS (sum of lines 1-84)	397, 832	100				1
	ONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 9100 BARBER AND BEAUTY SHOP	0	0				1
	9200 PHYSI CLANS PRI VATE OFFI CES	0	0	c c	0	0	1
	9300 NONPAI D WORKERS	0	0	C	0	0	
	9400 PATI ENTS LAUNDRY 9500 ALU/I LU	0	0			0	
98.00	Cross Foot Adjustments	0	0				98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B,	446, 891	63, 855	C	227, 547	0	102.00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	1. 123316	638. 550000				
104.00	Cost to be allocated (per Wkst. B, Part II)	0	0	C	0	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part)	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	105.00

	Financial Systems	LIONS GATE			of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der No. : 315499	Period: From 01/01/2023	Worksheet B-1	l
				To 12/31/2023	Date/Time Pre 6/24/2024 5:0	
	· · · · · ·	OTHER GENERAL		I	0/24/2024 3.0	
	Cast Contar Description	SERVICE ACTIVITIES				
	Cost Center Description	(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
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 12.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY					11.00
13.00						13.00
14.00						14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	31, 044				15.00
30.00		18, 535				30.00
31.00	03100 NURSING FACILITY	0				31.00
32.00		0				32.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0				33.00
40.00	04000 RADI OLOGY	0				40.00
41.00	04100 LABORATORY	0				41.00
42.00 43.00		0				42.00
43.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0				43.00
45.00	04500 OCCUPATI ONAL THERAPY	0				45.00
46.00		0				46.00
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0				47.00
48.00	04900 DRUGS CHARGED TO PATIENTS	0				48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0				50.00
51.00		0				51.00
60.00	OUTPATI ENT SERVICE COST CENTERS	0				60.00
61.00	06100 RURAL HEALTH CLINIC	0				61.00
62.00						62.00
70.00	OTHER REIMBURSABLE COST CENTERS	0				70 00
70.00 71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0				70.00
	07300 CMHC	0				73.00
00.00	SPECIAL PURPOSE COST CENTERS					
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE					80.00
82.00	08200 UTILIZATION REVIEW - SNF					82.00
83.00	08300 HOSPI CE	0				83.00
89.00	SUBTOTALS (sum of lines 1-84)	18, 535				89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0				90.00
91.00	09100 BARBER AND BEAUTY SHOP	Ő				91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0				92.00
93.00	09300 NONPALD WORKERS	0				93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 ALU/I LU	12, 509				94.00 95.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1, 182, 150				102.00
103.00		38. 079822				103.00
104.00	Cost to be allocated (per Wkst. B,	0				104.00
105 01	Part II)	0.000000				105 00
105.00) Unit cost multiplier (Wkst. B, Part	0. 000000				105.00
		i l				1

Health Financial Systems	LIONS GATE		In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST	CENTERS Provi der		eriod:	Worksheet C	
			rom 01/01/2023 o 12/31/2023	Date/Time Pre	nared
				6/24/2024 5:0	
Cost Center Description		Total (from	Total Charges		
		Wkst. B, Pt		di vi ded by	
		I, col. 18)		col. 2	
		1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS		1			
40. 00 04000 RADI OLOGY		36, 830			
41.00 04100 LABORATORY		45, 381	40, 399	1. 123320	
42.00 04200 I NTRAVENOUS THERAPY		C	0 0	0.000000	
43.00 04300 0XYGEN (INHALATION) THERAPY		138, 852		1. 337984	
44. 00 04400 PHYSI CAL THERAPY		1, 057, 786			
45.00 04500 OCCUPATI ONAL THERAPY		701, 950		0. 782795	
46.00 04600 SPEECH PATHOLOGY		174, 402	184, 654	0.944480	
47. 00 04700 ELECTROCARDI OLOGY		0	0 0	0.00000	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0 0	0.00000	
49.00 04900 DRUGS CHARGED TO PATIENTS		345, 303	295, 701	1. 167744	
50.00 05000 DENTAL CARE - TITLE XIX ONLY		0	0 0	0.00000	
51.00 05100 SUPPORT SURFACES		0	0 0	0.00000	51.00
OUTPATIENT SERVICE COST CENTERS					
60. 00 06000 CLINIC		0	0 0	0.00000	
61.00 06100 RURAL HEALTH CLINIC					61.00
62.00 06200 FQHC					62.00
71. 00 07100 AMBULANCE		0	0	0.00000	
100.00 Total		2, 500, 504	2, 599, 869		100.00

Health Financial Systems	LI ONS				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315499	Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narod
				10 12/31/2023	6/24/2024 5:0	pareu:)7 nm
		Title	XVIII (1)	Skilled Nursing		
				Facility		
		Health Care Pr	rogram Charge		Program Cost	
					-	
	Ratio of Cost	Part A	Part B	Part A (col.	Part B (col.	
	to Charges			1 x col. 2)	1 x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	FIENT COST					-
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY	1 100011	22.250		0 24 220	0	40.00
40. 00 04000 RADI 0L0GY 41. 00 04100 LABORATORY	1. 123311	23, 359		0 26, 239		10100
41.00 04100 LABORATORY 42.00 04200 INTRAVENOUS THERAPY	0. 000000			0 13, 766		
43. 00 04300 OXYGEN (INHALATION) THERAPY	1. 337984			0 0		1
43. 00 04400 PHYSI CAL THERAPY	1. 011434			0 628, 677		43.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 782795			0 495, 289		45.00
46. 00 04600 SPEECH PATHOLOGY	0. 944480			0 141, 342		46.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 141, 342	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 167744			0 345, 303	0	
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0	-	50.00
51.00 05100 SUPPORT SURFACES	0. 000000			0 0	0	
OUTPATIENT SERVICE COST CENTERS		. · · ·	I			
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 000000			0	0	71.00
100.00 Total (Sum of lines 40 - 71)		1, 735, 255		0 1, 650, 616	0	100.00
(1) For title V and VIV use columns 1 2 and 4 an						

(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	LI ONS (ATE		In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315499	Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		L				
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of co 2.00 Program vaccine charges (From your reco 3.00 Program costs (Line 1 x line 2) (Title E, Part I, line 18)	rds, or the PS	R)			1. 167744 0 0	1.00 2.00 3.00
Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Healt Costs to Total Costs Part A (Col. 2 / Col. 1)	- I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS ANCILLARY SERVICE COST CENTERS	FOR NURSING &	ALLIED HEALTH				
40.00 04000 RADI OLOGY 41.00 04100 LABORATORY 42.00 04200 I NTRAVENOUS THERAPY 43.00 04300 0XYGEN (I NHALATI ON) THERAPY 44.00 04400 PHYSI CAL THERAPY 45.00 04500 OCCUPATI ONAL THERAPY 46.00 04500 OCCUPATI ONAL THERAPY 46.00 04500 SPEECH PATHOLOGY 47.00 04700 ELECTROCARDI OLOGY 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 49.00 04900 DRUGS CHARGED TO PATI ENTS 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 51.00 05100 SUPPORT SURFACES 100.00 Total (Sum of Lines 40 - 52)	36, 830 45, 381 0 138, 852 1, 057, 786 701, 950 174, 402 0 0 345, 303 0 0 2, 500, 504		0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000	13,766 00 13,766 00 0 00 0 00 628,677 00 495,289 00 141,342 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40.00 41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00 100.00

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315499	Period: From 01/01/2023 To 12/31/2023		pare	
		Title XVIII	Skilled Nursing Facility	PPS		
				1.00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS					
	I NPATI ENT DAYS					
1.00	Inpatient days including private room days			35, 019	1.	
2.00	Private room days			0	2.	
3.00	Inpatient days including private room days applicable to the Pr	ogram		7, 363	3.	
4.00	Medically necessary private room days applicable to the Program	1		0	4.	
5.00	Total general inpatient routine service cost			17, 135, 979	5.	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
. 00	General inpatient routine service charges			23, 035, 836	6.	
. 00	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0.743884	7	
8.00	Enter private room charges from your records				8	
. 00	Average private room per diem charge (Private room charges line 2)	0.00	9			
0. 00						
					10 11	
2.00	Average per diem private room charge differential (Line 9 minus	line 11)		0.00	12	
	Average per diem private room cost differential (Line 7 times I			0.00		
	Private room cost differential adjustment (Line 2 times line 13			0.00		
	General inpatient routine service cost net of private room cost		minus line 14)	17, 135, 979		
5.00	PROGRAM INPATIENT ROUTINE SERVICE COST NET OF private room cost		minus inne 14)	17, 133, 777	1 13	
6.00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		489.33	16	
7.00	Program routine service cost (Line 3 times line 16)	5		3, 602, 937	17	
8.00	Medically necessary private room cost applicable to program (I	ine 4 times line 13)		0	18	
9.00	Total program general inpatient routine service cost (Line 17	plus line 18)		3, 602, 937	19	
0. 00	Capital related cost allocated to inpatient routine service cos line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		rt II column 18,	1, 120, 448	20	
1.00	Per diem capital related costs (Line 20 divided by line 1)			32.00	21	
	Program capital related cost (Line 3 times line 21)			235, 616		
	Inpatient routine service cost (Line 19 minus line 22)			3, 367, 321	23	
	Aggregate charges to beneficiaries for excess costs (From prov	ider records)		0	24	
	Total program routine service costs for comparison to the cost		inus line 24)	3, 367, 321		
	Enter the per diem limitation (1)	(,		26	
	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27	
	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)				28	

		1.00	
PART II CALCULATION OF INPATIENT NURS	SING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00 Total SNF inpatient days		35, 019	1.00
2.00 Program inpatient days (see instruct	i ons)	7,363	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. 210257	4.00
5.00 Program nursing & allied health cost	s for pass-through. (line 3 times line 4)	0	5.00

	Financial Systems LIONS G			u of Form CMS-2	2540-
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315499	Period: From 01/01/2023	Worksheet E Part I	
			To 12/31/2023		pared
				6/24/2024 5:0	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIM	BURSEMENT			
. 00	Inpatient PPS amount (See Instructions)			4, 959, 608	
2.00	Nursing and Allied Health Education Activities (pass throug	h payments)		0	2.0
3.00	Subtotal (Sum of lines 1 and 2)			4, 959, 608	3. (
. 00	Primary payor amounts			0	4.0
5.00	Coinsurance			318, 000	
5.00	Allowable bad debts (From your records)			0	6.0
. 00	Allowable Bad debts for dual eligible beneficiaries (See in	structions)		0	
. 00	Adjusted reimbursable bad debts. (See instructions)			0	
. 00	Recovery of bad debts - for statistical records only			0	9.
0.00	Utilization review			0	10.
1.00	Subtotal (See instructions)			4, 641, 608	11.
2.00	Interim payments (See instructions)			4, 548, 776	12.
3.00	Tentative adjustment			0	13.
4.00	OTHER adjustment (See instructions)			0	14.
4.50	Demonstration payment adjustment amount before sequestratio	n		0	14.
4.55	Demonstration payment adjustment amount after sequestration			0	14.
4.75	Sequestration for non-claims based amounts (see instruction	s)		0	14.
4.99	Sequestration amount (see instructions)			92, 832	14.
5.00	Balance due provider/program (see Instructions)			0	15.
6.00	Protested amounts (Nonallowable cost report items in accord	ance with CMS Pub. 15-2, s	section 115.2)	0	16.
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESS	SER OF COST OR CHARGES - "	TITLE XVIII ONLY		
7.00	Ancillary services Part B			0	17.
8.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.
9.00	Total reasonable costs (Sum of Lines 17 and 18)			0	19.
0.00	Medicare Part B ancillary charges (See instructions)			0	20.
1.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.
2.00	Primary payor amounts			0	22.
3.00	Coinsurance and deductibles			0	23.
4.00	Allowable bad debts (From your records)			0	24.
4.01	Allowable Bad debts for dual eligible beneficiaries (see in	structions)		0	24.
4. 02	Adjusted reimbursable bad debts (see instructions)			0	24.
5.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.
6.00	Interim payments (See instructions)			0	26.
7.00	Tentati ve adjustment			0	27.
28.00	Other Adjustments (See instructions) Specify			0	28.
28.50	Demonstration payment adjustment amount before sequestratio	n		0	28.
28.55	Demonstration payment adjustment amount after sequestration			0	28.
28.99	Sequestration amount (see instructions)			0	28.
29.00	Balance due provider/program (see instructions)			0	29.
30.00	Protested amounts (Nonallowable cost report items) in accor	dance with CMS Pub. 15-2.	section 115.2	0	30.

30.00 Protested amounts (Nonal I owable cost report items) in accordance with CMS Pub. 15-2, section 115.2 0 30.00

NALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315499	Period: From 01/01/202 To 12/31/202		epared
		Ti tl	e XVIII	Skilled Nursin Facility		
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
. 00	Total interim payments paid to provider	1.00	2.00 4,548,7	3.00	4.00	1.0
. 00	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		4, 348, 7	0	0	2.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
01	Program to Provi der ADJUSTMENTS TO PROVI DER			0	0	
01 02 03 04 05	ADJUSTMENTS TO PROVIDER			0 0 0	0	3. (3. (3. (
	Provider to Program					
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0	0 0 0 0 0	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		4, 548, 7	176	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	000000000000000000000000000000000000000	5.
50 51 52 99	TENTATI VE TO PROGRAM			0 0 0	000000000000000000000000000000000000000) 5.) 5.
99 00	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98) Determined net settlement amount (balance due) based on			0		6.
01 02	the cost report. (1) PROGRAM TO PROVIDER PROVIDER TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		4,548,7 Contr	0	0 Contractor	
				1.00	Number 2.00	

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

d-t	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column		F	eriod: rom 01/01/2023	Worksheet G	
y)			T	b 12/31/2023	Date/Time Pre 6/24/2024 5:0	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	Assets					_
	CURRENT ASSETS Cash on hand and in banks	6, 343, 813	0	0	0	1 1
0	Temporary investments	27, 466		0	0	
0	Notes receivable	0	0	0	0	3
	Accounts receivable	1, 824, 948		0	0	
)	Other receivables Less: allowances for uncollectible notes and accounts	813, 537	0	0	0	
	recei vabl e			0	0	
	Inventory	0	0	0	0	
	Prepaid expenses Other current assets	59, 229 368, 676		0	0	
	Due from other funds	308, 070	0	0	0	
	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	9, 437, 669		0	0	
	FIXED ASSETS					
	Land Land improvements	6, 316, 248 1, 693, 578		0	0	
	Less: Accumulated depreciation	1, 0, 3, 578	0	0	0	1
	Buildings	91, 469, 441	0	0	0	
	Less Accumulated depreciation	-49, 157, 104		0	0	
	Leasehold improvements Less: Accumulated Amortization	0	0	0	0	1 .
	Fixed equipment	10, 693, 615	0	0	0	
	Less: Accumulated depreciation	0	0	0	0	
	Automobiles and trucks	252, 008	0	0	0	
	Less: Accumulated depreciation	0	0	0	0	
	Major movable equipment Less: Accumulated depreciation	1, 420, 475	0	0	0	
	Minor equipment - Depreciable	0	0	0	0	
	Minor equipment nondepreciable	0	0	0	0	
	Other fixed assets	5, 210		0	0	
	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	62, 693, 471	0	0	0	2
	OTHER ASSETS Investments	21, 423, 027	0	0	0	2
00	Deposits on leases	0		0	0	
	Due from owners/officers	0	0	0	0	
	Other assets TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	7, 448, 267 28, 871, 294		0	0	-
	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	101, 002, 434		0	0	
	Liabilities and Fund Balances					
	CURRENT LI ABI LI TI ES	2 745 040	0	0	0	1,2
	Accounts payable Salaries, wages, and fees payable	2, 745, 869 2, 288, 830		0	0	-
	Payrol I taxes payable	0		0	0	
	Notes & Loans payable (Short term)	1, 355, 000	0	0	0	
	Deferred income	0	0	0	0	ľ
	Accelerated payments Due to other funds		0	o	0	40
	Other current liabilities	0	0	0	0	
	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	6, 389, 699	0	0	0	
	LONG TERM LI ABI LI TI ES		0			
	Mortgage payable Notes payable	49, 222, 211		0	0	
	Unsecured Loans	0	0	0	0	
00	Loans from owners:	0	0	0	0	4
	Other long term liabilities	44, 088, 485		0	0	
	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	93, 310, 696	0	0	0	
	TOTAL LIABILITIES (Sum of Lines 43 and 50)	99, 700, 395		0	0	
	CAPI TAL ACCOUNTS	1				
	General fund balance	1, 302, 039				5
	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		5
	Donor created - endowment fund balance - unrestricted			0		5
	Governing body created - endowment fund balance			0		5
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
	LEDIACEMENT AND EXNANSION		1			
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	1, 302, 039	0	0	0	59

STATEMENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315499		01/01/2023		
				То	12/31/2023	Date/Time Pr 6/24/2024 5:	
	General	Fund	Speci al	Purpo	se Fund	Endowment Fund	
	1.00	2.00	3.00		4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 31)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments)5.00INCREASE IN FOUNDATION INTEREST6.00CONTRIBUTIONS7.00INCREASE IN FOUNDATION INTEREST8.009.0010.00Total additions (sum of line 5 - 9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments)13.00NET ASSETS RELEASED FROM RESTRICTION14.00OTHER15.0017.0018.00Total deductions (sum of lines 13 - 17)19.00Fund balance at end of period per balance	497, 778 630, 635 103, 510 0 0 0 199, 341 4, 291 0 0 0	2.00 919,991 -646,243 273,748 1,231,923 1,505,671 203,632 1,302,039	3.00		4.00 0 0 0 0 0 0 0 0 0 0		1. 2. 3. 4. 0 5. 0 7. 0 10. 11. 12. 0 13. 0 14. 0 14. 0 15. 0 16. 0 17. 18. 19.
sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund	_			
	6.00	7.00	8.00	_			
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 31)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments)5.00INCREASE IN FOUNDATION INTEREST6.00CONTRIBUTIONS7.00INCREASE IN FOUNDATION INTEREST8.009.00	0	000000000000000000000000000000000000000		0			1. 2. 3. 4. 5. 6. 7. 8. 9.
 10.00 10.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 NET ASSETS RELEASED FROM RESTRICTION 14.00 OTHER 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance 	000	0 0 0 0		000			10. 11. 12. 13. 14. 15. 16. 17. 18. 19.

Heal th	Financial Systems	LIONS GATE				In Lie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315499		eriod: com 01/01/2023 o 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 6/24/2024 5:0	pared:
	Cost Center Description		•	I npati ent		Outpatient	Total	
	'			1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Care Services							
	SKILLED NURSING FACILITY			23, 035, 8	36		23, 035, 836	1.00
	NURSING FACILITY			20,000,0	0		20,000,000	2.00
	ICF/IID				0		0	3.00
	OTHER LONG TERM CARE				0		0	4.00
	Total general inpatient care services (Sum of lin	05 1 4)		23, 035, 8	~		23, 035, 836	5.00
	All Other Care Services	65 1 - 4)		23,035,0	50		23, 033, 830	5.00
	ANCI LLARY SERVICES			2, 455, 28	00	0	2, 455, 280	6.00
	CLINIC			2,400,20	60	0	2,455,260	7.00
	HOME HEALTH AGENCY COST					0	0	8.00
8.00 9.00						0	-	
						0	0	9.00
	RURAL HEALTH CLINIC					0	0	10.00
	FQHC					0	0	10.10
	CMHC				~	0	0	11.00
	HOSPICE			44 047 44	0	0	0	12.00
	OTHER PATIENT REVENUES			16, 267, 6		0	16, 267, 693	13.00
	Total Patient Revenues (Sum of lines 5 - 13) (Tra Worksheet G-3, Line 1)	nster column 3	το	41, 758, 80	09	0	41, 758, 809	14.00
	Cost Center Description							
	cost center bescription				ŀ	1.00	2.00	
	PART II - OPERATING EXPENSES					1.00	2.00	
	Operating Expenses (Per Worksheet A, Col. 3, Line	100)					38, 149, 808	1.00
	Add (Specify)	100)				0	30, 147, 000	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
	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)			1		38, 149, 808	15.00

Heal th	Financial Systems	LIONS GATE		In Lie	u of Form CMS-2	2540-10
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider No.: 315499	Peri od:	Worksheet G-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Prep 6/24/2024 5:0	
	· · · · · · · · · · · · · · · · · · ·				0/24/2024 5.0	7 pm
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,	col. 3, line 1	4)		41, 758, 809	1.00
2.00	Less: contractual allowances and discounts on pat				9, 556, 025	2.00
3.00	Net patient revenues (Line 1 minus line 2)				32, 202, 784	3.00
4.00	Less: total operating expenses (From Worksheet G-	2, Part II, li	ne 15)		38, 149, 808	4.00
5.00	Net income from service to patients (Line 3 minus	5 4)	-		-5, 947, 024	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				744, 583	6.00
7.00	Income from investments				2, 618, 777	7.00
8.00	Revenues from communications (Telephone and Inte	ernet service)			5, 236	8.00
9.00	Revenue from television and radio service				7, 088	
	Purchase di scounts				0	10.00
	Rebates and refunds of expenses				0	11.00
	Parking lot receipts				0	12.00
	Revenue from Laundry and Linen service				0	
	Revenue from meals sold to employees and guests				46, 596	14.00
	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical supplie		an patients		0	16.00
	Revenue from sale of drugs to other than patients				0	
	Revenue from sale of medical records and abstract				0	
	Tuition (fees, sale of textbooks, uniforms, etc.)				0	
	Revenue from gifts, flower, coffee shops, canteer	ı			0	
	Rental of vending machines				0	
	Rental of skilled nursing space				0	22.00
	Governmental appropriations				0	
	MISCELLANEOUS				145, 514	
	OTHER - AL/IL REVENUE				1, 616, 727	
	BARBER AND BEAUTY REVENUE				11, 225	
	TRANSPORTATION REVENUE				0	
	G&A OTHER REVENUE				90, 802	
	CHANGE IN NET ASSETS - AUXILIARY				14, 233	
	COVI D-19 PHE Funding				0	24.50
	Total other income (Sum of lines 6 - 24)				5, 300, 781	
26.00	Total (Line 5 plus line 25)				-646, 243	
27.00					0	27.00
28.00					0	
29.00	Total other evenence (Sum of Lines 27 20)				0	
	Total other expenses (Sum of lines 27 - 29) Net income (or loss) for the period (Line 26 minu	1000000			-646, 243	
31.00	Iner moune (or ross) for the period (Line 26 minu	is Time 30)			-040, 243	31.00