This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315177 Worksheet S Parts I, II & III Peri od: From 01/01/2022 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/30/2023 12:22 pm PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 5/30/2023 Time: 12:22 pm use only ] Manually prepared cost report 2 [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 3 ] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [ 1 ] Cost Report Status 6. Contractor No.

9. NPR Date:

11. Contractor Vendor Code

for no utilization.

7.[ N ] First Cost Report for this Provider CCN

8.[ N ] Last Cost Report for this Provider CCN

10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened

12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

(1) As Submitted

(4) Reopened

(5) Amended

5. Date Received:

(2) Settled without audit

(3) Settled with audit

use only

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 GATEWAY CARE CENTER ( 315177 ) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Joe E	Blachorsky	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Joe Bl achorsky			2
3	Signatory Title	CF0			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	-58, 676	2, 115	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	-58, 676	2, 115	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Health Financial Systems GATEWAY CARE CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315177 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/30/2023 12:22 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address:
Street: 139 GRANT AVENUE PO Box: 1.00 1.00 2.00 City: EATONTOWN State: NJ Zi p Code: 07724 2.00 3.00 County: MONMOUTH CBSA Code: 35154 Urban/Rural: U 3.00 3. 01 CBSA Code: 3. 01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF GATEWAY CARE CENTER 315177 01/01/1987 N Р 0 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2022 01/01/2022 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in N 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 103, 535 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 103, 535 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 Υ 38, 00 39.00 2 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 0

Health Financial Systems	GATEWAY CARE (	CENTER	In Lie	u of Form CMS-	2540-10	
SKILLED NURSING FACILITY AND SKILLED N	SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315177   Period:			Worksheet S-2		
COMPLEX INDENTIFICATION DATA			From 01/01/2022	Part I		
			To 12/31/2022			
					22 pm	
				Y/N		
				1. 00		
42.00 Are mal practice premiums and pai	42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost					
center? Enter Y or N. If yes, ch	eck box, and submit supporting	schedule listing cost	centers and			
amounts.		_				
43.00 Are there any home office costs	as defined in CMS Pub. 15-1, C	hapter 10?		N	43.00	
44.00 If line 43 is yes, enter the hom	e office chain number and ente	r the name and address	of the home		44. 00	
office on lines 45, 46 and 47.						
1.00	2.00		3. 00			
If this facility is part of a ch	ain organization, enter the na	me and address of the h	nome office on the	lines		
bel ow.	•					
45. 00 Name:	Contractor's Name:	Contrac	tor's Number:		45. 00	
46.00 Street:	PO Box:				46. 00	
47.00 City:	State:	Zi p Cod	e:		47. 00	

SKI LL	n Financial Systems ED NURSING FACILITY AND SKILLED NURSING FACILI	GATEWAY CARE CENTER  TY HEALTH CARE Provider		Peri od:	eu of Form CMS- Worksheet S-2	
	EX REIMBURSEMENT QUESTIONNAIRE		1	From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	epared:
				Y/N	5/30/2023 12: Date	22 pm
				1. 00	2. 00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy)	ses enter in column 1, "Y" fo	or Yes or "N" 1	for No. For all	the date	
	Completed by All Skilled Nursing Facilites					
. 00	Provider Organization and Operation  Has the provider changed ownership immediatel	v prior to the beginning of	the cost	N		1.0
	reporting period? If column 1 is "Y", enter	the date of the change in col	umn 2. (see			
	instructions)		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of		N			2.0
	3, "V" for voluntary or "I" for involuntary.					
00	Is the provider involved in business transaction contracts, with individuals or entities (e.g.		Y			3.0
	or medical supply companies) that are related	d to the provider or its				
	officers, medical staff, management personnel of directors through ownership, control, or 1					
	relationships? (see instructions)					
			Y/N 1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prepared		Y	С		4.0
	Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complete					
	available in column 3. (see instructions) If	no, see instructions.				
. 00	Are the cost report total expenses and total those on the filed financial statements? If of		N			5.0
	reconciliation.					
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
00	Column 1: Were costs claimed for Nursing Schollegal operator of the program? (Y/N)	ool? (Y/N) Column 2: Is the	provider the	N	N	6.0
00	Were costs claimed for Allied Health Programs			N		7. C
00	Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) se		for Nursing	N		8.0
	Joenoor and/or Affred Hearth Frogram: (1719) St	se mstructions.			Y/N	
	Bad Debts				1. 00	
00	Is the provider seeking reimbursement for back	d debts? (Y/N) see instruction	ons.		Y	9.0
). 00	If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy.	t collection policy change du	iring this cos	t reporting	N	10.0
1. 00	1.	d/or coinsurance waived? If "	Y", see instru	ucti ons.	N	11. C
	Bed Complement Have total beds available changed from prior	and manageting pariod2 If ")	/"	ati ana	N	1,2,0
2. 00	have total beus avairable changed from pirol	cost reporting period? IT		rt A	Part B	12. 0
		Description 0	Y/N	Date	Y/N	
	PS&R Data	0	1.00	2. 00	3. 00	
			Y	03/17/2023	Y	7 13. C
8. 00						13.0
3. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to					13.0
3. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and					13.0
	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.)		N		N	
	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		N		N	
	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"		N		N	
	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		N		N	
1. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14. C
↓. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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		N N		N N	14. C
↓. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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					14. 0
1. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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					14. 0
1. 00 5. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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					14. C
↓. 00 5. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.		N		N	14. 0
5. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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.		N N		N N	14. 0 15. 0
4. 00 5. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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.		N		N	14. 0 15. 0
3. 00 4. 00 5. 00 7. 00 3. 00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for Corrections of other PS&R data for Other? Describe the other adjustments:		N N		N N	14. 0 15. 0 16. 0

Heal th	Financial Systems GATEWAY C	ARE C	ENTER		In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAR	E	Provi der No.: 315177		eri od:	Worksheet S-2	!
COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To	com 01/01/2022 0 12/31/2022		pared:
				L		5/30/2023 12:	22 pm
			1. 00		2. (	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/position	CHAF	RLES	F	REED		19. 00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
20. 00	Enter the employer/company name of the cost report	EXEC	CUCARE ASSOCIATES				20. 00
	preparer.						
21. 00	Enter the telephone number and email address of the cost	(609	9)738-3200	(	CRWASSC@NETSCAP	PE. NET	21. 00
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems GATEWAY CAR SKILLED NURSING FACILITY HEALTH CARE GATEWAY CARE CENTER Provi der No.: 315177

| Peri od: | Worksheet S-2 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: COMPLEX REIMBURSEMENT QUESTIONNAIRE

				10 12/31/2022	Date/lime Prepared:   5/30/2023 12:22 pm
		Part B			
		Date			
		4. 00			
	PS&R Data				
13. 00	Was the cost report prepared using the PS&R	03/17/2023			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and 4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				14.00
14.00	for total and the provider's records for				14.00
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00
	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.				
16. 00					16. 00
10.00	adjustments made to PS&R data for				10.00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17.00					17. 00
	adjustments made to PS&R data for Other?				
	Describe the other adjustments:				
18. 00	Was the cost report prepared only using the				18. 00
	provider's records? If "Y" see Instructions.				
			3.00		
	Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title		VI CE-PRESI DENT		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 r	eport			20. 00
21 00	preparer.	of the cost			21.00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respective				21. 00
	Treport preparer in corumns rand 2, respectiv	Ciy.	I	T .	I

In Lieu of Form CMS-2540-10 GATEWAY CARE CENTER

Health Financial Systems GATEWAY CAR Provi der No.: 315177 Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/30/2023 12: 22 pm COMPLEX STATISTICAL DATA

Component   Number of Bads   Bads Days   Available   Title V Title XVIII   Title XIX						7 12/31/2022	5/30/2023 12: 2	
Available					I npa	atient Days/Vis	si ts	
1.00   SKILLED NURSING FACILITY		Component	Number of Beds		Title V	Title XVIII	Title XIX	
2.00   NURSING FACILITY				2. 00				
1.00   Component						3, 430		
MAME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   0				-				
5.00   Other Long Term Care   0			0	U		0		
A		1	0	0	U	U	U	
MOSPICE   O O O O O O O O O O O O O O O O O O			0	U				
Total   Sum of Fines 1-7   178			0	0	0	0	0	
Component   Other   Total   Title V   Title XVIII   Title XIX   Component   Component   Other   Total   Title V   Title XVIII   Title XIX   Component   Componen			_	64, 970		3, 430		
1.00   SKILLED NURSING FACILITY		·	Inpatient [	Days/Vi si ts		Di scharges		
1.00   SKILLED NURSING FACILITY		0	0+1	T-4-1	T: +1 - \/	T: +1 - W// 1 1	T: +1 - VIV	
1.00		Component						
2.00   NURSING FACILITY	1 00	SKILLED NURSING FACILLTY						1 00
1.00   CF/IID   0   0   0   0   0   0   0   0   0			0			00		
5.00			0	0	_			
SNF-Based CMHC	4.00	HOME HEALTH AGENCY COST	0	0				4.00
100   HOSPICE	5.00		0	0				5.00
Note	6.00							6.00
Discharges   Average Length of Stay			0	0		0		
Component   Other   Total   Title V   Title XVIII   Title XIX	8. 00	Total (Sum of lines 1-7)						8. 00
11.00			Di sch	arges	Aver	age Length of	Stay	
1.00		Component						
2. 00								
3.00   ICF/IID						51. 97		
4. 00   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   0								
5.00   Other Long Term Care   0   0   0   0   0   0   0   0   0			0	U			0.00	
Component   Comp			0	0				
NO			0	0				
Note   Total   (Sum of lines 1-7)   Average Length of Stay   Total   Title V   Title XVIII   Title XIX   Other			0	0	0.00	0.00	0.00	
Average Length of Stay			73	280				
Total   Title V   Title XVIII   Title XIX   Other		,			Admi s			
16.00							0.11	
1.00   SKILLED NURSING FACILITY   198.53   0   1111   135   59   1.00		Component						
2.00	1 00	SVILLED NUDSING EACHLITY						1 00
3.00   ICF/IID   0.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					111			
A . 00						_		
Solid   Other Long Term Care   O.00   O.00			0.00			Ü		
6.00 SNF-Based CMHC 7.00 HOSPICE 0.00 0 0 0 0 0 7.00 8.00 Total (Sum of lines 1-7) 198.53 0 111 135 59 8.00    Component   Component   Total   Employees on Payrol   Workers   21.00   22.00   23.00			0. 00				o	
Notal (Sum of lines 1-7)   198.53   0   111   135   59   8.00   111   135   59   8.00   111   135   59   8.00   111   135   59   8.00   111   135   59   8.00   111   135   59   8.00   111   135   59   8.00   111   135   59   8.00   111   135   59   8.00   111   135   59   8.00   111   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135   135	6.00	SNF-Based CMHC						6.00
Component   Employees on Payrol   Workers   21.00   22.00   23.00	7.00			0				7. 00
Total   Employees on Payrol   Workers   21.00   22.00   23.00     23.00     20.00   23.00     20.00   23.00     20.00   20.00     20.00   20.00     20.00     20.00     20.00     20.00     20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00	8. 00	Total (Sum of lines 1-7)		0		135	59	8. 00
Payrol   Workers     21.00   22.00   23.00			Adilii SSI ONS	Full IIme	Equi vai ent			
21.00   22.00   23.00		Component	Total					
1. 00     SKILLED NURSING FACILITY     305     125. 16     0.00     1.00       2. 00     NURSING FACILITY     0     0.00     0.00     2.00       3. 00     I CF/IID     0     0.00     0.00     3.00       4. 00     HOME HEALTH AGENCY COST     0.00     0.00     4.00       5. 00     Other Long Term Care     0     0.00     0.00     5.00       6. 00     SNF-Based CMHC     0.00     0.00     6.00       7. 00     HOSPICE     0     0.00     0.00     7.00			21.00					
2.00     NURSING FACILITY     0     0.00     0.00       3.00     ICF/IID     0     0.00     0.00       4.00     HOME HEALTH AGENCY COST     0.00     0.00     4.00       5.00     Other Long Term Care     0     0.00     0.00     5.00       6.00     SNF-Based CMHC     0.00     0.00     6.00       7.00     HOSPI CE     0     0.00     0.00     7.00	1 00	SKILLED NURSING FACILLEV						1 00
3.00     I CF/I I D     0     0.00     0.00     3.00       4.00     HOME HEALTH AGENCY COST     0.00     0.00     4.00       5.00     Other Long Term Care     0     0.00     0.00     5.00       6.00     SNF-Based CMHC     0.00     0.00     6.00       7.00     HOSPI CE     0     0.00     0.00     7.00			1					
4.00       HOME HEALTH AGENCY COST       0.00       0.00       4.00         5.00       Other Long Term Care       0.00       0.00       5.00         6.00       SNF-Based CMHC       0.00       0.00       6.00         7.00       HOSPI CE       0.00       0.00       0.00		·						
5.00     Other Long Term Care     0     0.00     0.00     5.00       6.00     SNF-Based CMHC     0.00     0.00     6.00       7.00     HOSPI CE     0     0.00     0.00     7.00			]					
7. 00 HOSPICE 0 0.00 0.00 7. 00		1	0					
8.00  Total (Sum of lines 1-7)   305  125.16  0.00    8.00								
	8. 00	lotal (Sum of lines 1-7)	305	125. 16	0.00			8. 00

			_	T	0 12/31/2022	Date/Time Pre 5/30/2023 12:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
4 00	SALARI ES	/ 544 504		/ 544 504	0/0 004 00	05.40	4 00
1.00	Total salaries (See Instructions)	6, 541, 501	0	6, 541, 501	260, 334. 00		
2.00	Physician salaries-Part A	0	0	0	0.00		
3.00	Physician salaries-Part B	0	0	0	0.00		
4.00	Home office personnel	0	0	0	0.00		4. 00
5.00	Sum of lines 2 through 4	( 541 501	0	U 4 F41 F01	0.00		
6.00	Revised wages (line 1 minus line 5)	6, 541, 501	0	6, 541, 501			
7.00	Other Long Term Care	0	0	0	0.00		
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		
9.00	CMHC	0	0	0	0.00		
10.00	HOSPI CE	0	0	0	0.00		10.00
11.00	Other excluded areas	0	0	0	0.00		11. 00
12. 00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12. 00
13.00	Total Adjusted Salaries (line 6 minus line	6, 541, 501	0	6, 541, 501	260, 334. 00	25. 13	13. 00
	12)						
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1, 483, 015	0	1, 483, 015	36, 342. 00	40. 81	14.00
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		15. 00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	1, 465, 008	0	1, 465, 008			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20. 00
21. 00	Physician Part B - WRC	0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 465, 008	0	1, 465, 008			22. 00
	instructions)						

In Lieu of Form CMS-2540-10 Health Financial Systems GATEWAY CARE CENTER

SNF WAGE INDEX INFORMATION Provi der No.: 315177 Peri od:

Worksheet S-3 Part III Date/Time Prepared: From 01/01/2022 To 12/31/2022 5/30/2023 12: 22 pm Amount Reclass. of Adj usted Paid Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 ÷ Reported col . 4) Worksheet A-6  $1 \pm col. 2$ Salary in col 5.00 1.00 2.00 3.00 4.00 PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0.00 0.00 1.00 819, 046 2.00 Administrative & General 21, 876. 00 0 819, 046 37.44 2.00 3.00 Plant Operation, Maintenance & Repairs 106, 144 0 106, 144 4, 304. 00 24.66 3.00 4.00 Laundry & Linen Service 55,006 55, 006 2, 762.00 19.92 4.00 5.00 Housekeepi ng 221, 513 0 221, 513 13, 981. 00 15.84 5.00 700, 856 0 36, 544. 00 19. 18 Di etary 700, 856 6.00 6.00 Nursing Administration 5, 477. 00 41.27 7.00 226, 026 226, 026 7.00 8.00 Central Services and Supply 0 0 0 0.00 0.00 8.00 9.00 Pharmacy 0 0 0 0.00 0.00 9. 00 01 Medical Records & Medical Records Library 0.00 10.00 0 n 0.00 10.00 Social Service 0 11.00 114, 779 114, 779 2, 144. 00 53.53 11.00

625, 470

2, 868, 840

0

0

625, 470

2, 868, 840

31, 138. 00

118, 226. 00

12.00 13.00

20.09

24. 27 14. 00

12.00

13.00

Nursing and Allied Health Ed. Act.

Other General Service

14.00 Total (sum lines 1 thru 13)

Health Financial Systems	GATEWAY CARE CENTER	In Lieu	u of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315177	From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2023 12:22 pm

	To 12/31/2022		
		Amount	
		Reported	
	DATE IV. WAS DELATED AGOTO	1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Shel tered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	33, 524	3. 00
4.00	Pri or Year Pensi on Servi ce Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	_	
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	626, 441	8.00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00		0	11. 00
12.00		0	12.00
13.00		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	Workers' Compensation Insurance	211, 026	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	499, 501	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	89, 346	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	5, 170	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 465, 008	24.00
		Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25.00
	•	. '	

				T	o 12/31/2022	Date/Time Pre	
	0	A	Fi	A -1: +1	Dei d Herre	5/30/2023 12: 2	22 pm
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col.		Average Hourly Wage (col. 3 ÷	
		Reported	bellet i tS		Salary in col.	col. 4)	
				1 + COI. 2)	3	COI . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	Direct Salaries			5. 55		2. 22	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	644, 104	144, 994	789, 098	14, 529. 00	54. 31	1.00
2.00	Licensed Practical Nurses (LPNs)	1, 062, 614	239, 204	1, 301, 818	30, 639. 00	42. 49	2.00
3.00	Certified Nursing Assistant/Nursing	1, 633, 953	367, 818	2, 001, 771	89, 261. 00	22. 43	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 340, 671	752, 016		·	30. 44	4.00
5.00	Physical Therapists	156, 099	35, 139	191, 238	·		5.00
6.00	Physical Therapy Assistants	0	0	0	0. 00	0. 00	6.00
7. 00	Physical Therapy Aides	0	0	0	0. 00	0. 00	7. 00
8.00	Occupational Therapists	161, 813	36, 426	198, 239	·	50. 40	8. 00
9.00	Occupational Therapy Assistants	0	0	0	0. 00	0. 00	9. 00
10.00	Occupational Therapy Aides	0	0	0	0. 00	0. 00	
11. 00	Speech Therapists	14, 078	3, 169	17, 247	1, 729. 00		
12. 00	Respiratory Therapists	0	0	0	0. 00		
13. 00	Other Medical Staff	0	0	0	0. 00	0. 00	13.00
	Contract Labor						
	Nursing Occupations	070 070				20.00	
14. 00	Registered Nurses (RNs)	373, 879		373, 879	·		
15. 00	Licensed Practical Nurses (LPNs)	361, 265		361, 265		58. 48	
16. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	670, 938		670, 938	24, 456. 00	27. 43	16. 00
17. 00	Total Nursing (sum of lines 14 through 16)	1, 406, 082		1, 406, 082	35, 094. 00	40. 07	17. 00
18. 00	Physical Therapists	32, 493		32, 493	·		18. 00
19. 00	Physical Therapy Assistants	32, 473		32, 473	0.00	0.00	
20. 00	Physical Therapy Assistants				0.00	0.00	
21. 00	Occupational Therapists			0	0.00	0.00	
22. 00	Occupational Therapy Assistants			0	0.00	0.00	
23. 00	Occupational Therapy Aides			١	0.00	0.00	
24. 00	Speech Therapists	44, 440		44, 440		65. 84	
25. 00	Respiratory Therapists	0		0	0.00		
	Other Medical Staff	o		Ö			26. 00
	•	'		•			

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/30/2023 12: 22 pm Provi der No.: 315177

Carrage   Carr			5/30/2023 12:	22 pm
1.00		Group	Days	
2.00		1. 00	2. 00	
2.00	1.00	RUX		1. 00
2.00				
4.00				
5.00   SHIK   5.00   SHIK   5.00   SHIK   5.00   SHIK   5.00   SHIK   7.00   SHIK				
Section   Sect				F 00
7.00 RMX				
S   00				
9.00   RLX   9.00   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   11.100   1				
10.00   RIB	8. 00	RML		8. 00
10.00   RIB	9. 00	RLX		9. 00
11.00   RUB				
12.00   RUA   11.00   RUC   11.1.00   RUC   11.00   RUC   11.00   RUC   11.00   RUC   RU				
13.00   RVC   13.00   RVG   14.00   RVG   14.00   RVG   14.00   RVG   RVG   14.00   RVG				
14.00   RWB   114.00   RW   115.00   RWB   116.00   RWB   116.00   RWB				
15.00   RW   15.00   RW   16.00   RW   16.00   RW   17.00   RW   18.00   RW   19.00   RW   19.				
16.00   RHC   17.00   RHB   17.00   RHB   17.00   RHB   17.00   RHB   18.00   RHB   17.00   RHB   17.00   RHB   17.00   RHB   18.00   RHB   19.00   RHB				
17. 00   Ref   17. 00   Ref   17. 00   Ref   18. 00   Ref   18. 00   Ref   19.				
18. 00				
19.00     20.00     21.00     21.00     21.00     22.00     21.00     22.00     22.00     22.00     23.00     24.00     24.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.00     25.0	17. 00	RHB		17. 00
20.00   RMB   20.00   RMA   21.00   22.00   RLB   22.00	18. 00	RHA		18. 00
20.00   RMB   20.00   RMA   21.00   22.00   RLB   22.00	19. 00	RMC		19. 00
21.00   RIMB   22.00   RIMB   22.00   RIMB   22.20   RIMB   22.20   RIMB   22.20   RIMB   22.20   RIMB   22.20   RIMB   22.20   RIMB   23.30   RIMB   23.3				
RLB				
23.00   RLA   23.00   RLA   23.00   RLA   23.00   RLA   25.00   RLA				
24.00   ES3   24.00   ES2   25.00   ES3   25.00   ES1   26.00   ES1   26.00   ES1   26.00   ES1   26.00   ES1   26.00   ES1   26.00   ES1   27.00   ES1   28.00   ES1   ES1				
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100	37. 00	LD2		37. 00
100				
40,00				
11 00   22 00   23 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 00   24 10 0				
A2 00   A3 00   CE2				
43.00     44.00     45.00     44.00     45.00     45.00     45.00     45.00     45.00     46.00     47.00     46.00     47.00     48.00     47.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.00     48.0				
44.00 45.00 46.00 46.00 46.00 47.00 48.00 48.00 48.00 49.00 50.00 50.00 51.00 52.00 53.00 53.00 54.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 56.00 57.00 58.00 58.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00				
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47.00 48.00 49.00 00 00 50.00 51.00 52.00 CA2 51.00 CA3 52.00 CA1 52.00 CA1 52.00 CA1 52.00 CA1 55.00 SE2 54.00 SE2 55.00 SE1 SE3 SS3 SS3 SS6 SS6 SS7 SS6 SS7 SS7 SS7 SS8 SS7 SS8 SS7 SS8 SS7 SS8 SS7 SS8 SS9 SS9 SS9 SS9 SS9 SS9 SS9 SS9 SS9				
48.00   CC1	46. 00	CD1		46. 00
48.00   CC1	47. 00	CC2		47. 00
49.00       CB2       49.00         50.00       CB1       50.00         51.00       CA2       51.00         52.00       CA1       52.00         53.00       SE3       53.00         54.00       SE2       54.00         55.00       SE1       55.00         56.00       SC       56.00         57.00       SSB       57.00         58.00       SSA       58.00         59.00       IB2       59.00         60.00       IB1       60.00         61.00       IA2       61.00         62.00       IA1       62.00         63.00       BB2       63.00         64.00       BB2       63.00         65.00       BA1       64.00         65.00       BA2       65.00         66.00       PE2       67.00         68.00       PE1       68.00         69.00       PD1       70.00         70.00       PC1       72.00         73.00       PB2       73.00         74.00       PB1       74.00				48. 00
50. 00       CB1       50. 00         51. 00       CA2       51. 00         52. 00       CA1       52. 00         53. 00       SE3       53. 00         54. 00       SE2       54. 00         55. 00       SE1       55. 00         56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       PE2       67. 00         68. 00       PE1       68. 00         69. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PC3       73. 00         74. 00       PB1       74. 00				
51. 00     CA2     51. 00       52. 00     SE3     52. 00       53. 00     SE3     53. 00       54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     SSA     58. 00       60. 00     I B2     59. 00       60. 00     I A2     61. 00       62. 00     I A1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA2     65. 00       66. 00     PE1     68. 00       69. 00     PD1     70. 00       70. 00     PD2     69. 00       70. 00     PC2     71. 00       72. 00     PC1     72. 00       73. 00     PB1     74. 00				1
52. 00     CA1     52. 00       53. 00     SE3     53. 00       54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     IB1     60. 00       61. 00     IA2     61. 00       62. 00     IA1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA2     65. 00       66. 00     BA1     66. 00       67. 00     PE2     67. 00       68. 00     PE1     68. 00       69. 00     PD0     69. 00       70. 00     PC2     71. 00       72. 00     PR1     72. 00       73. 00     PB1     74. 00				
53.00       SE3       53.00         54.00       SE2       54.00         55.00       SE1       55.00         56.00       SSC       56.00         57.00       SSB       57.00         58.00       SSA       58.00         59.00       IB2       59.00         60.00       IB1       60.00         61.00       IA2       61.00         62.00       IA1       62.00         63.00       BB2       63.00         64.00       BB1       64.00         65.00       BA2       65.00         66.00       BA1       66.00         67.00       PE2       67.00         68.00       PD1       70.00         70.00       PD1       70.00         71.00       PC2       71.00         72.00       PB1       73.00         74.00       PB1       74.00				
54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     IB1     60. 00       61. 00     IA2     61. 00       62. 00     IA1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA1     66. 00       67. 00     BA1     66. 00       69. 00     PE2     67. 00       68. 00     PD1     70. 00       70. 00     PD1     70. 00       71. 00     PC2     71. 00       72. 00     PB2     73. 00       74. 00     PB1     74. 00		CEO		
55. 00       SE1       55. 00         56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00		SES SES		
56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PPE1       68. 00         69. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00				
57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       64. 00       65. 00         64. 00       65. 00       66. 00         66. 00       67. 00       68. 00         68. 00       PE2       67. 00         69. 00       PD1       68. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00				
58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PE1       68. 00         69. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PC1       72. 00         73. 00       PB2       73. 00         74. 00       PB1       74. 00				
59. 00         60. 00         61. 00         61. 00         62. 00         63. 00         64. 00         65. 00         66. 00         67. 00         68. 00         69. 00         70. 00         70. 00         71. 00         72. 00         73. 00         74. 00				
59. 00         60. 00         61. 00         61. 00         62. 00         63. 00         64. 00         65. 00         66. 00         67. 00         68. 00         69. 00         70. 00         70. 00         71. 00         72. 00         73. 00         74. 00				
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70. 00 71. 00 72. 00 73. 00 74. 00 PC2 PC1 PC1 PC2 PC1 PC2 PC3 PC3. 00 PC1 PC3. 00 PC3. 00 PC3. 00 PC3. 00 PC3. 00 PC4. 00 PC5 PC7				
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73. 00 74. 00 PB1 73. 00 74. 00		PC1		
74.00 PB1 74.00				
75. UU PA2 75. 00				
	/5. UU	PA2	<u> </u>	/5.00

Health Financial Systems	GATEWAY CARE CENT	ΓER		In Lie	u of Form CMS-2540-10	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	P	Provi der	No.: 315177	Peri od:	Worksheet S-	7
				From 01/01/2022 To 12/31/2022	Date/Time Pro 5/30/2023 12:	
				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 V payments beginning 10/01/2003. Congress expe expenses. For lines 101 through 106: Enter i column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" f with direct patient care and related expense (See instructions)	cted this increase to n column 1 the amount r each category to to or yes or "N" for no	be used of the e tal SNF r if the sp	for direct pexpense for erevenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related Iter in Part I, Esociated	
101.00 Staffing						101. 00
102.00 Recruitment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105.00 OTHER (SPECIFY)	4 1 0)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, Ii	ne i, coiumh 3)	l				106. 00

Heal th	Financial Systems	GATEWAY CARE	CENTER		In Lie	u of Form CMS-2	2540-10
	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					rom 01/01/2022	D-+- /T: D	
				'	o 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	ZZ piii
				+ col . 2)	ons	Trial Balance	
				,	Increase/Decre		
					ase (Fr Wkst	col . 4)	
					A-6)		
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	T	1 770 100	4 770 400		4 070 070	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 779, 180			1, 879, 072	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		103, 535				2.00
3.00	00300 EMPLOYEE BENEFITS	010.04	1, 472, 553			1, 472, 553	3.00
4.00	00400 ADMINISTRATIVE & GENERAL	819, 046	2, 454, 912			3, 273, 958	4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	106, 144 55, 006	866, 522 10, 992			972, 666 65, 998	5. 00 6. 00
7. 00	00700 HOUSEKEEPING	221, 513	315, 779			537, 292	7. 00
8. 00	00800 DI ETARY	700, 856	813, 200			1, 514, 056	8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	226, 026	73, 748			299, 774	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	220, 020	227, 853			227, 853	10.00
11. 00	01100 PHARMACY		51, 232			51, 232	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	01, 232	31, 232		0	12. 00
13. 00	01300 SOCIAL SERVICE	114, 779	848	115, 627	0	115, 627	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0.0	1.10,027	0	0	14. 00
15. 00	01500 ACTIVITIES	625, 470	236, 973	862, 443	-		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	52375				3327	
30.00	03000 SKILLED NURSING FACILITY	3, 340, 671	1, 406, 082	4, 746, 753	3 0	4, 746, 753	30.00
31.00	03100 NURSING FACILITY	0	0	c	0	0	31.00
32.00	03200   CF/IID	o	0	l c	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	o	0	C	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	C	0	0	40. 00
41. 00	04100 LABORATORY	0	23, 645	23, 645	0	23, 645	1
42. 00	04200 I NTRAVENOUS THERAPY	0	0	C	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	C	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	156, 099	80, 493			236, 592	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	161, 813	0	161, 813		161, 813	1
46. 00	04600 SPEECH PATHOLOGY	14, 078	44, 440	58, 518	0	58, 518	1
47. 00	04700 ELECTROCARDI OLOGY	0	0			0	47. 00 48. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS		106, 632	106, 632		106, 632	48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		100, 632	100, 632		100, 632	50.00
51. 00	05100 SUPPORT SURFACES	0	0			0	51.00
31.00	OUTPATIENT SERVICE COST CENTERS	J			,		31.00
60. 00	06000 CLI NI C	0	0	C	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	o	0			0	61. 00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS			•			
70.00	07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
71.00	07100 AMBULANCE	0	0	C	0	0	71. 00
73.00	07300 CMHC	0	0	C	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	C	0	0	80. 00
81. 00	08100 I NTEREST EXPENSE		0	C	0	0	81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	0	0	C	0	0	
83. 00	08300 H0SPI CE	0	0	C	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	6, 541, 501	10, 068, 619	16, 610, 120	) 0	16, 610, 120	89. 00
00.00	NONREI MBURSABLE COST CENTERS						00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		0			0	
	09300 NONPALD WORKERS		0			0	1
	09400 PATIENTS LAUNDRY		0			0	94.00
100.00	1 1	6, 541, 501	10, 068, 619	16, 610, 120		16, 610, 120	1
	•				-		

 
 Heal th Financial
 Systems
 GATEWA

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Peri od: Worksheet A From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315177

				То	12/31/2022	Date/Time Pr 5/30/2023 12	
	Cost Center Description	Adjustments to	Net Expenses			5/30/2023 12	2. 22 piii
	<b>'</b>		For Allocation	1			
		Wkst A-8)	(col. 5 +-				
			col . 6)				
	GENERAL SERVICE COST CENTERS	6. 00	7. 00				
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES	-920, 767	958, 305				1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	720, 707	3, 643				2. 00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 472, 553	1			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-862, 788		1			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	-164, 502	808, 164				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	65, 998	1			6. 00
7.00	00700 HOUSEKEEPI NG	0	537, 292				7. 00
8. 00 9. 00	OO800   DI ETARY   OO900   NURSI NG ADMI NI STRATI ON	0	1, 514, 056	1			8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	299, 774 227, 853	1			10.00
11. 00	01100 PHARMACY	0	51, 232	1			11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0 1,7 2 3 2	)			12. 00
13.00	01300 SOCIAL SERVICE	0	115, 627	,			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0				14. 00
15.00	01500 ACTI VI TI ES	0	862, 443	8			15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		. 700 740	.I			
30.00	03000 SKILLED NURSING FACILITY	-23, 043		1			30.00
31. 00 32. 00	03100   NURSING FACILITY   03200   CF/IID	0	0				31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	1			33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>	1			- 00.00
40.00	04000 RADI OLOGY	0	0				40. 00
41.00	04100 LABORATORY	0	23, 645	5			41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0				42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0				43.00
44. 00	04400 PHYSI CAL THERAPY	0	236, 592	1			44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	161, 813 58, 518	1			45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0 30, 310	1			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	106, 632				49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0				50. 00
51.00	05100 SUPPORT SURFACES	0	0	)			51. 00
	OUTPATIENT SERVICE COST CENTERS	Ι ο		J			
60.00	O6000   CLINIC   O6100   RURAL HEALTH CLINIC	0	0				60.00
61. 00 62. 00	06200 FQHC	0	Ü	,			61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0				70. 00
71.00	07100 AMBULANCE	0	0				71. 00
73.00	07300 CMHC	0	0	)			73. 00
	SPECIAL PURPOSE COST CENTERS	_		ı			
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	0	1			80.00
	O8100   INTEREST EXPENSE   O8200   UTILIZATION REVIEW - SNF	0	0				81. 00 82. 00
83. 00	08300 HOSPI CE	0	0				83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 971, 100		1			89. 00
	NONREI MBURSABLE COST CENTERS	., , , , , , , , , , , , , , , , , , ,	, 33., 320				
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90.00
	09100 BARBER AND BEAUTY SHOP	0	0				91. 00
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	2			92.00
	09300 NONPAI D WORKERS	0	0				93.00
100.00	09400 PATIENTS LAUNDRY TOTAL	-1, 971, 100	14, 639, 020				94. 00 100. 00
100.00	/ ITOTAL	-1,7/1,100	14,037,020	1			1100.00

Health Financial Systems GATEWAY CARE CENTER In Lieu of Form C				u of Form CMS-2	2540-10	
RECLASSI FI CATI ONS			Peri od: From 01/01/2022	Worksheet A-6		
			To 12/31/2022	Date/Time Pre 5/30/2023 12:	pared: 22 pm	
			Increases			
	Cost Center	-	Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
(1) B - RECLASS LHI DEPRE						
1.00	CAP REL COSTS - BLD FIXTURES	GS &	1. 0	0 0	99, 892	1. 00
TOTALS						
100. 00	Total Reclassificat	`		0	99, 892	100. 00
	of columns 4 and 5 equal sum of column					
	9)					

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	GATEWAY CARE CE	NTER		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	From 01/01/2022		Worksheet A-6			
				To 12/31/2022	Date/Time Prep 5/30/2023 12:	
	Decreases					
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7.00	8. 00	9. 00	
(1) B - RECLASS LHI DEPRE						
1.00	CAP REL COSTS - MOV	ABLE	2. 0	0 0	99, 892	1.00
	EQUI PMENT					
TOTALS						
100. 00				0	99, 892	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS GATEWAY CARE CENTER

				Т	o 12/31/2022	Date/Time Prep 5/30/2023 12:2	
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S			1		
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	1, 975, 458	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1, 524, 057	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	3, 499, 515	0	0	0	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8.00
9. 00	Total (line 7 minus line 8)	3, 499, 515	0	0	0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	\$					
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	1, 975, 458	0				4.00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	1, 524, 057	0				6.00
7.00	Subtotal (sum of lines 1-6)	3, 499, 515	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	3, 499, 515	0				9. 00

Provi der No.: 315177 Peri od: Worksheet A-8 From 01/01/2022 | Worksheet A-8 | To 12/31/2022 | Date/Time Prepared:

				10 12/31/2022	5/30/2023 12:	
				Expense Classification on		22 piii
				To/From Which the Amount is		
				TO/TTOIN WITCH THE AMOUNT IS	to be Aujusteu	
	Description (1)	(2) Pacis For	Amount	Cost Contor	Li ne No.	
	Description (1)	(2) Basis For	Amount	Cost Center	Line No.	
		Adjustment	2 00	2 00	4. 00	
1. 00		1. 00 B	2.00	3.00		1. 00
1.00	Investment income on restricted funds	В	- 1, 920	ADMINISTRATIVE & GENERAL	4.00	1.00
2 00	(chapter 2)		_		0.00	2 00
2.00	Trade, quantity, and time discounts (chapter		C	1	0.00	2. 00
0.00	8)				0.00	
3.00	Refunds and rebates of expenses (chapter 8)		C		0.00	1
4.00	Rental of provider space by suppliers		C	)	0.00	4. 00
F 00	(chapter 8)				0.00	F 00
5.00	Tel ephone services (pay stations excluded)		С	1	0.00	5. 00
	(chapter 21)				0.00	, ,,,
6.00	Television and radio service (chapter 21)		C		0.00	1
7. 00	Parking lot (chapter 21)		C	I and the second	0.00	1
8.00	Remuneration applicable to provider-based	A-8-2	C	)		8. 00
	physician adjustment			1		
9. 00	Home office cost (chapter 21)		C	1	0.00	1
10.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	•
11. 00	Nonallowable costs related to certain		C	)	0.00	11. 00
	Capital expenditures (chapter 24)					
12. 00	Adjustment resulting from transactions with	A-8-1	-943, 104	1		12. 00
	related organizations (chapter 10)					
13. 00	Laundry and linen service		C	1	•	13. 00
14. 00	Revenue - Employee meals		C		•	14. 00
15. 00	Cost of meals - Guests		C	1	1	15. 00
16. 00	Sale of medical supplies to other than		C	)	0.00	16. 00
	patients					
17. 00	Sale of drugs to other than patients		C	1	0.00	
18. 00	Sale of medical records and abstracts		C		0.00	
19. 00	Vendi ng machi nes		C	)	0.00	19. 00
20.00	Income from imposition of interest, finance		C		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		C	)	0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		C	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		C	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24.00	Depreciationmovable equipment		C	CAP REL COSTS - MOVABLE	2.00	24. 00
				EQUI PMENT		
25.00	SALARIES ASST. ADM.	A	-4, 006	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	BAD DEBT EXP 30% NON MCD	A	-66, 862	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	MANAGEMENT FEE	A	-775, 000	ADMINISTRATIVE & GENERAL	4. 00	25. 02
25.03	PROMOTI ONAL ADVERTI SI NG	A	-15, 878	BADMINISTRATIVE & GENERAL	4.00	
25.04	NJ CORPORATE TAX	A	8, 672	ADMINISTRATIVE & GENERAL	4.00	25. 04
25.05	OTHER REV - MISC.	В	-8, 500	ADMINISTRATIVE & GENERAL	4.00	25. 05
25.06	SALE OF ELECTRICITY	В	-164, 502	PLANT OPERATION, MAINT. &	5. 00	25. 06
				REPAI RS	1	
25. 07			C		0.00	25. 07
25. 08			C		0.00	
100.00	Total (sum of lines 1 through 99) (Transfer	]	-1, 971, 100			100. 00
	to Worksheet A, col. 6, line 100)					
(4) D			CMC Dule 1E 1	1		

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

Health Financial Systems GATEWAY CARE STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME GATEWAY CARE CENTER

Provi der No.: 315177 OFFICE COSTS

			'	5/30/2023   Date/lime F	
	Li ne No.	Cost (	Center	Expense Items	
	1.00	2.		3. 00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
CLAIMED HOME OFFICE COSTS:	Т			Tee	
1.00		CAP REL COSTS FIXTURES	- BLDGS &	RE TAXES	1. 00
2.00	·	CAP REL COSTS	DI DCC 0	RENT	2.00
2.00		FI XTURES	- DLDG3 &	KLIVI	2.00
3.00		ADMI NI STRATI VE	& GENERAL	REALTY ADMIN	3.00
4.00	30.00	SKILLED NURSIN	G FACILITY	AI DES	4.00
5. 00	30.00	SKILLED NURSIN	G FACILITY	LPNS AND RNS	5.00
6. 00	0.00				6. 00
7.00	0.00	l .			7.00
8. 00	0.00				8. 00
9.00	0.00				9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column					10. 00
6, line 100 to Worksheet A-8, column 3, line 12.					
IZ.	Amount	Amount	Adjustments		
	Allowable In	Included in	(col. 4 minus		
	Cost	Wkst. A, col.	col . 5)		
		5			
	4.00	5. 00	6.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
CLAIMED HOME OFFICE COSTS:					
1.00	198, 411	198, 411		1	1. 00
2.00	639, 233	1, 560, 000			2.00
3. 00 4. 00	706	112 104	706		3.00
5.00	109, 051 714, 121	112, 104 734, 111	-3, 053 -19, 990		4. 00 5. 00
6.00	/14, 121	/34, 111	- 19, 990		6.00
7.00	0	0			7.00
8.00	0	0			8.00
9.00	0	0	ĺ		9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column	1, 661, 522	2, 604, 626	-943, 104	1	10. 00
6, line 100 to Worksheet A-8, column 3, line					
12.					[

				5/30/2023 12: 2	22 pm
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
BART II INTERRE ATLANGUER TO BELATER ORGANIE	7.4.T.I.O.N. (O) AND (O	D HOME OFFI OF			

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

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

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

1.00	Α	JONATHAN ROSENBERG	50.00	1.00
2. 00	Α	MURRAY MANDEL	20.00	2.00
3.00	Α	GEORGE GROSSBERG	20.00	3.00
4. 00	Α	IRVING BUAER	10.00	4.00
5. 00	G	I SREAL MINZER	0.00	5. 00
6. 00	D	MINDY ROSENBERG	0.00	6.00
7. 00			0.00	7.00
8. 00			0.00	8.00
9. 00			0.00	9.00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in rel ated organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

·	Rel ated Organi	zation(s) and/	or Home Office	
	Name	Percentage of	Type of Business	
		Ownershi p	3.	
	4.00	5. 00	6.00	1
DADT II. INTERDELATIONSHIP TO BELATER ORGANIE	14T1 011 (0) 411D (0D 11011E 0EEL 0E			_

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

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

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

1.00		GATEWAY EATONTOWN ASSOC	30. 00 REALTY	1.00
2.00		GATEWAY EATONTOWN ASSOC	20. 00 REALTY	2.00
3.00		GATEWAY EATONTOWN ASSOC	20. 00 REALTY	3.00
4.00		GATEWAY EATONTOWN ASSOC	10. 00 REALTY	4. 00
5.00		GATEWAY EATONTOWN ASSOC	20. 00 REALTY	5. 00
6.00		PEACE OF MIND STAFFING	100.00 NURSING AGENCY	6. 00
7.00			0. 00	7. 00
8.00			0. 00	8. 00
9.00			0. 00	9. 00
10.00			0.00	10. 00
100.00	G. Other (financial or non-financial)		0. 00	100. 00
	speci fy:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

  D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	12/31/2022	Date/Time Prep 5/30/2023 12:2	pared:
CAPITAL RELATED COSTS				5/30/2023 12.	22 piii		
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
	oost oontor bescription	for Cost	FIXTURES	EQUI PMENT	BENEFI TS	Subtotal	
		Allocation					
		(from Wkst A col. 7)					
	T	0	1. 00	2.00	3. 00	3A	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES	958, 305	958, 305				1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	3, 643	730, 303	3, 643			2. 00
3.00	00300 EMPLOYEE BENEFITS	1, 472, 553	4, 504	17	1, 477, 074		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 411, 170	58, 648	223	184, 941	2, 654, 982	4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	808, 164 65, 998	10, 976 25, 888	42 98	23, 967 12, 420	843, 149 104, 404	5. 00 6. 00
7. 00	00700 HOUSEKEEPING	537, 292	25, 004	95	50, 018	612, 409	7. 00
8. 00	00800 DI ETARY	1, 514, 056	96, 563	367	158, 253	1, 769, 239	8. 00
9. 00 10. 00	O0900   NURSI NG   ADMI NI STRATI ON   O1000   CENTRAL   SERVI CES & SUPPLY	299, 774 227, 853	13, 144 13, 928	50 53	51, 037 0	364, 005 241, 834	9. 00 10. 00
11. 00	01100 PHARMACY	51, 232	13, 720	0	o	51, 232	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	115, 627	4, 320	16	25, 917	145, 880	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	862, 443	0 26, 872	0 102	141, 231	0 1, 030, 648	14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	002/110	20,072	.02	111,7201	1, 555, 515	
30.00	03000 SKILLED NURSING FACILITY	4, 723, 710	598, 692		754, 327	6, 079, 005	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200   CF/IID	0	0	0	0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	Ö	0	0	o	Ö	33. 00
	ANCILLARY SERVICE COST CENTERS	1	ما		al		
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	23, 645	0	0	0	0 23, 645	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	Ö	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	236, 592 161, 813	26, 205 19, 082	100 73	35, 247 36, 537	298, 144 217, 505	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	58, 518	17, 331	66	3, 179	79, 094	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	106, 632	12, 127 3, 019	46 11	0	12, 173 109, 662	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	100, 032	3, 019	0	0	104, 002	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS  06000 CLINIC	0	O	0	ol	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200 FQHC						62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		O	0	ol	0	70. 00
71.00	07100 AMBULANCE		0	0	o	0	71.00
73. 00	07300 CMHC	0	0	0	o	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100   NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 HOSPI CE	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	1 477 074	14 (27 010	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	14, 639, 020	956, 303	3, 635	1, 477, 074	14, 637, 010	89. 00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	2, 002	8	0	2, 010	
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0	0	0	0	92. 00 93. 00
94.00	09400 PATIENTS LAUNDRY		Ö	Ö	o	Ö	94.00
98.00	Cross Foot Adjustments	0	0	0	O	0	98. 00
99. 00 100. 00	Negative Cost Centers   TOTAL	0 14, 639, 020	0 958, 305	0 3, 643	0 1, 477, 074	0 14, 639, 020	99. 00 100. 00
100.00	1.01/12	1 1, 337, 320	750, 505	5, 045	1, 177, 074	11, 557, 520	. 55. 66

						5/30/2023 12:	22 pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
			REPAI RS				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES					I	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT					I	2. 00
3.00	00300 EMPLOYEE BENEFITS					I	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 654, 982				I	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	186, 794	1, 029, 943			I	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	23, 130		1		I	6. 00
7.00	00700 HOUSEKEEPI NG	135, 675		1	777, 210		7. 00
8.00	00800 DI ETARY	391, 963		1	90, 065	2, 363, 749	
9.00	00900 NURSI NG ADMI NI STRATI ON	80, 643		1	12, 260	0	
10.00	01000 CENTRAL SERVICES & SUPPLY	53, 577	16, 224	1	12, 991	0	10.00
11.00	01100 PHARMACY	11, 350	0		0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	22 210	F 022		4 020	0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	32, 319	5, 032	0	4, 029	0 0	13. 00 14. 00
15. 00		228, 333	31, 302	_	25, 064	0	15. 00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	220, 333	31, 302		25, 064	0	15.00
30. 00		1, 346, 761	697, 394	157, 690	558, 403	2, 363, 749	30.00
31. 00		1, 340, 701	077, 374	1	330, 403	2, 303, 747	31.00
32. 00	03200   CF/IID	0	Ö		0	Ö	32.00
33. 00		0	Ö		0	Ö	1
00.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>		· · · · ·	<u> </u>		00.00
40. 00		0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	5, 238			0	Ö	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0,200	0		0	0	42. 00
43. 00		o	0	Ō	o	0	•
44.00		66, 052	30, 525	0	24, 441	0	44.00
45.00	• • • • • • • • • • • • • • • • • • •	48, 187	22, 228	1	17, 798	0	45. 00
46.00	04600 SPEECH PATHOLOGY	17, 523	20, 188	1	16, 165	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 697	14, 126	0	11, 311	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	24, 295	3, 517	0	2, 816	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51.00		0	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00		0	0	1		0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00							62. 00
	OTHER REIMBURSABLE COST CENTERS			1 -	_1	_	
70.00		0	0	1	0	0	
71.00		0	0			0	
73. 00		0	0	0	0	0	73. 00
00 00	SPECIAL PURPOSE COST CENTERS			1			00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE					I	80.00
81.00						I	81.00
		0	0		0	0	82.00
83. 00 89. 00		2, 654, 537	1, 027, 611	157, 690	775, 343		
69.00	NONREI MBURSABLE COST CENTERS	2,004,007	1,027,011	137, 090	110, 343	2, 303, 149	09.00
90. 00		0	0	0	0	0	90.00
91. 00		445	-		1, 867	0	1
92.00		1443	Z, 332	0	1, 007	0	1
93. 00				0		0	
94. 00			l n	٥	ا	0	94. 00
98. 00		, o	n	l o	n	Ö	98. 00
99. 00	,	l ol	Ö	o o	l ol	0	99. 00
100.00		2, 654, 982	1, 029, 943	157, 690	777, 210	_	
				•			

			10	12/31/2022	5/30/2023 12:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	22  0111
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	9. 00	10. 00	11. 00	12. 00	13. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00 O0300 EMPLOYEE BENEFITS						3. 00
4.00 OO400 ADMINISTRATIVE & GENERAL						4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00 00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00   00700   HOUSEKEEPI NG						7. 00
8. 00   00800   DI ETARY						8. 00
9.00 00900 NURSING ADMINISTRATION	472, 219					9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	0	324, 626	1			10. 00
11. 00   01100   PHARMACY	0	0	62, 582	_		11. 00
12. 00   01200   MEDI CAL RECORDS & LI BRARY	0	0	0	0		12. 00
13. 00 01300 SOCI AL SERVI CE	0	0	0	0	187, 260	13.00
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
INPATIENT ROUTINE SERVICE COST CENTERS	470.040	004 (04		ام	407.040	
30. 00 03000 SKILLED NURSING FACILITY	472, 219	324, 626	62, 582	0	187, 260	30.00
31. 00 03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00   03200   I CF/I I D	0	0	0	0	0	32. 00
33. 00 03300 OTHER LONG TERM CARE	0	0	0	O	0	33. 00
ANCILLARY SERVICE COST CENTERS		ما		ما		40.00
40. 00   04000   RADI OLOGY	0	0	0	U	0	40.00
41. 00   04100   LABORATORY	0	0	0	U	0	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	0	0	0	U	0	42. 00
43. 00 04300 0XYGEN (INHALATION) THERAPY	0	0	0	U O	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0	0	0	U		44. 00
45. 00 04500 OCCUPATIONAL THERAPY	0	0	0	U O	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	0	0	U O		46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	U	0	47. 00
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS 49.00   04900   DRUGS CHARGED TO PATIENTS	0	0	0	U O	0	48. 00 49. 00
		0	0	U O	0	
50.00   05000   DENTAL CARE - TITLE XIX ONLY 51.00   05100   SUPPORT SURFACES		0	0	U O	0	50. 00 51. 00
51. 00   05100  SUPPORT SURFACES   OUTPATIENT SERVICE COST CENTERS	Ч	U	U U	υ	0	31.00
60. 00 06000 CLINIC	l	0	0	ol	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC		0		o	0	61. 00
62. 00   06200 FQHC	١	O		ď	O	62. 00
OTHER REIMBURSABLE COST CENTERS				l		02.00
70. 00 07000 HOME HEALTH AGENCY COST	O	0	0	ol	0	70. 00
71. 00   07100   AMBULANCE	o	Ö	I	ő	0	71. 00
73. 00   07300   CMHC	0	0	0	ol	0	73. 00
SPECIAL PURPOSE COST CENTERS	91		<u> </u>	<sub>I</sub>		70.00
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	o	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	472, 219	324, 626	62, 582	o	187, 260	89. 00
NONREI MBURSABLE COST CENTERS	<u> </u>					
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00 09100 BARBER AND BEAUTY SHOP	0	o	0	o	0	91. 00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	o	0	o	0	92.00
93. 00   09300   NONPALD WORKERS	0	o	0	o	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	o	0	o	0	94.00
98.00 Cross Foot Adjustments	0	o				98. 00
99.00   Negative Cost Centers	0	o	0	o	0	99. 00
100. 00 TOTAL	472, 219	324, 626	62, 582	o	187, 260	100. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | To 12/ Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315177

				1	To 12/31/2022	Date/Time Pre 5/30/2023 12:	
			OTHER GENERAL			37 307 2023 12.	22 piii
			SERVI CE				
	Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATI ON					
	OFNEDAL CEDIUSE COCT OFNEDO	14. 00	15. 00	16. 00	17. 00	18. 00	
1 00	GENERAL SERVICE COST CENTERS			I			1 00
1. 00 2. 00	OO100   CAP REL COSTS - BLDGS & FIXTURES   OO200   CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMI NI STRATI VE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00	00700 HOUSEKEEPING						7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTI VI TI ES	0	1, 315, 347				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	1, 315, 347	13, 565, 036	0	13, 565, 036	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	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	0				1
41. 00	04100 LABORATORY	0	0	28, 883		,	1
42.00	04200 I NTRAVENOUS THERAPY	0	0	(		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	(140.44	-	0	
44. 00	04400 PHYSI CAL THERAPY	0	0	419, 162		419, 162	1
45.00	04500   OCCUPATI ONAL THERAPY   04600   SPEECH PATHOLOGY	0	0	305, 718		305, 718	1
46. 00 47. 00	04700 ELECTROCARDI OLOGY	0	0	132, 970		132, 970 0	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	40, 307		40, 307	1
49. 00	04900 DRUGS CHARGED TO PATTENTS		0	140, 290		140, 290	
50. 00	05000 DENTAL CARE - TITLE XIX ONLY		0	140, 270		1	1
51. 00	05100 SUPPORT SURFACES	0	0	1			1
01.00	OUTPATIENT SERVICE COST CENTERS		J J		<u>,                                     </u>		01.00
60.00	06000 CLI NI C	0	0	(	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0					
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	•		•	•	•	1
70.00	07000 HOME HEALTH AGENCY COST	0	0	(	0	0	70. 00
71.00	07100 AMBULANCE	0	0	(	0	0	71. 00
73.00	07300 CMHC	0	0	(	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 I NTEREST EXPENSE						81. 00
	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0		(	0	l e	
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 315, 347	14, 632, 366	5 0	14, 632, 366	89. 00
00.00	NONREI MBURSABLE COST CENTERS				\		00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (			1
91.00	09100 BARBER AND BEAUTY SHOP		0	6, 654			1
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS				-	0   0	1
94.00	09400 PATI ENTS LAUNDRY						
98.00	Cross Foot Adjustments				0		1
99.00	Negative Cost Centers						1
100.00		0	1, 315, 347	14, 639, 020	1		
100.00	1.0111	1	1, 515, 547	1 1,007,020	1	1 1,007,020	1.00.00

| Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315177

				То	12/31/2022	Date/Time Prep 5/30/2023 12:	
		CAPI TAL REI	_ATED COSTS		37 307 2023 12.	22 piii	
	Cost Contor Dosorintion	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	Cost Center Description	Directly Assigned New	FI XTURES	EQUI PMENT	Subtotal	BENEFITS	
		Capi tal					
		Related Costs	4.00	0.00	0.4	2.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	2A	3. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	4, 504		4, 521	4, 521	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	58, 648		58, 871	566	4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE		10, 976 25, 888		11, 018 25, 986	73 38	5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG	l o	25, 004		25, 099	153	7. 00
8.00	00800 DI ETARY	o	96, 563		96, 930	484	8. 00
9.00	00900 NURSING ADMINISTRATION	0	13, 144		13, 194	156	9. 00
10.00	1 1	0	13, 928	1	13, 981	0	10.00
11. 00 12. 00	1	0	0	0	0	0	11. 00 12. 00
13. 00			4, 320		4, 336	79	13. 00
14.00	1 1	o	0		0	0	14. 00
15. 00		0	26, 872	102	26, 974	432	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		500 (00	0.07/	,00,040	0.040	00.00
30. 00 31. 00	1 1	0	598, 692 0		600, 968	2, 310 0	30. 00 31. 00
32. 00	1 1		0	1	ol	0	32. 00
33. 00	1 1	o	0		Ö	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00		0	0		0	0	40.00
41. 00 42. 00		0	0		0	0	41. 00 42. 00
43. 00	1 1		0		0	0	43. 00
44. 00	1 1 7	o	26, 205		26, 305	108	44. 00
45. 00	1	0	19, 082	1	19, 155	112	45. 00
46. 00		0	17, 331	66	17, 397	10	46. 00
47. 00 48. 00	1 1	0	0 12, 127		0 12, 173	0	47. 00 48. 00
49. 00	1 1		3, 019		3, 030	0	49. 00
50.00	1 1	o	0		0	0	50.00
51. 00		0	0	0	0	0	51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS				ام	0	(0.00
60. 00 61. 00	1 1	0	0		0	0	60. 00 61. 00
62. 00	1		· ·			O.	62. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	1	0	0		0	0	70.00
71. 00 73. 00	1	0	0	1	0	0	71. 00 73. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>	U	73.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	1 1						81. 00
82. 00	1 1						82. 00
83. 00 89. 00		0	956, 303	3, 635	959, 938	0 4, 521	
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	730, 303	3, 033	737, 730	4, 321	07.00
90.00		0	0	0	0	0	90. 00
91. 00	1 1	0	2, 002	8	2, 010	0	91. 00
92.00		0	0	0	0	0	92.00
93. 00 94. 00		0	0		0	0	93. 00 94. 00
98. 00			0		0	U	98. 00
99. 00	Negative Cost Centers		0	0	ō	0	99. 00
100.00	O TOTAL	0	958, 305	3, 643	961, 948	4, 521	100. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315177 | Peri od: From 01/01/2022

Worksheet B
D22 Part II
D22 Date/Time Prepared:

12/31/2022 5/30/2023 12:22 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 59, 437 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 4, 182 15, 273 5.00 00600 LAUNDRY & LINEN SERVICE 26, 989 6.00 518 447 6.00 00700 HOUSEKEEPI NG 7.00 3.038 432 C 28.722 7.00 8.00 00800 DI ETARY 8,775 1,668 0 3, 328 111, 185 8.00 9.00 00900 NURSING ADMINISTRATION 1,805 227 0 9.00 453 1, 199 01000 CENTRAL SERVICES & SUPPLY 10.00 0 480 10.00 241 Ω 11.00 01100 PHARMACY 254 C 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 01300 SOCIAL SERVICE 724 75 0 13.00 13.00 149 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 C 0 0 14.00 15.00 01500 ACTI VI TI ES 5, 112 464 926 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 26, 989 20, 637 30.00 03000 SKILLED NURSING FACILITY 111, 185 30.00 30 149 10 341 03100 NURSING FACILITY 31.00 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 0 40.00 04100 LABORATORY 41.00 117 0 0 0 41.00 o 42 00 04200 I NTRAVENOUS THERAPY Ω 0 42 00 0 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 0 C 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 1, 479 453 903 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 1,079 330 0 658 0 45.00 04600 SPEECH PATHOLOGY 0 46 00 392 299 597 46 00 0 04700 ELECTROCARDI OLOGY 0 47.00 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 60 209 0 418 48.00 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 544 52 0 104 0 49.00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 C 0 50.00 0 05100 SUPPORT SURFACES 51.00 0 0 0 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C О 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 61.00 61.00 0 C 0 0 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 0 70.00 0 0 0 07100 AMBULANCE 0 0 71.00 r 0 0 71.00 73.00 07300 CMHC 0 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84) 15, 238 26, 989 59, 427 28, 653 111, 185 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 09100 BARBER AND BEAUTY SHOP 69 91.00 91.00 10 35 0 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 C 0 98.00 Cross Foot Adjustments 0 0 Λ 98 00 99.00 Negative Cost Centers 0 0 0 99.00 100.00 TOTAL 59.437 15, 273 26, 989 28, 722 111, 185 100. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | To 1

				10	12/31/2022	5/30/2023 12:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	<b>'</b>	ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
	T	9. 00	10. 00	11. 00	12. 00	13. 00	
4 00	GENERAL SERVICE COST CENTERS						4 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						3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00	00700 HOUSEKEEPING						7. 00
8.00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	15, 835					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	o	15, 901				10.00
11.00	01100 PHARMACY	o	0	254			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0		12.00
13.00	01300 SOCIAL SERVICE	0	0	0	0	5, 363	
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
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	45.005	45.004	05.4	ما	F 0/0	00.00
30.00	03000 SKILLED NURSING FACILITY	15, 835	15, 901	254	0	5, 363	
31. 00 32. 00	03100 NURSING FACILITY 03200   CF/IID	0	0		ol Ol	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	0	33.00
40. 00	04000 RADI OLOGY	0	0	O	0	0	40. 00
41. 00	04100 LABORATORY	o	0	l o	o	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	o	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	o	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	o	0	0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00	O5100   SUPPORT SURFACES   OUTPATIENT SERVICE COST CENTERS	l ol	0	0	0	0	51. 00
60. 00	06000 CLINIC	0	0	0	o	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0		Ö	0	61.00
62. 00	06200 FQHC		Ü		Ĭ	· ·	62. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	o	0	0	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100   INTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF		0			0	82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	15, 835	0 15, 901		0	5, 363	83. 00 89. 00
89.00	NONREI MBURSABLE COST CENTERS	15, 835	15, 901	254	υ	5, 303	89.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	0	O	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		0		o	0	
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES		0		o	0	
93. 00	09300 NONPAI D WORKERS		0	_	Ö	0	
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00	Cross Foot Adjustments	0	0	0			98. 00
99. 00	Negative Cost Centers	0	0		0	0	
100.00	TOTAL	15, 835	15, 901	254	O	5, 363	100. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | To 1 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315177

				Т	o 12/31/2022	Date/Time Pre 5/30/2023 12:	
			OTHER GENERAL			37 307 2023 12.	ZZ piii
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATI ON					
		14. 00	15. 00	16. 00	17. 00	18. 00	
4 00	GENERAL SERVICE COST CENTERS		I	ı			1 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	OO5OO  PLANT OPERATION, MAINT. & REPAIRS   OO6OO  LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPING						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12.00
13. 00	01300 SOCIAL SERVICE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITIES	0	33, 908				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	33, 908	873, 840	0	873, 840	30. 00
31.00	03100 NURSING FACILITY	0	0	C	0	0	31.00
32.00	03200   CF/IID	0	0	C	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	C	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	0			0	40. 00
41. 00	04100 LABORATORY	0	0			117	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	C		0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	_	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0	29, 248		29, 248	1
45. 00	04500 OCCUPATIONAL THERAPY	0	0	21, 334		21, 334	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	18, 695		18, 695	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY	0	0	12.940	_	12.940	47. 00 48. 00
49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	12, 860 3, 730		12, 860 3, 730	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	3, 730		3, 730	50.00
51. 00	05100 SUPPORT SURFACES	0				0	51.00
01.00	OUTPATIENT SERVICE COST CENTERS				ı		01.00
60.00	06000 CLINIC	0	0	С	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	1			0	61. 00
62. 00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	•	•	•			
70.00	07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
71.00	07100 AMBULANCE	0	0	C	0	0	71. 00
73.00	07300 CMHC	0	0	C	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 I NTEREST EXPENSE						81. 00
	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0		C	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	0	33, 908	959, 824	0	959, 824	89. 00
00.00	NONREI MBURSABLE COST CENTERS						00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	2 124	_	0	•
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	2, 124		2, 124	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS			C	_	0	
93.00	09400 PATI ENTS LAUNDRY					0	
98.00	Cross Foot Adjustments				0	0	
99. 00	Negative Cost Centers					0	99.00
100.00			33, 908		_	961, 948	
. 55. 50	1		1 00, 700	751,740	١	751, 740	1.00.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315177

				Т	o 12/31/2022	Date/Time Pre 5/30/2023 12:	
		CAPITAL REI	LATED COSTS			7 07 007 2020 12.	ZZ piii
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	·	FIXTURES	EQUI PMENT	BENEFITS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM COST)	
		1.00	2.00	3.00	4A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES	57, 451	I	I		I	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	57, 451	57, 451				2.00
3. 00	00300 EMPLOYEE BENEFITS	270					3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	3, 516 658					4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 552					6. 00
7.00	00700 HOUSEKEEPI NG	1, 499					7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	5, 789 788				1, 769, 239 364, 005	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	835				241, 834	•
11.00	01100 PHARMACY	0	0		0	51, 232	11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	259	0 259	1	0	0 145, 880	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0		14. 00
15. 00	01500 ACTIVITIES	1, 611	1, 611	625, 470	0	1, 030, 648	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	35, 892	35, 892	3, 340, 671	0	6, 079, 005	30.00
31. 00	03100 NURSING FACILITY	0	0	_			31. 00
32. 00 33. 00	03200   CF/IID 03300   OTHER LONG TERM CARE	0	0			-	32.00
33.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	33. 00
40. 00	04000 RADI OLOGY	0	0				40. 00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0		23, 645 0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY			0	_	0	42.00
44. 00	04400 PHYSI CAL THERAPY	1, 571				298, 144	44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	1, 144 1, 039				217, 505 79, 094	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	1,039	1,037			0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	727	727		_	12, 173	1
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	181	181 0		-	109, 662 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	ł				51.00
(0.00	OUTPATIENT SERVICE COST CENTERS						,,,,,,,
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0				60. 00 61. 00
62. 00	06200 FQHC						62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS	1 0	0	1 0		1 0	70.00
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE		ł .	•			70. 00 71. 00
73. 00	07300 CMHC	0	0	•		0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES	1	I	I		I	80. 00
81. 00	08100   NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF	_	_	_	_	_	82. 00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	57, 331	0 57, 331	0 6, 541, 501	0 -2, 654, 982	0 11, 982, 028	
07.00	NONREI MBURSABLE COST CENTERS	37,331	37,331	0, 341, 301	-2, 034, 702	11, 702, 020	0 7. 00
90.00		0					90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	120	120	0		2, 010 0	91. 00 92. 00
93. 00	09300 NONPALD WORKERS	0	Ö	1	_	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00		958, 305	3, 643	1, 477, 074		2, 654, 982	•
102.00	Part I)	16 490200	0.042411	0 335900		0 221542	102 00
103. 00 104. 00		16. 680389	0. 063411	0. 225800 4, 521		0. 221543 59, 437	103.00
	Part II)						
105.00	Unit cost multiplier (Wkst. B, Part			0. 000691		0. 004960	105. 00
	1 1117	I	ı	ı	ı	I	ı

				'	0 12/31/2022	5/30/2023 12:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	,
		OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(PATIENT DAYS)			(DATIENT DAVE)	
		REPAIRS (SQUARE FEET)				(PATIENT DAYS)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	F0 007					4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	53, 007	1				5. 00 6. 00
7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	1, 552 1, 499		49, 956			7.00
8. 00	00800 DI ETARY	5, 789	l .	5, 789			8.00
9. 00	00900 NURSING ADMINISTRATION	788	l .	788	1	55, 589	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	835	<b> </b>	835		0	10.00
11. 00	01100 PHARMACY	C	0	C	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	C	0	C	0	0	12. 00
13. 00	01300 SOCI AL SERVI CE	259	0	259	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	0	C	0	0	14. 00
15. 00	01500 ACTI VI TI ES	1, 611	0	1, 611	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	25.000	55 500	25.000	4// 7/7	FF 500	00.00
30.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	35, 892		1		55, 589	30.00
31. 00 32. 00	03200   CF/IID	C	1		ŭ	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		<b>I</b>		0	0	33.00
00.00	ANCI LLARY SERVI CE COST CENTERS		,				00.00
40.00	04000 RADI OLOGY	C	0	C	0	0	40.00
41.00	04100 LABORATORY	C	0	C	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	C	0	C	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	C	0	C	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	1, 571	I .	1, 571		0	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	1, 144	l e	1, 144		0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	1, 039		1, 039		0	46.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	727		727	_		47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS	181	1	181		0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY		1	10.		Ö	50.00
51.00	05100 SUPPORT SURFACES	C	o	C	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	C	<b> </b>	C		0	60.00
61. 00	06100 RURAL HEALTH CLINIC	C	0	C	0	0	
62. 00	06200 FOHC						62.00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	C	) 0		0	0	70.00
71.00	07100 AMBULANCE		1			l	71.00
73.00	07300 CMHC		1			l	73.00
70.00	SPECIAL PURPOSE COST CENTERS		,				70.00
80.00							80.00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	C	0	C	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	52, 887	55, 589	49, 836	166, 767	55, 589	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		) 0	1 0	0	0	90.00
90.00	09100 BARBER AND BEAUTY SHOP	120		1	_	1	
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES	120		1		1	
93. 00	09300 NONPALD WORKERS		1		_	Ö	
94. 00	09400 PATIENTS LAUNDRY		o o	l c	Ö	Ö	94.00
98.00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102.00		1, 029, 943	157, 690	777, 210	2, 363, 749	472, 219	102. 00
400 5	Part I)	40 1005	0.00/=:-	45 5535	44 1705::	0 .0.0	100 0-
103.00		19. 430321	l e			8. 494828	
104.00	Cost to be allocated (per Wkst. B, Part II)	15, 273	26, 989	28, 722	111, 185	15, 835	104. 00
105.00		0. 288132	0. 485510	0. 574946	0. 666709	0. 284859	105.00
	II)	3. 200102	355516	]	3.000.07		
		•	•	•		•	•

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

				T	o 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSI NG AND	
		SERVICES &	(PATIENT DAYS)	RECORDS &	(DATI ENT DAVE)	ALLI ED HEALTH	
		SUPPLY (PATIENT DAYS)		LIBRARY (PATIENT DAYS)	(PATIENT DAYS)	EDUCATION (ASSIGNED	
		(TATTENT DATS)		(TATTENT BATS)		TIME)	
		10.00	11.00	12. 00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS	I	T				1 00
1. 00 2. 00	OO100   CAP REL COSTS - BLDGS & FIXTURES   OO200   CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINISTRATIVE & 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 9. 00	OO8OO  DI ETARY   OO9OO  NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	55, 589					10.00
11. 00	01100 PHARMACY	33,307					11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	55, 589			12. 00
13.00	01300 SOCIAL SERVICE	0	O	) c	55, 589		13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	
15. 00	01500 ACTIVITIES	0	0	) <u> </u>	0	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	55, 589	55, 589	55, 589	55, 589	0	30.00
31. 00	03100 NURSING FACILITY	33, 369	33, 369	33, 369	33, 369	0	
32. 00	03200   CF/11D				o	0	
33.00	03300 OTHER LONG TERM CARE	0			0	0	
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0				0	1
41. 00	04100 LABORATORY	0	0		0	0	
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0			0	0	
44. 00	04400 PHYSI CAL THERAPY				0	0	
45. 00	04500 OCCUPATI ONAL THERAPY	0	o o		0	0	
46.00	04600 SPEECH PATHOLOGY	0	0	) c	0	0	46. 00
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				0	0	1
51. 00	05100 SUPPORT SURFACES		_		0	0	
01.00	OUTPATIENT SERVICE COST CENTERS			<u>,                                     </u>	<u> </u>		01.00
60.00	06000 CLI NI C	0		C	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	
62. 00	06200 FOHC						62.00
70. 00	OTHER REIMBURSABLE COST CENTERS  07000 HOME HEALTH AGENCY COST		0	) C	O	0	70.00
70.00	07100 AMBULANCE					0	
73. 00	07300 CMHC					0	1
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 I NTEREST EXPENSE						81.00
82. 00	08200   UTI LI ZATI ON REVI EW - SNF   08300   HOSPI CE					0	82. 00 83. 00
83. 00 89. 00	SUBTOTALS (sum of lines 1-84)	55, 589	55, 589	55, 589	55, 589	0	
07.00	NONREI MBURSABLE COST CENTERS	33,307	35, 567	7 33, 307	33, 307	0	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	) C	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	C	) c	0	0	
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	0	
93.00	09300 NONPAI D WORKERS	0	0		0	0	1
94. 00 98. 00	O9400 PATIENTS LAUNDRY   Cross Foot Adjustments			7		0	94. 00 98. 00
99. 00	Negative Cost Centers						99.00
102.00		324, 626	62, 582	2 0	187, 260	0	102. 00
	Part I)						
103.00		5. 839752	l .	1		0. 000000	
104. 00	Cost to be allocated (per Wkst. B, Part II)	15, 901	254	·  C	5, 363	0	104. 00
105. 00		0. 286046	0. 004569	0.000000	0. 096476	0. 000000	105, 00
	II)	3. 2000 10	3.00.007	3. 333300	1.070.70	2. 000000	
	•						

GATEWAY CARE CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315177

			То	12/31/2022   Date/Time Pre 5/30/2023 12:	
		OTHER GENERAL		07 007 2020 12.	ZZ piii
		SERVI CE			
	Cost Center Description	ACTI VI TI ES			
		(PATIENT DAYS) 15.00			
GE	ENERAL SERVICE COST CENTERS	10.00			
1.00 00	0100 CAP REL COSTS - BLDGS & FIXTURES				1. 00
	D200 CAP REL COSTS - MOVABLE EQUIPMENT				2. 00
1	0300 EMPLOYEE BENEFITS				3.00
1	0400 ADMINISTRATIVE & GENERAL 0500 PLANT OPERATION, MAINT. & REPAIRS				4. 00 5. 00
	0600 LAUNDRY & LINEN SERVICE				6. 00
	0700 HOUSEKEEPI NG				7. 00
8.00 00	D800 DI ETARY				8. 00
	0900 NURSING ADMINISTRATION				9. 00
	1000 CENTRAL SERVICES & SUPPLY				10.00
	1100 PHARMACY 1200 MEDICAL RECORDS & LIBRARY				11. 00 12. 00
	1300 SOCIAL SERVICE				13. 00
	1400 NURSING AND ALLIED HEALTH EDUCATION				14. 00
	1500 ACTIVITIES	55, 589			15. 00
	NPATIENT ROUTINE SERVICE COST CENTERS				
	3000 SKILLED NURSING FACILITY	55, 589			30.00
	3100 NURSING FACILITY 3200 ICF/IID	0			31. 00 32. 00
	3300 OTHER LONG TERM CARE	0			33. 00
	NCILLARY SERVICE COST CENTERS				
	4000 RADI OLOGY	0			40. 00
	4100 LABORATORY	0			41. 00
	4200 INTRAVENOUS THERAPY 4300 OXYGEN (INHALATION) THERAPY	0			42. 00 43. 00
	4400 PHYSI CAL THERAPY	0			44. 00
	4500 OCCUPATIONAL THERAPY	0			45. 00
1	4600 SPEECH PATHOLOGY	0			46. 00
1	4700 ELECTROCARDI OLOGY	0			47. 00
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS 4900 DRUGS CHARGED TO PATIENTS	0			48. 00 49. 00
	5000 DENTAL CARE - TITLE XIX ONLY	0			50.00
	5100 SUPPORT SURFACES	o			51. 00
	JTPATIENT SERVICE COST CENTERS				
	6000 CLINIC	0			60.00
	5100 RURAL HEALTH CLINIC 5200 FOHC	0			61. 00 62. 00
	THER REIMBURSABLE COST CENTERS				02.00
70.00 07	7000 HOME HEALTH AGENCY COST	0			70. 00
	7100 AMBULANCE	0			71. 00
73. 00 07		0			73. 00
	PECIAL PURPOSE COST CENTERS  BOOO MALPRACTICE PREMIUMS & PAID LOSSES				80. 00
	B100   NTEREST EXPENSE				81. 00
	3200 UTILIZATION REVIEW - SNF				82. 00
	HOSPI CE	0			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	55, 589			89. 00
	ONREIMBURSABLE COST CENTERS OOOO GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90. 00
	9100 BARBER AND BEAUTY SHOP	Ö			91.00
92.00 09	9200 PHYSICIANS PRIVATE OFFICES	0			92. 00
	9300 NONPALD WORKERS	0			93. 00
	9400 PATIENTS LAUNDRY	0			94.00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers				98. 00 99. 00
102.00	Cost to be allocated (per Wkst. B,	1, 315, 347			102.00
	Part I)				
103.00	Unit cost multiplier (Wkst. B, Part I)	23. 662001			103. 00
104. 00	Cost to be allocated (per Wkst. B,	33, 908			104. 00
105. 00	Part II)  Unit cost multiplier (Wkst. B, Part	0. 609977			105. 00
	II)	3.35,7,7			

Health Financial Systems	GATEWAY CARE CENTER	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR ANCILL	ARY AND OUTPATIENT COST CENTERS Provider No.:	315177   Peri od: From 01/01/2022 To 12/31/2022   Date/Ti me Prepared: 5/30/2023 12: 22 pm
Cost Center Description		al (from Total Charges Ratio (col. 1

		T	o 12/31/2022	Date/Time Prep	
Cost Center Description		Total (from	Total Charges	5/30/2023 12: 2	22 piii
cost center bescription		Wkst. B, Pt I,	Total Charges	di vi ded by	
		col . 18)		col. 2	
		1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS					
40. 00   04000   RADI OLOGY		0	0	0.000000	40.00
41. 00   04100   LABORATORY		28, 883	23, 645	1. 221527	41.00
42. 00   04200   I NTRAVENOUS THERAPY		0	0	0.000000	42.00
43.00 O4300 OXYGEN (INHALATION) THERAPY		0	0	0.000000	43.00
44. 00   04400   PHYSI CAL THERAPY		419, 162	249, 982	1. 676769	44.00
45. 00   04500   OCCUPATI ONAL THERAPY		305, 718	425, 869	0. 717869	45.00
46. 00   04600   SPEECH PATHOLOGY		132, 970	138, 134	0. 962616	46.00
47. 00 04700 ELECTROCARDI OLOGY		0	0	0.000000	47.00
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS		40, 307	0	0.000000	48.00
49.00 O4900 DRUGS CHARGED TO PATIENTS		140, 290	106, 632	1. 315646	49.00
50.00   05000   DENTAL CARE - TITLE XIX ONLY		0	0	0.000000	50.00
51. 00 05100 SUPPORT SURFACES		0	0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS					
60. 00  06000  CLI NI C		0	0	0. 000000	60.00
61. 00  06100 RURAL HEALTH CLINIC					61.00
62. 00  06200  FQHC					62.00
71. 00   07100   AMBULANCE		0	0	0. 000000	71.00
100. 00   Total	l	1, 067, 330	944, 262	l	100. 00

Health Financial Systems	GATEWAY CAF	RE CENTER		In Li∈	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315177	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Pre 5/30/2023 12:	
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care Pr	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	LENT COST					
ANCILLARY SERVICE COST CENTERS	_					_
40. 00   04000   RADI OLOGY	0. 000000			0	0	
41. 00   04100   LABORATORY	1. 221527			0	0	
42. 00   04200   I NTRAVENOUS THERAPY	0. 000000			0	0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0	0	
44. 00 O4400 PHYSI CAL THERAPY	1. 676769			0 135, 248		1
45. 00 04500 OCCUPATI ONAL THERAPY	0. 717869			0 89, 664		
46. 00 04600 SPEECH PATHOLOGY	0. 962616			0 42, 070		
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	1		0 0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1		0	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 315646			0	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	1		0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS	0.000000					
60. 00 06000 CLI NI C	0. 000000	0		0	0	
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00   06200   FQHC 71. 00   07100   AMBULANCE (2)	0.000000			0		62. 00 71. 00
100.00 Total (Sum of Lines 40 - 71)	0. 000000	249, 267		0 266, 982	0	100.00
	1	247, 207		U <sub> </sub> 200, 982	ı	1100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	у.					

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

Heal th	Financial Systems	GATEWAY CAF	RE CENTER		In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315177	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 12:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	1. 315646	1.00
2.00	Program vaccine charges (From your reco	rds, or the PS	&R)		,	20, 048	2. 00
3.00	Program costs (Line 1 x line 2) (Title 1	XVIII, PPS prov	viders, transf	er this amoun	t to Worksheet	26, 376	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied	
		· ·	(From Wkst. B,	Costs to Tota		Health Costs for Pass	
		18		Costs to Tota		Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)		3 X 001. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH	•			
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0.00000		0	40. 00
41.00	04100 LABORATORY	28, 883	0	0.0000		0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0.0000		0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0.0000		0	43. 00
44. 00	04400 PHYSI CAL THERAPY	419, 162		0.0000			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	305, 718		0.00000		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	132, 970	0	0.00000			46. 00 47. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	40. 307	0	0.0000		0 0	47.00
48.00	04900 DRUGS CHARGED TO PATIENTS	40, 307 140, 290		0.0000		0	48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	140, 230 N	0	0.0000		0	50.00
	05100 SUPPORT SURFACES	0		0.00000		0	
100.00		1, 067, 330	Ö	•	266, 982	_	100.00
				1	1	,	

OMBLIT	Financial Systems GATEWAY C	ARE CENTER	in Lie	u of Form CMS-2	2540-1
OMPU I	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315177	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/30/2023 12:	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
. 00	Inpatient days including private room days			55, 589	1.0
. 00	Private room days			0	2. 0
. 00	Inpatient days including private room days applicable to t			3, 430	
. 00	Medically necessary private room days applicable to the Pr	rogram		0	4.0
. 00	Total general inpatient routine service cost			13, 565, 036	5.0
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges			15, 855, 523	6.0
. 00	General inpatient routine service charges  (Line	5 divided by line 6)		0. 855540	
. 00	Enter private room charges from your records	e 3 di vi ded by Title 0)		0.055540	8.0
.00	Average private room per diem charge (Private room charges	s line 8 divided by private	room days line	0.00	
00	2)				
0. 00					
1. 00	Average semi-private room per diem charge (Semi-private r semi-private room days)	room charges line 10, divide	d by	0. 00	11. 0
2. 00	Average per diem private room charge differential (Line 9	minus line 11)		0.00	12. (
3. 00	Average per diem private room cost differential (Line 7 ti	mes line 12)		0.00	13. (
4. 00	Private room cost differential adjustment (Line 2 times li			0	
5. 00	General inpatient routine service cost net of private room PROGRAM INPATIENT ROUTINE SERVICE COSTS	n cost differential (Line 5	minus line 14)	13, 565, 036	15. (
6. 00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		244. 02	16. (
7. 00	Program routine service cost (Line 3 times line 16)			836, 989	
3. 00	Medically necessary private room cost applicable to progra			0	18. (
9. 00	Total program general inpatient routine service cost (Lir			836, 989	
0. 00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ce costs (From Wkst. B, Par	t II column 18,	873, 840	20.0
. 00	Per diem capital related costs (Line 20 divided by line 1	1)		15. 72	
2. 00	Program capital related cost (Line 3 times line 21)			53, 920	
. 00	Inpatient routine service cost (Line 19 minus line 22)			783, 069	
. 00	Aggregate charges to beneficiaries for excess costs (From		1: 24)	702.0(0	24.
. 00	Total program routine service costs for comparison to the Enter the per diem limitation (1)	cost ilmitation (Line 23 Mi	nus iine 24)	783, 069	25. 26.
. 00 '. 00	Inpatient routine service cost limitation (Line 3 times the	ne ner diem limitation line	26) (1)		27.
3. 00	Reimbursable inpatient routine service costs (Line 22 plus	the lesser of line 25 or	, , ,		28.
	(Transfer to Worksheet E, Part II, line 4) (See instructiones 26 and 27 are not applicable for title XVIII, but may be	,			l

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	55, 589	1. 00
2.00	Program inpatient days (see instructions)	3, 430	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. 061703	4. 00
5. 00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

ealth Financial Systems	GATEWAY CARE C	ENTER	In Lie	u of Form CMS-2	2540
OMPUTATION OF INPATIENT ROUTINE COSTS		Provi der No.: 315177	Peri od:	Worksheet D-1	
			From 01/01/2022	Parts I-II Date/Time Pre	nara
			To 12/31/2022	5/30/2023 12:	
		Title XIX	Skilled Nursing	Cost	- <u>-</u> P
		THE WAY	Facility	3331	
				1. 00	
PART I CALCULATION OF INPATIENT ROUTII	NE COSTS				
I NPATI ENT DAYS					
00 Inpatient days including private room	days			55, 589	1.
00 Private room days				0	2.
00 Inpatient days including private room				47, 212	3.
00 Medically necessary private room days		n		0	4
Total general inpatient routine servi	ce cost			13, 565, 036	5
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
OO General inpatient routine service cha				15, 855, 523	
General inpatient routine service cos	3 (	vided by line 6)		0. 855540	
20 Enter private room charges from your				0	8
O Average private room per diem charge 2)	(Private room charges line	e 8 divided by private	room days, line	0. 00	9
00 Enter semi-private room charges from	vour records			0	10
00 Average semi-private room per diem ch		charges line 10, divide	ed by	0.00	11
semi -pri vate room days)	3 ( )	3	,		ı
00 Average per diem private room charge	differential (Line 9 minus	s line 11)		0.00	12
00 Average per diem private room cost di	fferential (Line 7 times l	ine 12)		0.00	13
00 Private room cost differential adjust	ment (Line 2 times line 13	3)		0	14
00 General inpatient routine service cos	t net of private room cost	t differential (Line 5	minus line 14)	13, 565, 036	15
PROGRAM INPATIENT ROUTINE SERVICE COST					
00 Adjusted general inpatient service co		ded by line 1)		244. 02	
00 Program routine service cost (Line 3				11, 520, 672	
00 Medically necessary private room cost				0	18
00 Total program general inpatient routi				11, 520, 672	
00 Capital related cost allocated to inp		sts (From Wkst. B, Par	t II column 18,	873, 840	20
line 30 for SNF; line 31 for NF, or I				45 70	
00 Per diem capital related costs (Line				15. 72	
00 Program capital related cost (Line 3				742, 173	
00 Inpatient routine service cost (Line				10, 778, 499	
OO Aggregate charges to beneficiaries fo			muo lino 04)	10 770 400	
Total program routine service costs f	or comparison to the cost	limitation (Line 23 mi	nus iine 24)	10, 778, 499	
On Enter the per diem limitation (1)	tion (line 2 times the	a diam limitation line	24) (1)	0.00	26
ON Inpatient routine service cost limita Reimbursable inpatient routine service				11 520 772	
OO Reimbursable inpatient routine servic (Transfer to Worksheet E, Part II, Ii	` '	e resser or rine 25 or	11ne 27)	11, 520, 672	28
Lines 26 and 27 are not applicable for t		ed for title V and or t	itle XIX	ı	
				1. 00	
PART II CALCULATION OF INPATIENT NURS	NG & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH		55 500	

1.00	Total SNF inpatient days	55, 589	1.00
2.00	Program inpatient days (see instructions)	47, 212	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. 849305	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	GATEWAY CARE CEI	NTER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SET	TLEMENT FOR TITLE XVIII	Provi der No.: 315177	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 5/30/2023 12:22 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing Facility	PPS	
				4.00	
	DADT A LANDATION CODYLOG DDC DDC// DED COMPLITATION OF DELMBING	EMENT		1. 00	
1 00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS Inpatient PPS amount (See Instructions)	EMENI		2 1/7 570	1. 00
1. 00 2. 00	Nursing and Allied Health Education Activities (pass through pa	vmonto)		2, 167, 570 0	2. 00
3. 00	Subtotal (Sum of lines 1 and 2)	ymerits)		2, 167, 570	3. 00
4. 00	Primary payor amounts			2, 107, 570	4. 00
5. 00	Coi nsurance			376, 552	5. 00
6. 00	Allowable bad debts (From your records)			370, 332	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		156, 203	7. 00
8. 00	Adjusted reimbursable bad debts. (See instructions)	Ct1 0113)		242, 528	8. 00
9. 00	Recovery of bad debts - for statistical records only			242, 320	9. 00
10. 00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			2, 033, 546	11. 00
12. 00	Interim payments (See instructions)			2, 064, 499	12. 00
13. 00	Tentati ve adjustment			2,001,177	13. 00
14. 00	OTHER adjustment (See instructions)			0	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			3, 056	
14. 99	Sequestration amount (see instructions)			24, 667	14. 99
15.00	Balance due provider/program (see Instructions)			-58, 676	15. 00
16.00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2,	section 115.2)	0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - 7	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			26, 376	
19. 00	Total reasonable costs (Sum of Lines 17 and 18)			26, 376	
20. 00	Medicare Part B ancillary charges (See instructions)			20, 048	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			20, 048	
22. 00	Pri mary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	23. 00
24.00	Allowable bad debts (From your records)			0	24.00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			20, 048	25. 00
26. 00 27. 00	Interim payments (See instructions)			17, 681	26. 00 27. 00
28. 00	Tentative adjustment			0	28. 00
28. 50	Other Adjustments (See instructions) Specify Demonstration payment adjustment amount before sequestration			0	28. 00
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 55	Sequestration amount (see instructions)			252	28. 55 28. 99
29. 00	Balance due provider/program (see instructions)			2, 115	29. 00
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2	2, 113	30.00
55.50	1			٥١	50.00

Health Financial Systems	GATEWAY CARE CE	NTER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETT	FLEMENT TITLE V and TITLE XIX ONLY	Provi der No.: 315177	From 01/01/2022 To 12/31/2022	Worksheet E Part II Date/Time Prepared: 5/30/2023 12:22 pm
		Title XIX	Skilled Nursing	Cost

		Title XIX	Skilled Nursing	Cost	
			Facility		
			-	1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES			1.00	
1.00	Inpatient ancillary services (see Instructions)		T	0	1.00
2. 00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	
3.00	Outpatient services	3)		0	3.00
4. 00	Inpatient routine services (see instructions)			11, 520, 672	
5. 00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	1
6.00	Cost of covered services (Sum of lines 1 - 5)			11, 520, 672	1
7. 00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	1
8.00	SUBTOTAL (Line 6 minus line 7)	,		11, 520, 672	
9.00	Primary payor amounts			0	
10. 00	Total Reasonable Cost (Line 8 minus line 9)			11, 520, 672	10.00
	REASONABLE CHARGES		<u>'</u>	, , , , ,	
11.00	Inpatient ancillary service charges			0	11. 00
12.00	Outpati ent servi ce charges			0	12. 00
13.00	Inpatient routine service charges			0	13.00
14.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	14. 00
15.00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for pa			0	16. 00
17. 00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	17. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	l
19. 00	Total customary charges (see instructions)			0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)			0	
21. 00	Deductibles			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	
24. 00 25. 00	Subtotal (Line 22 minus line 23) Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)			0	
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl	v collected based on c	orrection of	0	
27.00	cost limit	y corrected based on c	orrection or	U	27.00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	program	0	28. 00
20.00	lutilization		p. 09. d	Ü	20.00
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depr	eciable assets (	0	30.00
	if minus, enter amount in parentheses)		`		
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31.00
32.00	Interim payments			0	32. 00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see	0	33. 00
	Instructions)				

From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/30/2023 12: 22 pm Title XVIII Skilled Nursing PPS

		11 11	e XVIII S	Killed Nursing	PPS	
		Innation	t Part A	Facility	t B	
		<u>'</u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 766, 351		17, 681	1. 00
2.00	Interim payments payable on individual bills, either		268, 411		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/16/2022	29, 737		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54	Cubatatal (Cum of Lines 2 01 2 40 minus aum of Lines 2 50		0 727		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   - 3.98)		29, 737		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 064, 499		17, 681	4. 00
4.00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		2,004,477		17,001	4.00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR			l		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
F F0	Provi der to Program					F F0
5.50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51 5. 52			0			5. 51 5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
5. 99	- 5. 98)		0		ا	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	PROGRAM TO PROVI DER		0		2. 115	6. 01
6. 02	PROVI DER TO PROGRAM		58, 676		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 005, 823		19, 796	7.00
			Contract	tor Name	Contractor	
					Number	
0.55	lu co i		1.	00	2. 00	
	Name of Contractor					8. 00
(1) Or	lines 3 5 and 6 where an amount is due provider to progr	am show the a	mount and date	on which the r	arovi der	

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

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

Provider No.: 315177 | Period: From 01/01/20 To 12/31/20

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/30/2023 12: 22 pm

11 y)					5/30/2023 12:	22 p
		General Fund	Speci fi c Er Purpose Fund	ndowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	sets RRENT ASSETS					+
	sh on hand and in banks	904, 946	O	0	О	1.
	mporary investments	0	Ö	0		
- 1	tes recei vabl e	0	ō	0	Ö	
00 Acc	counts receivable	2, 442, 171	O	0	0	4.
00 Otl	her recei vabl es	1, 124, 828	0	0	0	5.
00 Les	ss: allowances for uncollectible notes and accounts	-523, 414	0	0	0	6.
- 1	cei vabl e					
1	ventory	4, 000	1	0	0	
	epai d expenses	-823, 847	1	0	0	
1	her current assets	-741		0	0   0	
- 1	e from other funds TAL CURRENT ASSETS (Sum of lines 1 - 10)	3, 127, 943		0	1	
	KED ASSETS	3, 127, 743	<u> </u>	0		1 ''
00 Lai		1 0	0	0	0	12
	nd improvements	0	ő	0	l .	
- 1	ss: Accumulated depreciation	0	o	0	l o	
	ildings	0	0	0	0	
	ss Accumulated depreciation	0	О	0	0	16
00 Lea	asehold improvements	1, 975, 458	0	0	0	17
00 Les	ss: Accumulated Amortization	-1, 370, 091	0	0	0	18
00 Fi :	xed equipment	0	0	0	0	
00 Les	ss: Accumulated depreciation	0	0	0	0	
1	tomobiles and trucks	0	0	0	0	
1	ss: Accumulated depreciation	0	0	0	0	
1 -	jor movable equipment	1, 524, 057		0	0	
1	ss: Accumulated depreciation	-1, 514, 220	0	0	0	
	nor equipment - Depreciable	0		0	0	
	nor equipment nondepreciable her fixed assets			0		1 -
4	TAL FIXED ASSETS (Sum of lines 12 - 27)	615, 204		0	1	
	HER ASSETS	015, 204	·]	0		4 2
	vestments	1 0	0	0	0	20
4	posits on leases	0	ő	0	l	
	e from owners/officers	0	o	0	Ö	
1	her assets	12, 975	o	0	0	32
00 TO	TAL OTHER ASSETS (Sum of lines 29 - 32)	12, 975	0	0	0	3:
00 TO	TAL ASSETS (Sum of lines 11, 28, and 33)	3, 756, 122	0	0	0	34
	abilities and Fund Balances					4
	RRENT_LIABILITIES  counts payable	1, 855, 314	l	0	0	3!
	laries, wages, and fees payable	1, 000, 014		0	l	
	yroll taxes payable	12, 825		0		
	tes & Loans payable (Short term)	12,023		0	٥	
	ferred income		Ŏ	0	ĺ	1 .
- 1	celerated payments	0		· ·	Ĭ	40
	e to other funds	0	О	0	0	
1	her current liabilities	1, 068, 865	0	0	0	42
00 T0	TAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 937, 004	0	0	0	4:
LON	NG TERM LIABILITIES					
00 Moi	rtgage payable	0	0	0	1	
	tes payable	0	0	0	1	
	secured Loans	0	0	0	0	
1	ans from owners:	0	0	0	0	
4	her long term liabilities	0	0	0	0	
1	HER (SPECIFY)	0	0	0	0	
	TAL LONG TERM LIABILITIES (Sum of lines 44 - 49	2 027 004	0	0	0	
-	TAL LIABILITIES (Sum of lines 43 and 50) PITAL ACCOUNTS	2, 937, 004	0	0		5
	neral fund balance	819, 118				5
- 1	ecific purpose fund	017,110	O			5
	nor created - endowment fund balance - restricted			Ω		5
4	nor created - endowment fund balance - unrestricted			0		5!
4	verning body created - endowment fund balance			0		5
1	ant fund balance - invested in plant				О	
1	ant fund balance - reserve for plant improvement,				0	5
re	placement, and expansion					
	TAL FUND BALANCES (Sum of lines 52 thru 58)	819, 118	1	0	0	
	TAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	3, 756, 122	0	0	0	60
	)				I	

GATEWAY CARE CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der No.: 315177 | Peri od: | Worksheet G-1 | From 01/01/2022 | To | 12/31/2022 | Date/Time Prepa

					To 12/31/2022	Date/Time Prep 5/30/2023 12:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	1
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)		1, 047, 136 -228, 017		0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		819, 119		0		3. 00
4. 00	Additions (credit adjustments)					_	4. 00
5. 00 6. 00		0			0	0	5. 00 6. 00
7. 00		O			0	Ö	7. 00
8.00		0			0	0	8. 00
9. 00 10. 00	Total additions (sum of line 5 - 9)	0	0		0	0	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		819, 119		0		11. 00
12.00	Deductions (debit adjustments)						12. 00
13. 00 14. 00	ROUNDI NG	1			0	0	13. 00 14. 00
15. 00					0	0	15. 00
16. 00		O			0	0	16. 00
17. 00 18. 00	Total deductions (sum of lines 13 - 17)	0	1		0	0	17. 00 18. 00
19. 00	Fund balance at end of period per balance		819, 118		0		19. 00
	sheet (Line 11 - line 18)		DI I				
		Endowment Fund	PI ant	Funa			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00 2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	0			0		3. 00
4. 00	Additions (credit adjustments)						4. 00
5.00			0				5. 00
6. 00 7. 00			0				6. 00 7. 00
8.00			0				8. 00
9.00	T-t-1 -dditi (6 lin- 5 0)		0				9.00
10. 00 11. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0			0		10. 00 11. 00
12. 00	Deductions (debit adjustments)						12. 00
13.00	ROUNDI NG		0				13.00
14. 00 15. 00			0				14. 00 15. 00
16.00			0				16. 00
17. 00	Total deductions (sum of lines 12 17)		0				17. 00
18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	0			0		18. 00 19. 00
50	sheet (Line 11 - line 18)						

Health Financial Systems	GATEWAY CARE CENTER			In Lieu of Form CMS-2540-10		
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der No.: 315177	Peri od:	Worksheet G-2		

Heal th	Financial Systems GATEWAY CARE CENTER			In Lieu of Form CMS-2540-			
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315177	Peri od:	Worksheet G-2	
					From 01/01/2022		
					To 12/31/2022		pared:
						5/30/2023 12:	22 pm
	Cost Center Description			Inpati ent	Outpati ent	Total	
				1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY			15, 855, 52	23	15, 855, 523	1. 00
2.00	NURSING FACILITY				0	0	2. 00
3.00	ICF/IID				0	0	3. 00
4.00	OTHER LONG TERM CARE				0	0	4. 00
5.00	Total general inpatient care services (Sum of I	ines 1 - 4)		15, 855, 5	23	15, 855, 523	5. 00
	All Other Care Services	,					
6.00	ANCI LLARY SERVI CES			944, 20	62 0	944, 262	6. 00
7.00	CLINIC				0	0	7. 00
8.00	HOME HEALTH AGENCY COST				0	0	8. 00
9. 00	AMBULANCE				0	0	9. 00
10. 00	RURAL HEALTH CLINIC				0	0	
10. 10	FQHC				0	0	
	CMHC				0	0	11. 00
	HOSPI CE					0	12. 00
	OTHER (SPECIFY)					0	
	Total Patient Revenues (Sum of Lines 5 - 13) (T	ransfer column 3	to	16, 799, 78	85 0	1	
14.00	Worksheet G-3, Line 1)	Tansier Corumn 5	10	10, 777, 70	0	10, 777, 703	14.00
	Cost Center Description						
	cost center bescription				1. 00	2.00	
	PART II - OPERATING EXPENSES				1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Li	no 100)				16, 610, 120	1.00
2.00	Add (Specify)	ne 100)			0	10, 010, 120	2.00
3.00	Add (Specify)						3.00
4. 00					0		4.00
					0		
5.00					0		5. 00
6.00					0		6. 00
7.00					0	_	7. 00
8.00	Total Additions (Sum of lines 2 - 7)					0	
9.00	Deduct (Specify)				0		9. 00
10.00					0		10. 00
11. 00					0		11. 00
12.00					0		12.00
13. 00					0		13. 00
14.00	Total Deductions (Sum of lines 9 - 13)					0	
15. 00	Total Operating Expenses (Sum of lines 1 and 8,	minus line 14)				16, 610, 120	15. 00

Health Financial Systems	GATEWAY CARE CENTER			In Lieu of Form CMS-2540-10		
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der No.:	315177	Peri od: From 01/01/2022	Worksheet G-3	

STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315177	Peri od: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Pre 5/30/2023 12:	pared:
				1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		16, 799, 785	1.00
2. 00	Less: contractual allowances and discounts on patients account			600, 236	1
3. 00	Net patient revenues (Line 1 minus line 2)			16, 199, 549	
4. 00	Less: total operating expenses (From Worksheet G-2, Part II,	line 15)		16, 610, 120	1
5. 00	Net income from service to patients (Line 3 minus 4)			-410, 571	5. 00
0.00	Other income:			1107071	0.00
6. 00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			1, 920	
8. 00	Revenues from communications (Telephone and Internet service)	)		0	1
9.00	Revenue from television and radio service	,		0	1
10.00				0	
11. 00	Rebates and refunds of expenses			0	11.00
12.00				0	12. 00
13.00				0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other the	han patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients	·		0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of skilled nursing space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REV - MISC.			8, 500	24. 00
24. 01	SALE OF ELECTRICITY			164, 502	24. 01
24. 50	COVI D-19 PHE Fundi ng			7, 926	24. 50
25.00	Total other income (Sum of lines 6 - 24)			182, 848	25. 00
26.00	Total (Line 5 plus line 25)			-227, 723	26. 00
27.00	REIM EXP			294	27. 00
28. 00				0	28. 00
29. 00				0	29. 00
30.00	0 Total other expenses (Sum of lines 27 - 29)				30. 00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)			-228, 017	31. 00