	I Systems GA required by Law (42 USC 1395g; 42 CFR 413. since the beginning of the cost reporting p		ire to report can resul	t in all interim	u of Form CMS-2540-10 FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315177	Period: From 01/01/2023 To 12/31/2023	
PART I - COST I	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost rep	port		Date: 5/24/20	24 Time: 11:13 am
use only 2. [] Manual ly prepared cost report					
-	3. [0] If this is an amended report en	ter the numbe	r of times the provide	r resubmitted thi	s cost report
	3.01 [] No Medicare Utilization. Enter '				·
Contractor	4. [1]Cost Report Status	6. Contractor			
use only	(1) As Submitted	7 [N] Firs	t Cost Report for this	Provider CCN	
5	(2) Settled without audit		Cost Report for this		
	(3) Settled with audit	9. NPR Date:	cost kepolit for this		
	(4) Reopened				
	(5) Amended	10.[0][f]	ine 4, column 1 is "4"	: Enter number of	times reopened
		11.Contracto	r Vendor Code	4	
	5. Date Received:	12.[F] Medi	care Utilization. Ente	er "F" for full, '	'L" for low, or "N"
		for	no utilization.		

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GATEWAY CARE CENTER (315177) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Joe F	Blachorsky	ř	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 Blachorsky			2
3	Signatory Title	CFO			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	-32, 866	74	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	-32, 866	74	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.

000 City: EXTWINION East Code: 33154 Unarriterized (11) 21 Code: 37524 2. 01 Component Name Provider Date Operation Component Name Provider Date Operation 3. 01 Component Name Provider Date Operation No 4.00 So 0 6.00 4.00 So 0 6.00 03 SWF and SWF-Based Component Identification: SWF and	Skilled Nursing Facility complex Address: 00 Street: 139 GRANT AVENUE P0 Box: Clity: EATONTOWN State: NJ Zip Code:07724 00 County: MONMOUTH CBSA Code: 35154 Urban/Rural: U 01 CBSA Code: 35154 Urban/Rural: U 01 Component Name Provider CCN Date Certified Pagenent Other 00 SNF and SNF-Based Component Identification: N 1.00 2.00 3.00 4.00 5 00 SNF SNF and SNF-Based Component Identification: GATEWAY CARE CENTER 315177 01/01/1987 N 0 00 SNF-Based FMC SNF-Based FMC SNF-Based FMC SNF-Based FMC SNF-Based CORF Image: SNF State Sta		1.00
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9.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19. 9.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19. 9.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19. 9.01 Straight Line 77.720 20. 0.00 Straight Line 77.720 21. 0.00 Sum of the Year's Digits 77.720 23. 3.00 Sum of the Year's Digits 77.720 23. 3.00 Sum of the Year's Digits 77.720 24. 5.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? N 25. 7.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27. 3.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28. 9.00 Was there a substantial decrease enter "Y" for each component and type of service that qualifies for the exemption. N N 29. 1.00 2.00 Striled Nursing Facility	9.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. 9.01 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	Y	18.00
0.00 Straight Line 77,720 0.00 0.00 Declining Balance 21. 0.01 2.00 Sum of the Year's Digits 77,720 20. 3.00 Sum of Line 20 through 22 77,720 20. 4.00 If depreciation is funded, enter the balance as of the end of the period? 77,720 22. 5.00 Were there any disposal of capital assets during the cost reporting period? N 25. 5.00 Were there any disposal of capital assets during the cost reporting period? N 25. 5.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? N 25. 7.00 Did you cease to participate in the Medicare program at end of the period to which this cost report rapplies? (Y/N) N 27. 8.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 27. 9.00 Skilled Nursing Facility contains a public or non-public provider that qualifies for an exemption from the application of the easer of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 0.00 0.00 9.00 Skilled Nursing Facility N N 30. 30.		N	19.00 19.01
3.00 Sum of line 20 through 22 77,720 23. 4.00 If depreciation is funded, enter the balance as of the end of the period. 04. 6.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) N 24. 6.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? N 25. 7.00 Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N) N 28. 7.00 Did you cease to participate in the Medicare program at end of the period to which this cost report prior cost N 28. 7.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 28. 7.00 Did you cease to participate in the Medicare proportion of allowable cost from prior cost N 28. 7.00 Did you cease to participate in the Medicare 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. 0.00 Nilled Nursing Facility N N 30. 1.00 2.00 SNF-Based HNA N N 32. 2.00 SNF-Based FOHC<			20.00 21.00
5.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) N 25. 6.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N) N 25. 6.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N) N 25. 7.00 Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N) N 27. 8.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28. Part APart B Other 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. N N 29. 0.00 Nkrising Facility N N N 30. 0.00 ICF/11D N N N 33. 0.00 SNF-Based DNC N N 35. 0.00 SNF-Based fOHC N 35. 36. 0.00 SNF-Based OLTC Y/N	3.00 Sum of line 20 through 22		1
7.00 Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N) 27. applies? (Y/N) Part A Part B Other reports? (Y/N) 28. Part A Part B Other reports? (Y/N) Part A Part B Other reports? (Y/N) 28. 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. N N 29. 9.00 Skilled Nursing Facility N N N 30. 31. 0.01 CF(1ID N N N 32. 33. 33. 2.00 SNF-Based RHC N N N 32. 3.00 SNF-Based CMHC N N 33. 5.00 SNF-Based OLTC Y/N 1.00 2.00 7.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 37. 3.00 SNF-Based OLTC Y/N 4 33. 3.00 SNF-Based CMHC N N 37. 3.00 SNF-Based CMHC	5.00 Were there any disposal of capital assets during the cost reporting period? (Y/N)	N	25.00
8.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28. Part A Part B Other 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. N N 29. 9.00 Skilled Nursing Facility N N N 31. 2.00 SNF-Based HHA N N 32. 3.00 SNF-Based FOHC N N 33. 0.00 SNF-Based CMHC N N 33. 0.00 SNF-Based CMHC N N 35. 0.00 SNF-Based CMHC N N 35. 0.00 SNF-Based OLTC Y/N 1.00 2.00 7.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Y 37. regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 38. 8.00 Are you legally-required to carry malpractice insurance? (Y/N) Y 38. 9.00	7.00 Did you cease to participate in the Medicare program at end of the period to which this cost report	N	27.00
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. 9.00 9.00 Skilled Nursing Facility N N 29.00 0.00 Nursing Facility N N N 30.0 2.00 SNF-Based HHA N N 30.0 31.00 2.00 SNF-Based HHA N N N 32.2 3.00 SNF-Based RHC N N 33.4 4.00 SNF-Based CMHC N N 35. 5.00 SNF-Based OLTC Y/N 35. 6.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Y 37. 7.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Y 38. 8.00 Are you legally-required to carry malpractice insurance? (Y/N) Y 38. 9.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "occurrence", enter 2. 9.00 39.	8.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost	N	28.00
of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29. 9.00 Skilled Nursing Facility N N 29. 0.00 Nursing Facility N N 30. 0.00 Nursing Facility N N 31. 0.00 SNF-Based HHA N N 32. 3.00 SNF-Based FOHC N N 33. 4.00 SNF-Based FOHC N N 33. 5.00 SNF-Based CMHC N N 35. 6.00 SNF-Based OLTC Y/N 36. 36. Y/N 37. regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 38. 8.00 Are you legally-required to carry malpractice insurance? (Y/N) Y 38. 39. 9.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 2 39. 39. 1.01 Losses Self Insurance Premiums Paid Losses Self Insurance	1.00 2	2.00 3.00	
0.00 Nursing Facility N 30. 1.00 ICF/IID N 31. 2.00 SNF-Based HHA N 32. 3.00 SNF-Based RHC N 33. 4.00 SNF-Based FQHC N 34. 5.00 SNF-Based CMHC N 34. 6.00 SNF-Based OLTC N N 35. 7.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 38. 8.00 Are you legally-required to carry mal practice insurance? (Y/N) Y 38. 9.00 Is the mal practice a "claims-made" or "occurrence", enter 2. Premiums Paid Losses Self Insurance	of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for		
3.00 SNF-Based RHC 33. 1.00 SNF-Based FOHC 34. 5.00 SNF-Based CMHC N 35. 5.00 SNF-Based OLTC N 35. Y/N 1.00 2.00 7.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Y 37. 7.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Y 37. 8.00 Are you legally-required to carry malpractice insurance? (Y/N) Y 38. 9.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 2 39. "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance	0.00 Nursing Facility 1.00 ICF/IID	N	29.00 30.00 31.00
5.00 SNF-Based CMHC N 35. 5.00 SNF-Based OLTC Y/N 36. Y/N 1.00 2.00 7.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 37. 8.00 Are you legally-required to carry malpractice insurance? (Y/N) Y 38. 9.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "ccurrence", enter 2. Y 38. Premiums Paid Losses Self Insurance	3. OO SNF-Based RHC	N	32.00 33.00 34.00
1.00 2.00 7.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 37. 8.00 Are you legally-required to carry malpractice insurance? (Y/N) Y 38. 9.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 2 39. "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance	5. 00 SNF-Based CMHC 5. 00 SNF-Based OLTC	N	35.00 36.00
regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 38. 8.00 Are you legally-required to carry malpractice insurance? (Y/N) Y 38. 9.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 2 39. "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance	1.00	2.00	37.00
"claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance	regardless of the level of care given for Titles V & XIX patients? (Y/N) 3.00 Are you legally-required to carry malpractice insurance? (Y/N) Y		38.00
	"claims-made" enter 1. If the policy is "occurrence", enter 2.		1 0 5 1
		[°] Insurance	39.00

Heal th	Financial Systems	GATEWAY CARE CE	NTER		In Lieu	u of Form CN	IS-2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3		Period:	Worksheet S	5-2
COMPLE	X INDENTIFICATION DATA				From 01/01/2023 To 12/31/2023	Part I Date/Time F	Pronarod
					10 12/31/2023	5/24/2024	
						Y/N	
						1.00	
42.00	Are malpractice premiums and paid losse					N	42.00
	center? Enter Y or N. If yes, check box	c, and submit supporting s	schedule listing	cost ce	enters and		
	amounts.						
	Are there any home office costs as defi					N	43.00
	If line 43 is yes, enter the home offic	ce chain number and enter	the name and ad	ldress of	f the home		44.00
	office on lines 45, 46 and 47.						
	1.00	2.00			3.00		
	If this facility is part of a chain org	ganization, enter the nam	e and address of	f the ho	me office on the	lines	
	bel ow.						
45.00	Name:	Contractor's Name:	Co	ontracto	or's Number:		45.00
46.00	Street:	PO Box:					46.00
47.00	Ci ty:	State:	Zi	ip Code:			47.00

	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2023	Worksheet S-2 Part II	2
WPL	EX RELINDURSEMENT QUESTI UNIVALIRE				To 12/31/2023		
					Y/N	Date	
	General Instruction: For all column 1 respons	soc optor in column	1 "V" fo	r Voc or "N"	1.00	2.00	
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites						
00	Provider Organization and Operation Has the provider changed ownership immediated reporting period? If column 1 is "Y", enter				N		1. (
	linstructions)			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 3, "V" for voluntary or "I" for involuntary.			Ν			2.0
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or the relationships? (see instructions)	., chain home offic d to the provider c l, or members of th	ces, drug or its ne board	Y			3. (
		· · · · ·		Y/N	Туре	Date	
	Figure ist Data and Departs			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A" Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	" for Áudited, "C" te copy or enter da	for ate	Y	С	10/31/2024	4. (
00	Are the cost report total expenses and total those on the filed financial statements? If o reconciliation.	revenues di fferent	t from	Ν			5.
					Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities						
00	Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2	2: Is the	provider the	N	N	6.
00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during	s? (Y/N) see instru	uctions.		N N N	N	7.
00	legal operator of the program? (Y/N)	s? (Y/N) see instru ng the cost reporti	uctions.		N		7.
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	s? (Y/N) see instru ng the cost reporti	uctions.		N	N Y/N 1.00	6. (7. (8. (
00 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se Bad Debts	s? (Y/N) see instrung the cost reportiee instructions.	uctions. ing period	for Nursing	N	Y/N 1.00	7. 8.
	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	s? (Y/N) see instrung the cost reporties instructions.	uctions. ing period	for Nursing	NN	Y/N	7. 8. 9.
00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	s? (Y/N) see instrung the cost reporti ee instructions. d debts? (Y/N) see t collection policy	uctions. ing period instructio y change du	for Nursing ns. ring this cos	N N t reporting	Y/N 1.00 Y	7. 8. 9. 10.
00 00 00 . 00 . 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.	s? (Y/N) see instru ng the cost reporti ee instructions. d debts? (Y/N) see t collection policy d/or coinsurance wa	uctions. ing period instructio y change du aived? lf "	for Nursing ns. ring this cos Y", see instr	N N t reporting uctions.	Y/N 1.00 Y N	7.
00 00 00 . 00 . 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	s? (Y/N) see instrung the cost reporti ee instructions. d debts? (Y/N) see t collection policy d/or coinsurance wa	uctions. ing period instructio y change du aived? If "Y	for Nursing ns. ring this cos Y", see instr ", see instru Pa	N N t reporting uctions. ctions. rt A	Y/N 1.00 Y N N Part B	7. 8. 9. 10.
20 20 20 20 . 00 . 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	s? (Y/N) see instru ng the cost reporti ee instructions. d debts? (Y/N) see t collection policy d/or coinsurance wa	uctions. ing period instructio y change du aived? If "Y	for Nursing ns. ring this cos Y", see instr ", see instru	N N t reporting uctions. ctions.	Y/N 1.00 Y N N	7. 8. 9. 10. 11.
00 00 00 00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	s? (Y/N) see instrung the cost reporties instructions. d debts? (Y/N) see t collection policy d/or coinsurance wat cost reporting per	uctions. ing period instructio y change du aived? If "Y	for Nursing ns. ring this cos Y", see instr ", see instru Pa Y/N	N N t reporting uctions. ctions. rt A Date	Y/N 1.00 Y N N Part B Y/N	7. 8. 9. 10. 11. 12.
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to	s? (Y/N) see instrung the cost reporties instructions.	uctions. ing period instructio y change du aived? If "Y	for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00	7. 8. 9. 10. 11. 12. 13.
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used	s? (Y/N) see instrung the cost reportiee instructions.	uctions. ing period instructio y change du aived? If "Y	for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00 Y	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	7. 8. 9. 10. 11. 12. 12. 13. 14.
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the	s? (Y/N) see instrung the cost reportiee instructions.	uctions. ing period instructio y change du aived? If "Y	for Nursing ns. ring this cos Y", see instru Pa Y/N 1.00 Y	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y N	7. 8. 9. 10. 11. 12. 13. 14. 15.
00 00 00 00 00 00 00 00 00 00 00 00 00	<pre>legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. </pre>	s? (Y/N) see instrung the cost reportiee instructions.	uctions. ing period instructio y change du aived? If "Y	for Nursing ns. ring this cos Y", see instru Pa Y/N 1.00 Y N N	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y N N	7. 8. 9. 10. 11.

Heal th	Financial Systems	GATEWAY CAR	RE CENTER		In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILIT X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2023	Worksheet S-2 Part II	
					To 12/31/2023	Date/Time Pre 5/24/2024 11:	
			1.	00	2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title	e/position	CHARLES		REED		19.00
	held by the cost report preparer in columns 1	, 2, and 3,					
	respectively.						
20.00	Enter the employer/company name of the cost r	report	EXECUCARE ASSO	OCI ATES			20.00
	preparer.						
21.00	Enter the telephone number and email address	of the cost	(609)738-3200		CRWASSC@NETSCAF	PE. NET	21.00
	report preparer in columns 1 and 2, respectiv						

Heal th	Financial Systems	GATEWAY CAR	RE CENTER	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der No.: 315177	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/24/2024 11:	pared:
		Part B				
		Date				
	PS&R Data	4.00				
13.00	Was the cost report prepared using the PS&R	02/01/2024				13.00
10.00	only? If either col. 1 or 3 is "Y", enter	02/01/2021				10.00
	the paid through date of the PS&R used to					
	prepare this cost report in cols. 2 and					
	4. (see Instructions.)					
14.00	Was the cost report prepared using the PS&R					14.00
	for total and the provider's records for					
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used to prepare this cost report in columns 2 and					
	4.					
15.00	If line 13 or 14 is "Y", were adjustments					15.00
101.00	made to PS&R data for additional claims that					10100
	have been billed but are not included on the					
	PS&R used to file this cost report? If "Y",					
	see Instructions.					
16.00	If line 13 or 14 is "Y", then were					16.00
	adjustments made to PS&R data for					
	corrections of other PS&R Report					
17.00	information? If yes, see instructions. If line 13 or 14 is "Y", then were					17.00
17.00	adjustments made to PS&R data for Other?					17.00
	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	I, 2, and 3,				
20.00	respectively. Enter the employer/company name of the cost r	conort				20.00
20.00	preparer.					20.00
21.00	Enter the telephone number and email address	of the cost				21.00
	report preparer in columns 1 and 2, respectiv					
	· · · · ·	- 1				

<i lle<="" th=""><th>Financial Systems ED NURSING FACILITY AND SKILLED NURSIN X STATISTICAL DATA</th><th></th><th>E CENTER Provi der</th><th></th><th>eriod: rom 01/01/2023</th><th></th><th>pared:</th></i>	Financial Systems ED NURSING FACILITY AND SKILLED NURSIN X STATISTICAL DATA		E CENTER Provi der		eriod: rom 01/01/2023		pared:
				Inpa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Avai I abl e	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
00	SKILLED NURSING FACILITY	178	64, 970	0	2, 158	47, 193	1.00
00	NURSING FACILITY	0	0	0		0	2.00
00 00	ICF/IID HOME HEALTH AGENCY COST	0	0	0	0	0	3.00 4.00
00	Other Long Term Care	0	0	0	0	0	5.00
00	SNF-Based CMHC		-				6.0
00	HOSPI CE	0	0	0	0	0	7.0
00	Total (Sum of lines 1-7)	178	64, 970	0	2, 158	47, 193	8.0
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
0.0		6.00	7.00	8.00	9.00	10.00	
00	SKILLED NURSING FACILITY NURSING FACILITY	5, 136	54, 487	0	29	156 0	1.0
00 00	ICF/IID	0	0	0		0	2.0 3.0
00	HOME HEALTH AGENCY COST	0	0			0	4.0
00	Other Long Term Care	0	0				5. C
00	SNF-Based CMHC						6.0
00	HOSPICE	0	0	0	0	0	7.C
00	Total (Sum of lines 1-7)	5, 136 Di scha	54, 487 arges	0 Aver	29 age Length of	156 Stav	8. C
						3	
	Component	0ther 11.00	Total 12.00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
00	SKILLED NURSING FACILITY	61	246	0.00	74.41	302.52	1.0
00	NURSING FACILITY	0	0	0.00		0.00	2.0
00	ICF/IID	0	0			0.00	3.0
00	HOME HEALTH AGENCY COST						4.0
00 00	Other Long Term Care SNF-Based CMHC	0	0				5. C
00	HOSPICE	0	0	0.00	0.00	0.00	7.0
00	Total (Sum of lines 1-7)	61	246	0.00		302.52	8.0
		Average Length			si ons		
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
	componente	16.00	17.00	18.00	19.00	20.00	
00	SKILLED NURSING FACILITY	221.49	0	69	119	46	1. C
00	NURSING FACILITY	0.00	0		0	0	2.0
00		0.00			0	0	3. (
00 00	HOME HEALTH AGENCY COST Other Long Term Care	0.00				0	4. (5. (
00	SNF-Based CMHC	0.00				0	6.0
00	HOSPICE	0.00	0	0	0	0	7.0
00	Total (Sum of lines 1-7)	221. 49	0	69	119	46	8.0
		Admissions	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I 22. 00	Workers 23.00			
00	SKILLED NURSING FACILITY	21.00	135.07	23.00			1.0
00	NURSING FACILITY	0	0.00				2.0
00	ICF/IID	0	0.00	0.00			3.0
00	HOME HEALTH AGENCY COST		0.00	0.00			4.0
00	Other Long Term Care	0	0.00				5.0
00	SNF-Based CMHC HOSPI CE		0.00	0.00			6. C
00		0	0.00	0.00			

SNF WAGE INDEX INFORMATION Provider No.: 315177 Period: Period: To 12/37/2023 Worksheet S-3 part II Amount Reported Amount Reported Reclass. of Salaries from Salaries (col. 1 ± col. 2) Paid Hours Related to Salary in col. 3 and Paid Hours Varage Hourly Wage (col. 3 + col. 4) PART II - DIRECT SALARIES 1.00 2.00 3.00 4.00 5.00 SALARIES 5 SALARIES 0 0 0 0.00 0.00 2.00 0 Total salaries (See Instructions) 8, 103, 052 0 8, 103, 052 280, 942.00 28.84 1.00 2.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 0.00 3.00 0 O total salaries (See (Instructions) 8, 103, 052 0 8, 103, 052 280, 942.00 28.84 1.00 0 0 0 0 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Heal th	Financial Systems	GATEWAY CA	RE CENTER		In Lie	eu of Form CMS-2	2540-10
Reported Salaries from Salaries (col. 2) Related to Salaries (col. 3) Wage (col. 3) 1.00 2.00 3.00 4.00 5.00 SALARIES	SNF WA	GE INDEX INFORMATION				From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 5/24/2024 11:	pared: <u>13 am</u>
PART 11 - DIRECT SALARIES SALARIES SALARIES 1.00 2.00 3.00 4.00 5.00 PART 11 - DIRECT SALARIES SALARIES 0 0 2.00 3.00 4.00 5.00 Salaries-Part A 0 0 0.00 0.00 0.00 2.8.84 1.00 1.00 2.00 8, 103.052 280.942.00 28.84 1.00 2.00 Physic clan salaries-Part A 0 0 0.00 0.00 0.00 2.00 3.00 Home office personnel 0 0 0 0.00 0.								
PART 11 - DIRECT SALARIES SALARIES SALARIES SALARIES SALARIES SALARIES Salaries (See Instructions) 8, 103, 052 0 8, 103, 052 280, 942. 00 28. 84 1.00 2.00 Physician salaries-Part A 0 0 0 0.00 0.00 0.00 0.00 2.00 3.00 4.00 3.00 Physician salaries-Part B 0 0 0 0 0.00<								
PART II - DI RECT SALARIES SALARIES SALARIES SALARIES SALARIES 1.00 Total salaries (See Instructions) 8, 103, 052 0 8, 103, 052 280, 942.00 28.84 2.00 Physician salaries-Part A 0 0 0 0.00 0.00 0.00 0.00 3.00 4.00 Home office personnel 0 0 0 0.00 0.00 0.00 4.00 5.00 Sum of lines 2 through 4 0 0 0 0.00				Worksheet A-6	1 ± col. 2)	5	col. 4)	
SALARIES 1.00 Total salaries (See Instructions) 8, 103, 052 0 8, 103, 052 280, 942. 00 28. 84 1. 00 2.00 Physician salaries-Part A 0 0 0.00 0.00 0.00 0.00 0.00 28. 84 1. 00 3.00 Physician salaries-Part B 0 0 0 0.00 0.00 0.00 28. 84 6.00 Kevised wages (line 1 minus line 5) 8, 103, 052 0 8, 103, 052 280, 942. 00 28. 84 6. 00 7.00 Other Long Term Care 0 0 0 0.00 0.00 0.00 7. 00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 1. 00 10.00 HOSPI (CE 0			1.00	2.00	3.00	4.00	5.00	
1.00 Total salaries (See Instructions) 8, 103, 052 0 8, 103, 052 280, 942. 00 28. 84 1. 00 2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 0.00 0.00 2.00 4.00 Home office personnel 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 4.00 5.00 Sum of lines 2 through 4 0 0 0 0.00 0.								
2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2.00 3.00 Physician salaries-Part B 0 0 0 0.00 0.00 0.00 3.00 4.00 Home office personnel 0 0 0.00			1		1			
3.00 Physician salaries-Part B 0 0 0 0.00 0.00 3.00 4.00 Home office personnel 0 0 0 0.00 0.00 3.00 5.00 Sum of lines 2 through 4 0 0 0.00			8, 103, 052	C	8, 103, 05			
4.00 Home office personnel 0 0 0 0.00 0.00 4.00 5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 0.00 5.00 6.00 Revised wages (line 1 minus line 5) 8, 103, 052 0 8, 103, 052 280, 942.00 28.84 6.00 7.00 Other Long Term Care 0 0 0 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 8.00 9.00 CMHC 0 0 0 0.00 0.00 0.00 8.00 10.00 HOSPICE 0 0 0 0.00 0.00 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0 0.00 0.00 11.00 12.00 through 11) 1 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (line 6 minus line 8, 103, 052 0 8, 103, 052 280, 942.00 28.84 13.00		5	0	C				
5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 5.00 6.00 Revised wages (line 1 minus line 5) 8, 103, 052 0 8, 103, 052 280, 942. 00 28.84 6.00 7.00 Other Long Term Care 0 0 0 0.00 0.00 8.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 8.00 9.00 CMHC 0 0 0 0.00 0.00 8.00 10.00 HOSPICE 0 0 0 0.00 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0.00 0.00 10.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 10.00 13.00 Total Adjusted Salaries (Line 6 minus Line 8, 103, 052 0 8, 103, 052 280, 942.00 28.84 13.00 15.00 Contract Labor: Physician services-Part A 0 <td< td=""><td></td><td>5</td><td>0</td><td>C</td><td></td><td></td><td></td><td></td></td<>		5	0	C				
6.00 Revised wages (line 1 minus line 5) 8, 103, 052 0 8, 103, 052 280, 942. 00 28. 84 6. 00 7.00 Other Long Term Care 0 0 0 0.00			0	C				
7.00 Other Long Term Care 0 0 0 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 8.00 9.00 CMHC 0 0 0 0.00 0.00 9.00 9.00 CMHC 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0.00 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (Line 6 minus Line 8, 103, 052 0 8, 103, 052 280, 942.00 28.84 13.00 14.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0 0 0 16.00 WAGE-RELATED COSTS To<			0	C				
8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 8.00 9.00 CMHC 0 0 0 0.00 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0.00			8, 103, 052	C	8, 103, 05			
9.00 CMHC 0 0 0 0.00 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0 0.00 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0 0.00 0.00 10.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 11.00 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 8, 103, 052 0 8, 103, 052 280, 942.00 28.84 13.00 12.00 OTHER WAGES & RELATED COSTS			0	C				
10.00 HOSPICE 0 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 11.00 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 8,103,052 0 8,103,052 280,942.00 28.84 13.00 14.00 Contract Labor: Patient Related & Mgmt 895,934 0 895,934 22,678.00 39.51 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS			0	C				
11.00 Other excluded areas 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of Lines 7 through 11) 0 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 8,103,052 0 8,103,052 280,942.00 28.84 13.00 14.00 Contract Labor: Patient Related & Mgmt 895,934 0 895,934 22,678.00 39.51 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 WAGE-RELATED COSTS 0 0 0 0 0.00 0.00 16.00 17.00 Wage-related costs core (See Part IV) 1,625,728 0 1,625,728 17.00 18.00 18.00 Wage-related costs other (See Part IV) 0 0 0 0 19.00 19.00 Wage related costs (excluded units) 0 0 0 20.00 20.00 19.00 Physician Part A - WRC 0 0 0 20.00 20.00			0					
12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 8,103,052 0 8,103,052 280,942.00 28.84 13.00 OTHER WAGES & RELATED COSTS O O O O O No O O O O O O O O O O O O 0 0			0					
13.00 through 11) Total Adjusted Salaries (line 6 minus line 12) 8,103,052 0 8,103,052 280,942.00 28.84 13.00 14.00 Contract Labor: Patient Related & Mgmt 895,934 0 895,934 22,678.00 39.51 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,625,728 0 1,625,728 17.00 18.00 18.00 Wage-related costs (excluded units) 0 0 0 19.00 20.00 Physician Part A - WRC 0 0 0 21.00 21.00 22.00 Total Adjusted Wage Related cost (see 1,625,728 0 1,625,728 22.00			0					
12) OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Pati ent Related & Mgmt 895,934 0 895,934 22,678.00 39.51 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office sal aries & wage related costs 0 0 0 0.00 16.00 WAGE-RELATED COSTS 11, 625, 728 0 1, 625, 728 17.00 16.00 Wage-related costs core (See Part IV) 1, 625, 728 0 1, 625, 728 17.00 18.00 Wage-related costs other (See Part IV) 1, 625, 728 0 1, 625, 728 17.00 18.00 Wage related costs (excluded units) 0 0 0 0 19.00 20.00 Physician Part A - WRC 0 0 0 20.00 20.00 21.00 21.00 21.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00		through 11)	0					
OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 895,934 0 895,934 22,678.00 39.51 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,625,728 0 1,625,728 17.00 18.00 Wage-related costs other (See Part IV) 0 0 0 18.00 19.00 Physician Part A - WRC 0 0 0 19.00 20.00 Physician Part B - WRC 0 0 20.00 21.00 22.00 Total Adjusted Wage Related cost (see 1,625,728 0 1,625,728 22.00	13.00		8, 103, 052	C	8, 103, 05	280, 942. 00	28.84	13.00
15.00 Contract Labor: Physician services-Part A 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,625,728 0 1,625,728 17.00 18.00 Wage-related costs (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 20.00 20.00 21.00 Physician Part B - WRC 0 0 21.00 22.00		OTHER WAGES & RELATED COSTS		•			•	
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) 1,625,728 0 1,625,728 17.00 18.00 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 21.00 22.00 1,625,728 0 1,625,728 22.00	14.00	Contract Labor: Patient Related & Mgmt	895, 934	C	895, 93	22, 678. 00	39. 51	14.00
WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,625,728 0 1,625,728 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 Potal Adjusted Wage Related cost (see 1,625,728 0 1,625,728 22.00	15.00	Contract Labor: Physician services-Part A	0	C		0 0.00	0.00	15.00
17.00 Wage-related costs core (See Part IV) 1,625,728 0 1,625,728 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 21.00 21.00 22.00 Total Adjusted Wage Related cost (see 1,625,728 0 1,625,728 22.00	16.00	Home office salaries & wage related costs	0	C		0 0.00	0.00	16.00
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 1,625,728 0 1,625,728 22.00				-				
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 1,625,728 0 1,625,728 22.00	17.00		1, 625, 728	C	1, 625, 72	28		
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 1,625,728 0 1,625,728 22.00	18.00	Wage-related costs other (See Part IV)	0	C		0		18.00
21.00 Physician Part B - WRC 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 1,625,728 0 1,625,728 22.00	19.00	Wage related costs (excluded units)	0	C		0		19.00
22.00 Total Adjusted Wage Related cost (see 1,625,728 0 1,625,728 22.00	20.00		0	C		0		
			0	C		0		
	22.00	Total Adjusted Wage Related cost (see instructions)	1, 625, 728	C	1, 625, 72	28		22.00

Heal th	Financial Systems	GATEWAY CA	RE CENTER		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2023 To 12/31/2023		nared
						5/24/2024 11:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	1			1		
1.00	Employee Benefits	0	0	(0.00		
2.00	Administrative & General	821, 846		821, 840			2.00
3.00	Plant Operation, Maintenance & Repairs	124, 542	0	124, 542	2 4, 265. 00	29. 20	3.00
4.00	Laundry & Linen Service	271, 510	0	271, 510	0 15, 323. 00	17.72	4.00
5.00	Housekeepi ng	186, 390	0	186, 390	9, 537. 00	19.54	5.00
6.00	Dietary	1,009,550	0	1, 009, 550	43, 522. 00	23. 20	6.00
7.00	Nursing Administration	1, 430, 627	0	1, 430, 62	43, 745. 00	32.70	7.00
8.00	Central Services and Supply	0	0	(0.00	0.00	8.00
9.00	Pharmacy	0	0	(0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	(0.00	0.00	10.00
11.00	Soci al Servi ce	79, 976	0	79, 970	5 2, 125. 00	37.64	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
	Other General Service	684, 376	0	684, 376	33, 251. 00	20. 58	13.00
14.00	Total (sum lines 1 thru 13)	4, 608, 817		4, 608, 81	7 174, 913.00	26.35	14.00
					1		

	Financial Systems	GATEWAY CARE CENTER	In Lie	u of Form CMS-2	2540-
SNF WA	GE RELATED COSTS	Provi der No.: 315177	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Pre 5/24/2024 11:	pared
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETIREMENT COST				
. 00	401K Employer Contributions			0	
2.00	Tax Sheltered Annuity (TSA) Employer Con			0	
. 00	Qualified and Non-Qualified Pension Plan	Cost		-1, 584	
. 00	Prior Year Pension Service Cost			0	4.0
	PLAN ADMINISTRATIVE COSTS (Paid to Extern	nal Organization)			
. 00	401K/TSA Plan Administration fees			0	
. 00	Legal /Accounting/Management Fees-Pension			0	
. 00	Employee Managed Care Program Administra	tion Fees		0	7.0
	HEALTH AND INSURANCE COST				
. 00	Health Insurance (Purchased or Self Fund	ed)		669, 959	
. 00	Prescription Drug Plan			0	
	Dental, Hearing and Vision Plan			0	
	Life Insurance (If employee is owner or			0	1
	Accident Insurance (If employee is owner			0	1
	Disability Insurance (If employee is own			0	
	Long-Term Care Insurance (If employee is	owner or beneficiary)		0	1
	Workers' Compensation Insurance			245, 000	
6.00		t year, not the extraordinary accrual require	ed by FASB 106.	0	16.
	Non cumulative portion)				
	TAXES				1
	FICA-Employers Portion Only			701, 706	
	Medicare Taxes - Employers Portion Only			0	
	Unemployment Insurance			0	1
0.00	State or Federal Unemployment Taxes			8, 168	20.
4 00	OTHER				1 01
	Executive Deferred Compensation			0	
	Day Care Cost and Allowances			0	1
	Tuition Reimbursement	22)		2,479	
4.00	Total Wage Related cost (Sum of lines 1	- 23)		1, 625, 728	24.
				Amount Reported	
				1.00	
	Part B - Other than Core Related Cost			1.00	
	OTHER WAGE RELATED COST			0	25.

Direct Salaries Provider No.: 315177 Period: From 01/01/2023 To 12/31/2023 Worksheet S-3 Part V Date/Time Prepared: 5/24/2024 11: 13 am Direct Salaries Reported Benefits Salaries (col. 1) 1 + col. 2) Paid Hours Salary in col. Average Hourly Wage (col. 3 + col. 4) Direct Salaries 1.00 2.00 3.00 4.00 5.00 Licensed Practical Nurses (RNs) 864,850 171,954 1,036,804 15,177.00 68.31 1.00 2.00 Licensed Practical Nurses (LPNs) 1,279,468 254,391 1,538,859 34,528.00 44.42 2.00 3.00 Certified Nursing Assistant/Nursing 1,026,538 204,102 1,230,640 49,052.00 25.09 3.00 4.00 Total Nursing (sum of lines 1 through 3) 3,170,856 630,447 3,801,303 98,757.00 38.49 4.00 5.00 Physical Therapy Assistants 0 0 0 0 0.00 0.00 5.00 6.00 Physical Therapy Asistants 9,048 9,041,02 1,230,640 49,052.00 25.00 3.00 <
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$
Di rect Salari es Nursi ng Occupati ons 1.00 Regi stered Nurses (RNs) 864,850 171,954 1,036,804 15,177.00 68.31 1.00 2.00 Li censed Practi cal Nurses (LPNs) 1,279,468 254,391 1,533,859 34,528.00 44.42 2.00 3.00 Certi fi ed Nursi ng Assi stant/Nursi ng 1,026,538 204,102 1,230,640 49,052.00 25.09 3.00 Assi stants/Ai des 1 1 3,170,856 630,447 3,801,303 98,757.00 38.49 4.00 5.00 Physi cal Therapi sts 0 0 0 0.00 54.66 5.00 6.00 Physi cal Therapy Assi stants 0 0 0 0.00 0.00 6.00 7.00 Physi cal Therapy Aides 0 0 0 0.00 0.00 7.00 8.00 Occupati onal Therapy Aides 97,418 19,369 116,787 2,328.00 50.17 8.00
Nursing Occupations 1.00 Registered Nurses (RNs) 864,850 171,954 1,036,804 15,177.00 68.31 1.00 2.00 Licensed Practical Nurses (LPNs) 1,279,468 254,391 1,533,859 34,528.00 44.42 2.00 3.00 Certified Nursing Assistant/Nursing 1,026,538 204,102 1,230,640 49,052.00 25.09 3.00 Assistants/Ai des 1 704,856 630,447 3,801,303 98,757.00 38.49 4.00 5.00 Physical Therapists 178,270 35,445 213,715 3,910.00 54.66 5.00 6.00 Physical Therapy Assistants 0 0 0 0.00 0.00 6.00 7.00 Physical Therapy Aides 97,418 19,369 116,787 2,328.00 50.17 8.00
1.00 Registered Nurses (RNs) 864,850 171,954 1,036,804 15,177.00 68.31 1.00 2.00 Licensed Practical Nurses (LPNs) 1,279,468 254,391 1,533,859 34,528.00 44.42 2.00 3.00 Certified Nursing Assistant/Nursing 1,026,538 204,102 1,230,640 49,052.00 25.09 3.00 Assistants/Aides 178,270 35,447 3,801,303 98,757.00 38.49 4.00 5.00 Physical Therapists 0 0 0.00 0.00 6.00 7.00 Physical Therapy Assistants 0 0 0 0.00 0.00 6.00 7.00 Physical Therapy Assistants 97,418 19,369 116,787 2,328.00 50.17 8.00
2.00 Li censed Practical Nurses (LPNs) 1, 279, 468 254, 391 1, 533, 859 34, 528.00 44.42 2.00 3.00 Certified Nursing Assistant/Nursing 1, 026, 538 204, 102 1, 230, 640 49, 052.00 25.09 3.00 4.00 Total Nursing (sum of lines 1 through 3) 3, 170, 856 630, 447 3, 801, 303 98, 757.00 38.49 4.00 5.00 Physical Therapists 178, 270 35, 445 213, 715 3, 910.00 54.66 5.00 6.00 Physical Therapy Assistants 0 0 0 0.00 0.00 6.00 7.00 Physical Therapy Aides 97, 418 19, 369 116, 787 2, 328.00 50.17 8.00
3.00 Certified Nursing Assistant/Nursing Assistants/Ai des 1,026,538 204,102 1,230,640 49,052.00 25.09 3.00 4.00 Total Nursing (sum of lines 1 through 3) 3,170,856 630,447 3,801,303 98,757.00 38.49 4.00 5.00 Physical Therapists 178,270 35,445 213,715 3,910.00 54.66 5.00 6.00 Physical Therapy Assistants 0 0 0 0.00 6.00 7.00 Physical Therapy Aides 0 0 0 0.00 7.00 8.00 Occupational Therapists 97,418 19,369 116,787 2,328.00 50.17 8.00
Assi stants/Ai desAssi stants/Ai desAssi stants/Ai desAssi stants/Ai des4.00Total Nursing (sum of Lines 1 through 3)3, 170, 856630, 4473, 801, 30398, 757.0038.494.005.00Physical Therapists178, 27035, 445213, 7153, 910.0054.665.006.00Physical Therapy Assi stants0000.000.006.007.00Physical Therapy Ai des0000.007.008.00Occupati onal Therapists97, 41819, 369116, 7872, 328.0050.178.00
5.00Physical Therapists178,27035,445213,7153,910.0054.665.006.00Physical Therapy Assistants0000.006.007.00Physical Therapy Aides0000.007.008.00Occupational Therapists97,41819,369116,7872,328.0050.178.00
6.00 Physical Therapy Assistants 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 97,418 19,369 116,787 2,328.00 50.17 8.00
7.00 Physical Therapy Aides 0 0 0.00 0.00 7.00 8.00 Occupational Therapists 97,418 19,369 116,787 2,328.00 50.17 8.00
8.00 Occupational Therapists 97,418 19,369 116,787 2,328.00 50.17 8.00
9.00 Occupational Therapy Assistants 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
10.00 Occupational Therapy Aides 0 0 0.00 0.00 10.00
11. 00 Speech Therapists 47, 691 9, 482 57, 173 1, 034. 00 55. 29 11. 00
12.00 Respiratory Therapists 0 0 0.00 0.00 12.00
13.00 Other Medical Staff 0 0 0.00 13.00
Contract Labor
Nursing Occupations
14.00 Registered Nurses (RNs) 128,794 128,794 1,332.00 96.69 14.00
15.00 Li censed Practical Nurses (LPNs) 89, 308 89, 308 1, 761.00 50.71 15.00
16.00 Certified Nursing Assistant/Nursing 653, 235 653, 235 19, 211.00 34.00 16.00
17.00 Total Nursing (sum of lines 14 through 16) 871, 337 871, 337 22, 304.00 39.07 17.00
18.00 Physical Therapists 23,914 23,914 351.00 68.13 18.00
19.00 Physical Therapy Assistants 0 0.00 0.00 19.00
20.00 Physical Therapy Aides 0 0.00 0.00 20.00
21.00 Occupational Therapists 0 0 0.00 0.00 21.00
22.00 Occupational Therapy Assistants 0 0 0.00 0.00 22.00
23.00 Occupational Therapy Aides 0 0 0.00 0.00 23.00
24.00 Speech Therapists 683 683 23.00 29.70 24.00
25.00 Respiratory Therapists 0 0.00 0.00 25.00
26.00 Other Medical Staff 0 0.00 0.00 26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	GATEWAY CARE CENTER Provider No.: 315177	Peri od:	u of Form CMS Worksheet S-	
		From 01/01/2023 To 12/31/2023	Date/Time Pr 5/24/2024 11	epared:
		Group	Days	
1.00		1.00 RUX	2.00	1.00
2.00		RUL		2.00
3.00 4.00		RVX RVL		3.00
5.00		RHX		5.00
6.00		RHL		6.00
7.00 8.00		RMX RML		7.00
9.00		RLX		9.00
10.00		RUC		10.00
11.00		RUB		11.00
12. 00 13. 00		RUA RVC		12.00
14.00		RVB		14.00
15.00		RVA		15.00
16. 00 17. 00		RHC RHB		16.00 17.00
18.00		RHA		18.00
19.00		RMC		19.00
20. 00 21. 00		RMB RMA		20.00
22.00		RLB		22.00
23.00		RLA		23.00
24. 00 25. 00		ES3 ES2		24.00 25.00
26.00		ES1		25.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00 30.00		HD2 HD1		29.00 30.00
31.00		HC2		31.00
32.00		HC1		32.00
33. 00 34. 00		HB2 HB1		33.00 34.00
35.00		LE2		35.00
36.00		LE1		36.00
37. 00 38. 00		LD2 LD1		37.00 38.00
39.00		LC2		39.00
40. 00		LC1		40.00
41.00		LB2		41.00
42. 00 43. 00		LB1 CE2		42.00
44.00		CE1		44.00
45.00		CD2		45.00
46. 00 47. 00		CD1 CC2		46.00 47.00
48.00		CC1		48.00
49.00		CB2		49.00
50. 00 51. 00		CB1 CA2		50.00 51.00
52.00		CA1		52.00
53.00		SE3		53.00
54. 00 55. 00		SE2 SE1		54.00 55.00
56.00		SSC		56.00
57.00		SSB		57.00
58. 00 59. 00		SSA I B2		58.00 59.00
60. 00		I B2		60.00
61.00		I A2		61.00
62.00 63.00		I A1		62.00
63. 00 64. 00		BB2 BB1		63.00 64.00
65. 00		BA2		65.00
66.00		BA1		66.00
67.00 68.00		PE2 PE1		67.00 68.00
69.00		PD2		69.00
70.00		PD1		70.00
71.00		PC2		71.00
72. 00 73. 00		PC1 PB2		72.00 73.00
74.00		PB1		74.00
75. 00		PA2		75.00

Health Financial Systems	GATEWAY CARE CE	INTER		In Lie	u of Form C	MS-2540-10	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315177	Period:	Worksheet	S-7	
				From 01/01/2023 To 12/31/2023		Prepared: 11:13 am	
				Group	Days		
				1.00	2.00		
76.00				PA1		76.00	
99.00				AAA		99.00	
100. 00 TOTAL						100.00	
			Expenses	Percentage	Y/N		
			1.00	2.00	3.00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, Li	ine 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00	

	Financial Systems	GATEWAY CARE				u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315177	Period: From 01/01/2023	Worksheet A	
					To 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Cost Center Description	Sal ari es	Other		1 Recl assi fi cati	Reclassi fi ed	
				+ col. 2)	ons I ncrease/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1	2 4/2 255	2.4(2.2)		2 527 422	1 1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		2, 463, 355 85, 254	2, 463, 3 85, 2		2, 537, 432 11, 177	1.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 611, 093			1, 611, 093	
4.00	00400 ADMI NI STRATI VE & GENERAL	821, 846	2, 358, 630	3, 180, 4		3, 180, 476	•
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	124, 542	625, 940	750, 48		750, 482	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	271, 510	0	271, 5		271, 510	
7.00	00700 HOUSEKEEPI NG	186, 390	69, 029	255, 4		255, 419	
8.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	1,009,550	546, 459	1, 556, 00		1, 556, 009	•
9.00 10.00	01000 CENTRAL SERVICES & SUPPLY	1, 430, 627	107, 061 204, 205	1, 537, 68 204, 20		1, 537, 688 204, 205	
	01100 PHARMACY	0	32, 713	32, 7		32, 713	•
	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	•
13.00	01300 SOCIAL SERVICE	79, 976	0	79, 9	76 0	79, 976	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
15.00	01500 ACTI VI TI ES	684, 376	206, 082	890, 4	58 0	890, 458	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2 170 05/	071 227	4 042 10	93 0	4 042 102	1 20 00
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	3, 170, 856	871, 337	4, 042, 19	73 U	4, 042, 193 0	30.00
	03200 CF/I D	0	0		0 0	0	
	03300 OTHER LONG TERM CARE	0	0		0 0	0	•
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	0	0		0 0	0	
	04100 LABORATORY	0	7, 538	7, 5	38 0	7, 538	•
	04200 INTRAVENOUS THERAPY	0	0	2.5		0	42.00
	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	178, 270	2, 532 77, 429	2, 5 255, 6		2, 532 255, 699	
	04500 OCCUPATI ONAL THERAPY	97, 418	0	97, 4		97, 418	•
	04600 SPEECH PATHOLOGY	47, 691	683	48, 3		48, 374	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	04900 DRUGS CHARGED TO PATIENTS	0	55, 216	55, 2		55, 216	
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0 0	0	
51.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0 0	0	51.00
60.00	06000 CLINIC	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS		0			0	70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0 31, 865		0 0 55 0	0	70.00
	07300 CMHC	0	31, 805	31,0	0 0		
70.00	SPECIAL PURPOSE COST CENTERS						/ 0. 00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0 0	0	80.00
	08100 INTEREST EXPENSE		0		0 0	0	
	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	
	08300 HOSPICE	0 102 052	0 254 421	17 450 4	0 0 73 0	17 450 472	
00 00	SUBTOTALS (sum of lines 1-84)	8, 103, 052	9, 356, 421	17, 459, 4	73 0	17, 459, 473	89.00
89.00	NONRELMBURSABLE COST CENTERS						-
	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
90.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0 0		0 0 0 0	0	
90. 00 91. 00 92. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0 0 0	0 0 0		0 0 0 0 0 0	-	91.00 92.00
90. 00 91. 00 92. 00 93. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0 0 0 0	0 0 0		0 0 0 0 0 0 0 0	0 0 0	91.00 92.00 93.00
90. 00 91. 00 92. 00 93. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0 0 0 0 8, 103, 052	0 0 0 9, 356, 421	17, 459, 4	0 0 0 0 0 0 0 0 0 0 73 0	0	91.00 92.00 93.00 94.00

	Financial Systems FIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	GATEWAY CA		No.: 315177	Peri od:	u of Form CMS- Worksheet A	2040-1
NLULA33	STITICATION AND ADJUSTMENT OF TREAL DREANCE OF	EXI ENSES	TTOVIGET	NO 515177	From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Cost Center Description	Adjustments to					
			For Allocation				
		Wkst A-8)	(col. 5 +-				
		6.00	col. 6) 7.00	-			
0	GENERAL SERVICE COST CENTERS	0.00	1.00				
	DO100 CAP REL COSTS - BLDGS & FIXTURES	-1, 563, 375	974, 057				1.00
2.00	DO200 CAP REL COSTS - MOVABLE EQUI PMENT	0	11, 177				2.00
3.00 0	DO300 EMPLOYEE BENEFITS	0	1, 611, 093				3.00
4.00 0	DO400 ADMINISTRATIVE & GENERAL	-162, 150	3, 018, 326				4.00
5.00 0	DO500 PLANT OPERATION, MAINT. & REPAIRS	-133,047					5.0
. 00	DO600 LAUNDRY & LINEN SERVICE	0	271, 510				6.0
7.00	DO700 HOUSEKEEPI NG	0	255, 419				7.0
	DO800 DI ETARY	-211		1			8.0
0.00	DO900 NURSI NG ADMI NI STRATI ON	0		1			9.0
	01000 CENTRAL SERVICES & SUPPLY	0	204, 205	1			10.0
	D1100 PHARMACY	0	32, 713	1			11.0
	D1200 MEDICAL RECORDS & LIBRARY	0	02,710	1			12.0
	D1300 SOCIAL SERVICE	0	79, 976				13.0
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	, , , , , , , , , , , , , , , , , , , ,				14.0
	D1500 ACTIVITIES	0	890, 458				15.0
	NPATIENT ROUTINE SERVICE COST CENTERS		070,430				- 15.0
	03000 SKILLED NURSING FACILITY	-2, 482	4,039,711				30.0
	D3100 NURSING FACILITY	2, 402	4,037,711	1			31.0
	03200 CF/I D	0		•			32.0
	D3300 OTHER LONG TERM CARE	0					33.0
	ANCI LLARY SERVICE COST CENTERS	0					_ 55.0
	24000 RADI OLOGY	0	C				40.0
	D4100 LABORATORY		7, 538				40.0
	04200 I NTRAVENOUS THERAPY		7,550				41.0
			2 5 2 2				
	04300 OXYGEN (INHALATION) THERAPY	0	2, 532	1			43.0
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	-4	255, 695	1			44.0
			97, 418				45.0
			48, 374	1			46.0
	04700 ELECTROCARDI OLOGY		0				47.0
	04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0					48.0
	04900 DRUGS CHARGED TO PATIENTS	0	55, 216				49.0
	D5000 DENTAL CARE - TITLE XIX ONLY	0	0				50.0
	05100 SUPPORT SURFACES	0	C				51.0
-	DUTPATIENT SERVICE COST CENTERS		C	1			
		0		•			60.0
	D6100 RURAL HEALTH CLINIC	0	C				61.0
							62.0
	OTHER REIMBURSABLE COST CENTERS						
	D7000 HOME HEALTH AGENCY COST	0		•			70.0
	07100 AMBULANCE	0		1			71.0
	07300 CMHC	0	C				73.0
	SPECIAL PURPOSE COST CENTERS	1		1			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	C				80.0
	08100 INTEREST EXPENSE	0	0				81.0
	08200 UTILIZATION REVIEW - SNF	0	C				82.0
	D8300 HOSPI CE	0	0				83.0
9.00	SUBTOTALS (sum of lines 1-84)	-1, 861, 269	15, 598, 204				89.0
	VONREI MBURSABLE COST CENTERS	1	1	1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90.0
	09100 BARBER AND BEAUTY SHOP	0	0				91.0
	09200 PHYSICIANS PRIVATE OFFICES	0	0				92.0
	D9300 NONPAID WORKERS	0	0				93.0
<i>₹</i> 4.00 (D9400 PATIENTS LAUNDRY	0	0				94.0
	TOTAL	-1, 861, 269	15, 598, 204	1			100.0

Health Financial Systems	GATEWAY CARE CE	In Lie	In Lieu of Form CMS-2			
RECLASSI FI CATI ONS		Provi der No.: 315177			Worksheet A-6	
				From 01/01/2023 To 12/31/2023		pared: 13 am
			Increases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
(1) B - RECLASS LHI DEPRE					_	
1.00	CAP REL COSTS - BLE	GS &	1. (00 00	74,077	1.00
	FI XTURES					
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	74, 077	100.00
	of columns 4 and 5	must				
	equal sum of column	s 8 and				
	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 CENTER			In Lieu of Form CMS-2540-1			
RECLASSI FI CATI ONS				Period:	Worksheet A-6		
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 13 am	
	Decreases						
	Cost Center	•	Line #	Sal ary	Non Salary		
	6.00		7.00	8.00	9.00		
(1) B - RECLASS LHI DEPRE							
1.00	CAP REL COSTS - MOVA EQUI PMENT	ABLE	2. (0 00	74, 077	1.00	
TOTALS							
100.00				0	74, 077	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.

	Financial Systems	GATEWAY CAR			In Lieu of Form CMS-2540			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315177	Peri From To	od: 01/01/2023 12/31/2023	Worksheet A-7 Date/Time Prep 5/24/2024 11:	pared:
				Acqui si ti or	is			
	Description	Begi nni ng Bal ances	Purchases	Donation		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANC	ES						
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	3.0
4.00	Building Improvements	1, 975, 458	0		0	0	0	4.0
5.00	Fixed Equipment	0	0		0	0	0	5.0
6.00	Movable Equipment	1, 524, 057	0		0	0	0	6.0
7.00	Subtotal (sum of lines 1-6)	3, 499, 515	0		0	0	0	7.0
8.00	Reconciling Items	0	0		0	0	0	8.0
9.00	Total (line 7 minus line 8)	3, 499, 515			0	0	0	9.0
	Description	Endi ng Bal ance						
			Depreci ated					
		(00	Assets					
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANC	6.00	7.00					
1.00	Land	ES O	0					1.0
2.00	Land Improvements	0	0					2.0
2.00 3.00	Buildings and Fixtures	0	0					3.0
3.00 4.00	Building Improvements	1, 975, 458	0					3.0 4.0
4.00 5.00	Fixed Equipment	1, 9/0, 408						4.0 5.0
5.00 6.00	Movable Equipment	1, 524, 057						6.0
7.00	Subtotal (sum of lines 1-6)	3, 499, 515						7.0
8.00	Reconciling Items	3,477,010						8.0
8.00 9.00	Total (line 7 minus line 8)	3, 499, 515	0					9.00
7.00		5,477,515	0	1				9.0

	Financial Systems	GATEWAY CAR		N 045477		u of Form CMS-2	
JUST	MENTS TO EXPENSES		Provi der	No.: 315177	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8	
					10 12/31/2023	Date/Time Pre 5/24/2024 11:	
				Expense C	lassification on		
				To/From Whic	ch the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
		Adjustment 1.00	2.00		3.00	4.00	
0	Investment income on restricted funds	В		ADMI NI STRATI		4.00	1
	(chapter 2)						
00	Trade, quantity, and time discounts (chapter		0			0.00	2
00	8) Refunds and rebates of expenses (chapter 8)		0			0.00	3
00	Rental of provider space by suppliers		0			0.00	
	(chapter 8)						
0	Telephone services (pay stations excluded)		0			0.00	5
00	(chapter 21) Television and radio service (chapter 21)		0			0.00	6
00	Parking lot (chapter 21)		0			0.00	
00	Remuneration applicable to provider-based	A-8-2	0			2.00	8
	physician adjustment						
00	Home office cost (chapter 21)		0			0.00	
00 00	Sale of scrap, waste, etc. (chapter 23) Nonallowable costs related to certain		0			0.00	
00	Capital expenditures (chapter 24)		0			0.00	'
00	Adjustment resulting from transactions with	A-8-1	-1, 567, 622				12
	related organizations (chapter 10)		_				
00 00	Laundry and linen service Revenue - Employee meals		0			0.00 0.00	
00	Cost of meals - Guests		0			0.00	
00	Sale of medical supplies to other than		0			0.00	
	patients						
	Sale of drugs to other than patients		0			0.00	
00 00	Sale of medical records and abstracts Vending machines		0			0.00 0.00	
00	Income from imposition of interest, finance		0			0.00	
00	or penal ty charges (chapter 21)		0			0.00	
00	Interest expense on Medicare overpayments		0			0.00	2'
	and borrowings to repay Medicare						
00	overpayments Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	REVIEW - SNE	82.00	22
00	(chapter 21)		0			02.00	24
00	Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23
~~			0	FI XTURES		2.00	1
00	Depreciationmovable equipment			CAP REL COST EQUIPMENT	S - MUVABLE	2.00	24
00	SALARIES ASST. ADM.	А		ADMI NI STRATI	VE & GENERAL	4.00	25
01	BAD DEBT EXP 30% NON MCD	A	-141, 357	ADMI NI STRATI	VE & GENERAL	4.00	
02	BAD DEBT EXP 30% NON MCD	A		ADMI NI STRATI		4.00	
03	MARKETING / PROMOTIONAL ADVERTISING	A		ADMI NI STRATI		4.00	
04 05	PENALTIES RESIDENT PD CLAIMS (CB)	A A		ADMI NI STRATI ADMI NI STRATI		4.00 4.00	
05	OTHER REVENUE MISC	B		ADMI NI STRATI		4.00	
07	SALE OF ELECTRICITY	B			ION, MAINT. &	5.00	
				REPAI RS		_	
08	Tatal (our of Lines 1 through 00) (Tr. C		0			0.00	
<i>i</i> . UU	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1, 861, 269				100

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

Health Financial Systems	GATEWAY CA	RE CENTER		In Lie	u of Form CMS	-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOME	E Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet A- Parts I-II Date/Time Pr 5/24/2024 11	epared:
	Line No.	Cost (Center	Expense		
	1.00	2.		3.		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT			
CLAIMED HOME OFFICE COSTS:						
1.00		CAP REL COSTS	- BLDGS &	REAL ESTATE TAX	KES	1.00
2.00		CAP REL COSTS	- BLDGS &	RENT		2.00
		FI XTURES				
3.00	4.00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEE		3.00
4.00	4.00	ADMI NI STRATI VE	& GENERAL	REALTY ADMIN		4.00
5.00	8.00	DI ETARY		RELATED DI ETARY	ſ	5.00
6.00	30.00	SKILLED NURSIN	G FACILITY	RELATED NURSING	3	6.00
7.00	44.00	PHYSICAL THERA	PY	RELATED THERAP	ſ	7.00
8.00	0.00					8.00
9.00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu	S		
	Cost	Wkst. A, col.	col. 5)			
		5	(
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANIZATIONS	OR	
CLAIMED HOME OFFICE COSTS:	197, 106	197, 139	-3	2		1.00
1.00	646, 658			-		
2.00 3.00	646, 658 798, 365					2.00
4.00						
5.00	85			15		4.00 5.00
6.00	20, 847 245, 749					6.00
7.00	245, 749 387	248, 231 391				7.00
8.00	387	391		4		8.00
9.00	0	0		0		9,00
10.00 TOTALS (sum of lines 1-9). Transfer column	0 1, 909, 197	-		0		9.00
6, line 100 to Worksheet A-8, column 3, line	1, 707, 197	3,470,019	-1, 507, 62	~		10.00
12.						
1	I	I	I	I		I

Health Financial Systems	GATEWAY CARE CENTER			In Lie	u of Form CMS-2	2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provider 1		Period: From 01/01/2023 To 12/31/2023	Worksheet A-8- Parts I-II Date/Time Prep 5/24/2024 11:	bared:
	Symbol (1)	Nan	e	Percentage of Ownership		
	1.00	2.0	0	3.00		

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

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

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

1.00		A	JONATHAN ROSENBERG	96.00	1.00
2.00		A	ESTHER ROSENBERG	4.00	2.00
3.00		A	JONATHAN ROSENBERG	96.00	3.00
4.00		A	ESTHER ROSENBERG	4.00	4.00
5.00		F	MINDY ROSENBERG	0.00	5.00
6.00				0.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial)			0.00	100.00
	speci fy:				

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

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

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

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

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

rel ated organi zati on.

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						
	4.00	5.00	6.00					
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	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	GATEWAY EATONTOWN ASSOCIATES	96.00 REALTY	1.00
	LLC		
2.00	GATEWAY EATONTOWN ASSOCIATES	4.00 REALTY	2.00
	LLC		
3.00	JER ROSE MANAGEMENT	50. 00 MANAGEMENT	3.00
4.00	JER ROSE MANAGEMENT	50. 00 MANAGEMENT	4.00
5.00	PEACE OF MIND STAFFING	100.00 STAFFI NG	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

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

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

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

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

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

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

Heal th	Financial Systems	GATEWAY CAR	E CENTER		In Lie	u of Form CMS-2	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315177	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/24/2024 11:	
			CAPI TAL REL	ATED COSTS		10/21/2021 111	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 3.00 4.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	974, 057 11, 177 1, 611, 093 3, 018, 326	974, 057 4, 578 59, 612	11, 1 5 68	53 1, 615, 724	3, 242, 496	1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY	617, 435 271, 510 255, 419 1, 555, 798	11, 156 26, 313 25, 415 98, 150	30	28 24, 833 52 54, 138 52 37, 166 26 201, 301		5.00 6.00 7.00 8.00
9. 00 10. 00 11. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	1, 535, 778 1, 537, 688 204, 205 32, 713	13, 360 14, 157 0	1!	53 285, 263 62 0 0 0	1, 836, 464 218, 524 32, 713	9.00 10.00 11.00
13. 00 14. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0 79, 976 0 890, 458	0 4, 391 0 27, 314		0 0 50 15, 947 0 0 13 136, 463	0 100, 364 0 1, 054, 548	12.00 13.00 14.00 15.00
30.00	INPATI ENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	4, 039, 711	608, 533	6, 98		5, 287, 486	30.00
32.00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	31.00 32.00 33.00
	ANCI LLARY SERVI CE COST CENTERS	-			-	-	
40.00 41.00 42.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0 7, 538 0	0 0 0		0 0 0 0 0 0	0 7, 538 0	40.00 41.00 42.00
43.00 44.00	04300 OXYGEN(I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	2, 532 255, 695	0 26, 636		0 0 06 35, 547	2, 532 318, 184	43.00 44.00
45.00 46.00 47.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	97, 418 48, 374 0	19, 396 17, 616 0		23 19, 425 02 9, 509 0 0	136, 462 75, 701 0	45.00 46.00 47.00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0 55, 216 0	12, 326 3, 069 0		41 0 35 0 0 0	12, 467 58, 320 0	48.00 49.00 50.00
	05100 SUPPORT SURFACES OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	51.00
61. 00 62. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC	00	0		0 0 0 0	0	60.00 61.00 62.00
	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00 73.00	07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	31, 865 0	0		0 0 0 0	31, 865 0	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						80.00 81.00 82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONRELMBURSABLE COST CENTERS	0 15, 598, 204	0 972, 022	11, 1		0 15, 596, 146	83.00 89.00
90.00 91.00 92.00 93.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0 0 0 0	0 2, 035 0	:	0 0 23 0 0 0	0 2, 058 0 0	90.00 91.00 92.00 93.00
93.00 94.00 98.00 99.00	09300 NONPALD WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers		0			0	93.00 94.00 98.00 99.00
100.00	0	15, 598, 204	974, 057	11, 1	77 1, 615, 724		

	Financial Systems	GATEWAY CAR				u of Form CMS-	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 01/01/2023 Fo 12/31/2023	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	5/24/2024 11: DI ETARY	I3 am
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	1					1
1.00 2.00 3.00 4.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	3, 242, 496 171, 955	005 507				1.00 2.00 3.00 4.00
5.00 6.00	00600 LAUNDRY & LINEN SERVICE	92, 683	825, 507 24, 170		5		5.00 6.00
7.00	00700 HOUSEKEEPING	83, 745	24, 170				7.00
8.00	00800 DI ETARY	488, 427	90, 155			2, 484, 251	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	483, 188	12, 272		6, 710	2, 101, 201	1
10.00	01000 CENTRAL SERVICES & SUPPLY	57, 495	13,004		7, 110	0	1
11.00	01100 PHARMACY	8, 607	0		0 0	0	1
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0 0	0	12.00
13.00	01300 SOCIAL SERVICE	26, 407	4, 034	0	2, 205	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0 0	0	14.00
15.00	01500 ACTI VI TI ES	277, 460	25, 089	(13, 718	0	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			
30.00	03000 SKI LLED NURSI NG FACI LI TY	1, 391, 176	558, 965			2, 484, 251	30.00
31.00	03100 NURSING FACILITY	0	0			0	
32.00	03200 I CF/I I D	0	0			0	1
33.00	03300 OTHER LONG TERM CARE	0	0	(0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	40.00
40.00	04100 LABORATORY	1, 983	0			0	
42.00	04200 I NTRAVENOUS THERAPY	1, 705	0			0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	666	0			0	
44.00	04400 PHYSI CAL THERAPY	83, 717	24, 466		13, 377	0	
45.00	04500 OCCUPATIONAL THERAPY	35, 904	17, 816			0	45.00
46.00	04600 SPEECH PATHOLOGY	19, 918	16, 181	(8, 847	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 280	11, 322	(6, 191	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	15, 344	2, 819			0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			0	
51.00	05100 SUPPORT SURFACES	0	0	(0 0	0	51.00
(0.00		0	0			0	1 (0 00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0			0	
62.00	06200 FQHC	0	0		0	0	62.00
02.00	OTHER REIMBURSABLE COST CENTERS	1 1					02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	(0 0	0	70.00
71.00	07100 AMBULANCE	0	0			0	
73.00	07300 CMHC	0	0	(0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	(0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	3, 241, 955	823, 638	469, 116	424, 360	2, 484, 251	89.00
00.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN					0	90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP	0 541	1, 869			0	
91.00	09200 PHYSICIANS PRIVATE OFFICES	041	1,009		1,022	0	1
93.00	09300 NONPALD WORKERS	0	0			0	
94.00	09400 PATIENTS LAUNDRY	0	0			0	1
98.00	Cross Foot Adjustments	0	0		0	0	1
99.00	Negative Cost Centers	0	0	0	o o	0	99.00
100.00		3, 242, 496	825, 507	469, 116	425, 382	2, 484, 251	100.00
	· · ·						•

	Financial Systems	GATEWAY CAR	E CENTER		In Lie	eu of Form CMS-2	2540-10
COST #	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315177	Period: From 01/01/2023 To 12/31/2023		
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	2, 338, 634					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	296, 133				10.00
11.00	01100 PHARMACY	0	0	41, 3	20		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0 0		12.00
13.00	01300 SOCIAL SERVICE	0	0		0 0	133, 010	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15.00	01500 ACTI VI TI ES	0	0		0 0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			1
30.00	03000 SKILLED NURSING FACILITY	2, 338, 634	296, 133	41, 3	20 0	133, 010	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200 CF/I D	0	0		0 0		32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCI LLARY SERVICE COST CENTERS	1		1			
40.00	04000 RADI OLOGY	0	0		0 0		40.00
41.00		0	0		0 0		41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0		0 0		43.00 44.00
44.00	04400 PHISICAL THERAPT	0	0				44.00
46.00	04600 SPEECH PATHOLOGY	0	0				45.00
47.00	04700 ELECTROCARDI OLOGY	0	0				47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0			o o	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0		50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0		51.00
	OUTPATIENT SERVICE COST CENTERS			I			
60.00	06000 CLI NI C	0	0		0 0	0 0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	1 1		1		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		0	0		0 0	0 0	73.00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
81.00	08200 UTILIZATION REVIEW - SNF						81.00
83.00	08300 HOSPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	2, 338, 634	296, 133	41, 3			1
07.00	NONREI MBURSABLE COST CENTERS	2, 330, 034	270, 133	ц <u>т</u> , 5.		100,010	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0		91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0 0	92.00
93.00	09300 NONPAID WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
98.00	Cross Foot Adjustments	0	0				98.00
99.00	Negative Cost Centers	0	0		0 0	-	
100.00) TOTAL	2, 338, 634	296, 133	41, 3	20 0	133, 010	100. 00

Heal th	Financial Systems	GATEWAY CA	RE CENTER		In Lie	eu of Form CMS-	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi de	r No.: 315177	Period: From 01/01/2023 To 12/31/2023		
			OTHER GENERA	L		072172021 11.	
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS		1	1		1	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00 3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00							11.00
12.00 13.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						12.00 13.00
13.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTI VI TI ES			15			15.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		1,0,0,0				10.00
30.00	03000 SKILLED NURSING FACILITY	0	1, 370, 8	15 14, 676, 5	32 0	14, 676, 532	30.00
31.00	03100 NURSING FACILITY	0		0	0 0	0	31.00
32.00	03200 CF/I D	0		0	0 0		32.00
33.00	O3300 OTHER LONG TERM CARE	0		0	0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS		1				40.00
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY			0 0 9,5	0 0 21 0		40.00
41.00	04200 INTRAVENOUS THERAPY			9,0		9, 521	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0		0 3, 1	0	3, 198	
44.00	04400 PHYSI CAL THERAPY	0		0 439, 7		439, 744	•
45.00	04500 OCCUPATIONAL THERAPY	0		0 199, 9	23 0	199, 923	45.00
46.00	04600 SPEECH PATHOLOGY	0		0 120, 6	47 0	120, 647	•
47.00	04700 ELECTROCARDI OLOGY	0		0	0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0 33, 2		33, 260	
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY			0 78, C 0	24 0 0 0		
51.00	05100 SUPPORT SURFACES			0	0 0		
01100	OUTPATIENT SERVICE COST CENTERS		1		0		
60.00	06000 CLI NI C	0		0	0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0		0	0 0	0	61.00
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE			0 0 31,8	0 0 65 0		70.00
	07300 CMHC			0 31, 6	0 0		1
70.00	SPECIAL PURPOSE COST CENTERS					<u> </u>	/ 0. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0		0	0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	1, 370, 81	15 15, 592, 7	14 0	15, 592, 714	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	1	0	0 0	0	90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP			0 5,4		5, 490	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES			0	0 0	0	
93.00	09300 NONPAI D WORKERS	0		0	0 0	Ő	
94.00	09400 PATIENTS LAUNDRY	0		0	0 0	0	
98.00	Cross Foot Adjustments	0		0	0 0	0	
99.00	Negative Cost Centers	0		0	0 0		
100.00	TOTAL	0	1, 370, 81	15 15, 598, 2	04 0	15, 598, 204	1100.00

ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315177 Period: From 01/01 To 12/31 CAPITAL RELATED COSTS Cost Center Description Directly Assigned New Capital Related Costs 0 1.00 2.00 2A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES Provider No.: 315177 Period: From 01/01 To 12/31 Period: From 01/01 Period: Fro	/2023 Date/Time Prepa 5/24/2024 11: 13 al EMPLOYEE BENEFITS	
Cost Center Description Directly Assigned New Capital Related Costs Cost Center S Cost Center Description Capital Related Costs Cost CenterS Cost CenterS Capital Capita	BENEFITS	
Assigned New Capital Related Costs I.00 GENERAL SERVICE COST CENTERS I.00 CAP REL COSTS - BLDGS & FIXTURES I.00 Interview	BENEFITS	
O 1.00 2.00 2A I.00 CAP REL COST CENTERS Image: Cost of the second s	2.00	
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES	3.00	
		1.00
2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 3. 00 00300 EMPLOYEE BENEFITS 0 4, 578 53	4, 631 4, 631	2.00 3.00
	0, 296 470	3.00 4.00
	1, 284 71	5.00
	6, 615 155	6.00
	5, 707 107	7.00
	9, 276 577	8.00
		9.00
		10.00
11. 00 01100 PHARMACY 0 0 0 12. 00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0		11.00 12.00
		13.00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0		14.00
		15.00
INPATIENT ROUTINE SERVICE COST CENTERS		
	5, 517 1, 811 3	30.00
31.00 03100 NURSING FACILITY 0 0 0		31.00
		32.00
33.00 O3300 OTHER LONG TERM CARE O	0 3	33.00
40. 00 04000 RADI OLOGY 0 0 0	0 0 4	40.00
41.00 04100 LABORATORY 0 0 0		41.00
42. 00 04200 I NTRAVENOUS THERAPY 0 0 0 0		42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY 0 0 0	0 0 4	43.00
		44.00
		45.00
		46.00
47. 00 04700 ELECTROCARDI OLOGY 0 0 0 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 12, 326 141 1		47.00 48.00
		48.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0		50.00
51.00 05100 SUPPORT SURFACES 0 0 0		51.00
OUTPATIENT SERVICE COST CENTERS		
60. 00 06000 CLINIC 0 0 0	0 6	60.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0		61.00
	6	62.00
OTHER REIMBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST 0 0	0 0 7	70 00
71. 00 07100 AMBULANCE 0 0 0		70.00 71.00
73. 00 07300 CMHC 0 0 0		73.00
SPECIAL PURPOSE COST CENTERS	,	
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	3	80.00
81.00 08100 INTEREST EXPENSE		81.00
82. 00 08200 UTILIZATION REVIEW - SNF		82.00
83.00 08300 HOSPICE 0 0 0		83.00
89.00 SUBTOTALS (sum of lines 1-84) 0 972,022 11,154 98 NONREI MBURSABLE COST CENTERS 0 972,022 11,154 98	3, 176 4, 631 8	89.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0	0 9	90.00
		90.00
92. 00 09200 PHYSI CLANS PRI VATE OFFICES 0 0 0		92.00
93. 00 09300 NONPAI D WORKERS 0 0 0		93.00
94. 00 09400 PATIENTS LAUNDRY 0 0 0		94.00
98.00 Cross Foot Adjustments		98.00
99.00 Negative Cost Centers 0 0 100.00 TOTAL 0 974,057 11,177 98		99.00
	5, 234 4, 631 10	00.00

	Financial Systems	GATEWAY CAR				u of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	1	Period: From 01/01/2023 Fo 12/31/2023	Worksheet B Part II Date/Time Pre 5/24/2024 11:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1 00	GENERAL SERVICE COST CENTERS	1		1	1		1 1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	60, 766 3, 223 1, 737 1, 569 9, 154 9, 056 1, 078 161 0 495	14, 578 427 412 1, 592 217 230 0 0 71	28, 934 ((((((4 27, 795 3, 221 438 465 0 0 0 0 144	113, 820	9.00 10.00 11.00 12.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	495	0		0 0	0	
	01500 ACTI VI TI ES	5, 200	443		896	0	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 SKI LLED NURSI NG FACI LI TY	26, 070	9, 870			113, 820	
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D	0	0		0 0 0	0	
32.00	03300 OTHER LONG TERM CARE	0	0			0	1
00100	ANCI LLARY SERVICE COST CENTERS				<u> </u>		
40.00	04000 RADI OLOGY	0	0		0 0	0	40.00
41.00	04100 LABORATORY	37	0		0 0	0	
42.00	04200 INTRAVENOUS THERAPY	0	0		0	0	
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	12 1, 569	0 432		0 0 0 874	0	
45.00	04500 OCCUPATI ONAL THERAPY	673	315		637	0	
46.00	04600 SPEECH PATHOLOGY	373	286		578	0	1
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	61	200	1	404	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	288	50	1	101	0	
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0			0	
51.00	OUTPATIENT SERVICE COST CENTERS	U	0	<u> </u>	0	0	51.00
60.00	06000 CLINIC	0	0) (0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	(0 0	0	61.00
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS			1			70.00
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	1		0	
	07300 CMHC	0	0				73.00
	SPECIAL PURPOSE COST CENTERS				<u> </u>		10100
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPICE	0	U 14 E4E	20.02		112 020	1
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	60, 756	14, 545	28, 93	4 27, 728	113, 820	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	10	33	1	67	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	1	0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	
98.00	Cross Foot Adjustments		~		0	0	
99.00 100.00	Negative Cost Centers TOTAL	60 744	0 14, 578	20.02		0 113, 820	
100.00		60, 766	14, 5/8	28, 93	4 27, 795	113,820	100.00

Heal th	n Financial Systems	GATEWAY CAR	E CENTER		In Lie	u of Form CMS-:	2540-10
ALLOC	ATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/24/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS 00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG 00800 DI ETARY	24.042					2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	24,042	16, 09	2			9.00 10.00
11.00		0		0 16	1		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0			0 0		12.00
13.00	01300 SOCIAL SERVICE	0	(0	0 0	5, 197	13.00
14.00		0		°	0 0	0	14.00
15.00		0		0	0 0	0	15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	24,042	16, 09	2 16	1 0	5, 197	30.00
31.00		24,042			0 0	0	31.00
32.00		0			0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0		0	0 0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS	-		-1	-		
40.00		0			0 0	0	40.00
41.00 42.00		0		0	0 0	0	41.00 42.00
42.00		0		0		0	42.00
44.00		0		0	0 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0		0	0 0	0	45.00
46.00		0		0	0 0	0	46.00
47.00		0		0	0 0	0	47.00
48.00 49.00		0		0		0	48.00 49.00
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		0	0 0	0	49.00 50.00
51.00		0		-	0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00		0			0 0	0	60.00
61.00		0		0	0 0	0	61.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00		0		0	0 0	0	70.00
71.00		0			0 0	0	71.00
73.00		0		0	0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00							80.00
81.00 82.00							81.00 82.00
83.00		0		0	0 0	0	
89.00		24,042	16, 09				
	NONREI MBURSABLE COST CENTERS						
90.00		0		0	0 0	0	
91.00		0			0 0	0	
92.00 93.00		0			0 0	0	92.00
94.00		0		ŏ	0 0	0	94.00
98.00		0		-	0	Ū	98.00
99.00	Negative Cost Centers	0		0	0 0	0	99.00
100.0	0 TOTAL	24, 042	16, 09	2 16	1 0	5, 197	100.00

Heal th	Financial Systems	GATEWAY CA	RE CENTER		In Lie	u of Form CMS-:	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS			No.: 315177	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/24/2024 11:	
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	OTHER GENERAL SERVICE ACTIVITIES	- Subtotal	Post Step-Down Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 00
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ \end{array}$	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ \end{array}$
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITIES	0	34, 55	7			15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	0	34, 55	7 896, 0	41 0	896, 041	30.00
31.00	03100 NURSI NG 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 0	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS	0		al	0		40.00
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY	0		0	0 0 37 0	0 37	40.00
41.00	04200 INTRAVENOUS THERAPY	0			0 0	0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0		0	12 0	12	1
44.00	04400 PHYSI CAL THERAPY	0		0 29,9		29, 919	
45.00	04500 OCCUPATI ONAL THERAPY	0		0 21, 3	00 00	21, 300	45.00
46.00	04600 SPEECH PATHOLOGY	0		0 19, 0	82 0	19, 082	46.00
47.00	04700 ELECTROCARDI OLOGY	0		0	0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0 13, 1		13, 132	
49.00	04900 DRUGS CHARGED TO PATIENTS	0		0 3, 5		3, 543	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		0	0 0	0	
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVICE COST CENTERS	0		0	0 0	0	51.00
60.00	06000 CLINIC	0		0	0 0	0	60,00
61.00	06100 RURAL HEALTH CLINIC	0		o	0 0	0	
62.00	06200 FQHC			-			62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0		0	0 0		
	07100 AMBULANCE	0		0	0 0		
73.00	07300 CMHC	0		0	0 0	0	73.00
80, 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0		0	0 0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	0	34, 55	7 983, 0	66 0	983, 066	89.00
	NONREI MBURSABLE COST CENTERS	i		1			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0	0 0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0		0 2,1	68 0	2, 168	1
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0			0 0	0	•
93.00 94.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY					0	
94.00 98.00	Cross Foot Adjustments					0	
99.00 99.00	Negative Cost Centers	0		ŏ	0 0	0	
100.00		0	34, 55	7 985, 2			
		,		•			•

2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 57,451 2.0 2.0 2.00	Heal th	Financial Systems	GATEWAY CA	RE CENTER		In Lie	u of Form CMS-	2540-10
To 12/31/2023 District Time Program Cost Center Description BLOS & EXEMPTS (BAUMET) NOVABLE (BAUMET) (BAUMET) NOVABLE (BAUMET) (BAUMET) Description Adv 4.00 1 0.00 0.0000 (AP EL COST - CAULEG) (BAUMET) 1.00 2.00 3.00 AA 4.00 2 0.00000 (AP EL COST - CAULEG) (BAUMET) 1.00 2.00 3.00 AA 4.00 2 0.00000 (AP EL COST - MORAGE TEXTURES) (COURDE TEXTURE CENTER TEXTURES) 2.70 8.103.052 -3.242.496 0.23.283.434 4.00 2 0.00000 (AP EL COST - MORAGE TEXTURES) 2.77 8.103.052 -3.242.496 0.23.282.434 4.00 1 0.00000 (AP EL COST - MORAGE TEXTURES) 2.78 1.00.052 1.23.284.43 4.00 0 0.00000 (AP EL COST - MORAGE TEXTURES) 2.79 5.	COST A	LLOCATION - STATISTICAL BASIS		Provi der			Worksheet B-1	
Cost Center Description CAPITAL RELATED 00515 BLEGS (SUMPFET) (SUMPFET) (SUMPFET) BLEGVEE (SUMPFET)							Date/Time Pre	pared:
Loss Cost Genter Description HURS & EQUINET (SUMMET FEED) ROWING (SUMMET FEED) ROWING (SUMMET FEED) Record II at a with NL STRUT W (SUMMET) 0 00000 (00000 (SUMMET) 1.00 2.00 3.100 4A 4.00 1 0.00 00000 (SUMMET) 57.481 (SUMMET) 57.451 (SUMMET) 57			0451 TAL 55				5/24/2024 11:	13 am
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94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.0 98.00 Cross Foot Adjustments 99.00 Negative Cost Centers 99.0 99.00 11,177 1,615,724 99.0 99.0 102.00 Cost to be allocated (per Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 103.0 104.00 Cost to be allocated (per Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 103.0 105.00 Unit cost multiplier (Wkst. B, Part Fart I) 0.000572 0.004931 105.0			-	-				
98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 974,057 11,177 1,615,724 3,242,496 102.00 103.00 Unit cost multiplier (Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 103.00 104.00 Cost to be allocated (per Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 103.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000572 0.004931 105.00			-	-				
99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 974,057 11,177 1,615,724 3,242,496 102.00 103.00 Unit cost multiplier (Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 103.00 104.00 Cost to be allocated (per Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 103.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000572 0.004931 105.00			0	0	0	0	0	
102.00 Cost to be allocated (per Wkst. B, Part I) 10.974,057 11,177 1,615,724 3,242,496 102.0 103.00 Unit cost multiplier (Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 103.0 104.00 Cost to be allocated (per Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000572 0.004931 105.00								98.00
103.00 Part I) 16.954570 0.194548 0.199397 0.263108 10.0 104.00 Cost to be allocated (per Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 10.0 105.00 Unit cost multiplier (Wkst. B, Part 0.000572 0.004931 105.00			074 057	44 477	1 / 45 30			99.00
103.00 Unit cost multiplier (Wkst. B, Part I) 16.954570 0.194548 0.199397 0.263108 103.0 104.00 Cost to be allocated (per Wkst. B, Part II) 16.954570 0.194548 0.199397 0.263108 103.0 105.00 Unit cost multiplier (Wkst. B, Part 0.000572 0.004931 105.0	102.00		974,057	11, 177	1, 615, 724	ł	3, 242, 496	102.00
104.00 Cost to be allocated (per Wkst. B, Part II) 4,631 60,766 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000572 0.004931 105.00	103 00		16 05/570	0 10/5/0	0 10020-	,	0 262100	103 00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.000572 0.004931 105.00			10. 9545/0	0. 194548				
105.00 Unit cost multiplier (Wkst. B, Part 0.000572 0.004931 105.00	104.00				4,03		00,700	104.00
	105.00				0.000572	2	0.004931	105.00

Health Financial Systems		GATEWAY CAR				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASI	S		Provi der		eriod: rom 01/01/2023	Worksheet B-1	
					o 12/31/2023		
Cost Center Descriptio	on	PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	NURSI NG	
			LINEN SERVICE (PATIENT DAYS)		(MEALS SERVED)	ADMI NI STRATI ON	
		REPAI RS	(FAITENT DATS)			(PATIENT DAYS)	
		(SQUARE FEET)	(00	7.00	0.00	0.00	
GENERAL SERVICE COST CENTER	S	5.00	6.00	7.00	8.00	9.00	
1.00 00100 CAP REL COSTS - BLDGS							1.00
2.00 00200 CAP REL COSTS - MOVABI	LE EQUI PMENT						2.00
3.00 00300 EMPLOYEE BENEFITS 4.00 00400 ADMINISTRATIVE & GENEF	2A1						3.00 4.00
5.00 00500 PLANT OPERATION, MAIN		53,007					5.00
6.00 00600 LAUNDRY & LINEN SERVIC		1, 552	54, 510				6.00
7. 00 00700 HOUSEKEEPI NG		1,499	0				7.00
8.00 00800 DI ETARY 9.00 00900 NURSI NG ADMI NI STRATI ON	J	5, 789 788		5, 789 788		54, 510	8.00 9.00
10.00 01000 CENTRAL SERVICES & SUF		835	0	835		0	1
11.00 01100 PHARMACY		0	C	0	0	0	
12. 00 01200 MEDICAL RECORDS & LIBF 13. 00 01300 SOCIAL SERVICE	RARY	0 259	0	0 259	0	0	
14.00 01400 NURSING AND ALLIED HEA	ALTH EDUCATION	239					1
15. 00 01500 ACTIVITIES		1, 611	0		-		1
INPATIENT ROUTINE SERVICE C				1	1		
30. 00 03000 SKILLED NURSING FACILI 31. 00 03100 NURSING FACILITY	TY	35, 892 0	54, 510			54, 510 0	1
32. 00 03200 I CF/I I D		0		-	-		
33.00 03300 OTHER LONG TERM CARE		0	C				
ANCI LLARY SERVI CE COST CENT	ERS						1
40. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY		0	0		-		
42. 00 04200 I NTRAVENOUS THERAPY		0		0	0	0	
43.00 04300 OXYGEN (INHALATION) TH	IERAPY	0	C	0	0	0	1
44.00 04400 PHYSI CAL THERAPY		1, 571	0	1, 571		0	
45. 00 04500 OCCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY		1, 144 1, 039		1, 144 1, 039		0	
47. 00 04700 ELECTROCARDI OLOGY		0	0	0		0	
48.00 04800 MEDICAL SUPPLIES CHARC		727	0	727		0	
49.00 04900 DRUGS CHARGED TO PATIE		181	0	181		0	
50. 00 05000 DENTAL CARE - TITLE XI 51. 00 05100 SUPPORT SURFACES	X UNLY	0					
OUTPATIENT SERVICE COST CEN	TERS						
60. 00 06000 CLINIC		0	C			0	
61.00 06100 RURAL HEALTH CLINIC 62.00 06200 FQHC		0	C	0	0	0	
OTHER REIMBURSABLE COST CEN	TERS						62.00
70.00 07000 HOME HEALTH AGENCY COS		0					70.00
71.00 07100 AMBULANCE		0			-		71.00
73.00 07300 CMHC SPECIAL PURPOSE COST CENTER	e	0	0	0	0	0	73.00
80. 00 08000 MALPRACTICE PREMIUMS &							80.00
81.00 08100 INTEREST EXPENSE							81.00
82.00 08200 UTI LI ZATI ON REVIEW - 5	SNF	0					82.00
83.00 08300 HOSPICE 89.00 SUBTOTALS (sum of line	as 1-84)	0 52, 887	54, 510	49, 836	163, 530	0 54, 510	
NONREI MBURSABLE COST CENTER		02,007	01,010	17,000	100,000	01,010	
90.00 09000 GIFT, FLOWER, COFFEE S		0	C				
91. 00 09100 BARBER AND BEAUTY SHOP 92. 00 09200 PHYSI CLANS PRI VATE OFF		120	0	120	0	0	1
92. 00 09200 PHYSI CLANS PRI VATE OFF 93. 00 09300 NONPALD WORKERS	TUES	0			0	0	1
94. 00 09400 PATI ENTS LAUNDRY		0	c c	0	0	0	1
98.00 Cross Foot Adjustments	5						98.00
99.00 Negative Cost Centers	(nor Wket R	925 507	140 114	425 202	2 404 251	2 220 424	99.00
102.00 Cost to be allocated (Part I)	μοι ωκει. Β,	825, 507	469, 116	425, 382	2, 484, 251	2, 338, 634	102.00
103.00 Unit cost multiplier ((Wkst. B, Part I)	15. 573547	8. 606054	8. 515133	15. 191408	42. 902844	103.00
104.00 Cost to be allocated ((per Wkst. B,	14, 578	28, 934	27, 795	113, 820	24, 042	104.00
Part II) 105.00 Unit cost multiplier (Wkst. B Part	0. 275020	0. 530802	0. 556390	0. 696019	0. 441057	105 00
		0.2,0020					

	Financial Systems	GATEWAY CA				u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2023	Worksheet B-1	
				T	o 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	NURSI NG AND	
		SERVICES & SUPPLY	(PATIENT DAYS)	RECORDS & LI BRARY	(PATIENT DAYS)	ALLI ED HEALTH EDUCATI ON	
		(PATIENT DAYS)		(PATIENT DAYS)	· /	(ASSI GNED	
						TIME)	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3.00 4.00
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	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8.00 9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	54, 510					10.00
11.00	01100 PHARMACY	0	54, 510				11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0.,0.0			12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION				,	0	13.00 14.00
15.00	01500 ACTI VI TI ES	0	-	-	-	0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	1			1
30.00	03000 SKI LLED NURSI NG FACI LI TY	54, 510				0	
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D				-	0	31.00 32.00
33.00	03300 OTHER LONG TERM CARE				-	0	•
	ANCILLARY SERVICE COST CENTERS	1	1				1
40.00	04000 RADI OLOGY	0				0	
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0			-	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0			0	0	
44.00	04400 PHYSI CAL THERAPY	0	0) C	0	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0		0	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY				0	0	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	C	C	0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	-	-	-	0	
51.00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	C) C	0	0	51.00
60, 00	06000 CLINIC	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0				0	•
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS	0	C		0	0	70.00
	07100 AMBULANCE						70.00
	07300 CMHC	0	0) C	0	0	
~~ ~~	SPECIAL PURPOSE COST CENTERS	1	1	1			
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
81.00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						81.00
83.00	08300 HOSPI CE	0	0	c c	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	54, 510	54, 510	54, 510	54, 510	0	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	C		0	0	90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP				-	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0) C	0	0	1
93.00	09300 NONPAI D WORKERS	0	0	0	0	0	
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0			0	0	
98.00 99.00	Negative Cost Centers						98.00 99.00
102.00		296, 133	41, 320	c c	133, 010	0	102.00
	Part I)						
103.00 104.00		5. 432636 16, 092				0.000000	103.00 104.00
104.00	Part II)	10, 092	101		5, 197	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part	0. 295212	0. 002954	0. 000000	0. 095340	0.000000	105.00
	11)	l					I

	Financial Systems LLOCATION - STATISTICAL BASIS	GATEWAY CAR	Provider No.: 315177	Period:	u of Form CMS-2540-1 Worksheet B-1
CU31 F	LEUCATION - STATISTICAL DASIS			From 01/01/2023	
				To 12/31/2023	Date/Time Prepared: 5/24/2024 11:13 am
		OTHER GENERAL			
	Cost Center Description	SERVICE ACTIVITIES			
		(PATIENT DAYS)			
		15.00			
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00	00300 EMPLOYEE BENEFITS				3.00
4.00	00400 ADMI NI STRATI VE & GENERAL				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG				6. 00 7. 00
8.00	00800 DI ETARY				8.00
9.00	00900 NURSI NG ADMI NI STRATI ON				9.00
10.00	01000 CENTRAL SERVICES & SUPPLY				10.00
11.00	01100 PHARMACY				11.00
12.00	01200 MEDICAL RECORDS & LIBRARY				12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION				13.00
	01500 ACTIVITIES	54, 510			15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	01/010			10100
30.00	03000 SKI LLED NURSI NG FACI LI TY	54, 510			30.00
	03100 NURSING FACILITY	0			31.00
32.00	03200 I CF/I I D	0			32.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0			33.00
40.00	04000 RADI OLOGY	0			40.00
41.00	04100 LABORATORY	0			41.00
42.00	04200 I NTRAVENOUS THERAPY	0			42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0			43.00
44.00	04400 PHYSI CAL THERAPY	0			44.00
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0			45. 00 46. 00
40.00	04700 ELECTROCARDI OLOGY	0			40.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0			49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			50.00
51.00	05100 SUPPORT SURFACES	0			51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0			60.00
61.00	06100 RURAL HEALTH CLINIC	0			61.00
62.00	06200 FQHC				62.00
	OTHER REIMBURSABLE COST CENTERS	1			
70.00	07000 HOME HEALTH AGENCY COST	0			70.00
	07100 AMBULANCE 07300 CMHC	0			71.00
, 5. 00	SPECIAL PURPOSE COST CENTERS				/3.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00	08100 INTEREST EXPENSE				81.00
82.00	08200 UTILIZATION REVIEW - SNF	_			82.00
83.00	08300 HOSPICE	0 E4 E10			83.00
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	54, 510			89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90.00
91.00	09100 BARBER AND BEAUTY SHOP	0			91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0			92.00
93.00	09300 NONPAI D WORKERS	0			93.00
94.00 98.00	09400 PATIENTS LAUNDRY	0			94.00 98.00
98.00 99.00	Cross Foot Adjustments Negative Cost Centers				98.00
102.00	5	1, 370, 815			102.00
	Part I)				
103.00		25. 147955			103.00
104.00		34, 557			104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 633957			105.00
		2. 000 / 0 /			1.00.00

Health Financial Systems GATEW.	AY CARE CENTER	In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST C	ENTERS Provider No.: 315177	Period:	Worksheet C	
		From 01/01/2023 To 12/31/2023	Date/Time Pre	nared
			5/24/2024 11:	
Cost Center Description	Total (from			
	Wkst. B, Pt I	1	di vi ded by	
	<u>col. 18)</u>		col. 2	
	1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS			0.00000	
40. 00 04000 RADI OLOGY		0 0	0.00000	
41.00 04100 LABORATORY	9, 52	7, 538		
42. 00 04200 I NTRAVENOUS THERAPY		0 0	0.000000	
43. 00 04300 0XYGEN (INHALATION) THERAPY	3, 19			
44. 00 04400 PHYSI CAL THERAPY	439, 74			
45. 00 04500 OCCUPATI ONAL THERAPY	199, 92		0. 684923	
46.00 04600 SPEECH PATHOLOGY	120, 64	68, 802		
47. 00 04700 ELECTROCARDI OLOGY		0 0	0.000000	
48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	33, 26		0.000000	
49.00 04900 DRUGS CHARGED TO PATIENTS	78, 02	24 55, 216	1.413069	•
50.00 05000 DENTAL CARE - TITLE XIX ONLY		0 0	0.00000	•
51. 00 05100 SUPPORT SURFACES		0 0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS		0 0	0,000000	(0.00
60. 00 06000 CLINIC		0 0	0. 000000	
61. 00 06100 RURAL HEALTH CLINIC				61.00
62. 00 06200 FQHC	21.0	F 21.04F	1 000000	62.00
71. 00 07100 AMBULANCE	31, 86			•
100. 00 Total	916, 18	713, 543		100. 00

41.00 04100 LABORATORY 1.263067 0 0 0 42.00 04200 I NTRAVENOUS THERAPY 0.000000 0 0 0 0 43.00 04300 OXYGEN (I NHALATI ON) THERAPY 1.263033 0 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66, 370 0 114, 141 0 45.00 04500 OCCUPATI ONAL THERAPY 0.684923 74, 530 0 51, 047 0	
PART 1 CALCULATION OF ANCI LLARY AND OUTPATIENT COST Part A Part B Part A (col. 1) Part B Part A (col. 2) Part B (col. 3) 40.00 04000 RADIOLOGY 0.000000 0	
PART I - CALCULATION OF ANCI LLARY AND OUTPATI ENT COST Part A Part A Part A Part B Part A (col. 1) Part B (col. 1) x col. 2) x col. 3) 40.00 04000 RADIOLOGY 0.000000 0 </td <td></td>	
PART I - CALCULATION OF ANCI LLARY AND OUTPATIENT COST - Column 3) - Column 3)	
PART I CALCULATION OF ANCI LLARY AND OUTPATI ENT COST Part A Part B Part A (col. 1 x col. 2) Part B (col. 1 x col. 3) 40.00 04000 RADI OLOGY 0.000000 0	
PART I CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS 0.000000 0	
to Charges (Fr. Wkst. C Col um 3) x col. 2) x col. 3) 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVI CE COST CENTERS 0.00000 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04200 I NTRAVENOUS THERAPY 0.000000 0 0 0 0 43.00 04300 OXYGEN (I NHALATION) THERAPY 1.263033 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66, 370 0 114, 141 0 45.00 04500 OCUPATI ONAL THERAPY 0.684923 74, 530 0 51, 047 0	
to Charges (Fr. Wkst. C Col um 3) x col. 2) x col. 3) 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVI CE COST CENTERS 0.00000 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04200 I NTRAVENOUS THERAPY 0.000000 0 0 0 0 43.00 04300 OXYGEN (I NHALATION) THERAPY 1.263033 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66, 370 0 114, 141 0 45.00 04500 OCUPATI ONAL THERAPY 0.684923 74, 530 0 51, 047 0	
to Charges (Fr. Wkst. C Column 3) x col. 2) x col. 3) PART 1 - CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04000 RADI OLOGY 0.000000 0 0 0 0 40.00 04100 LABORATORY 1.263067 0 0 0 0 0 43.00 04300 NYGEN (INHALATI ON) THERAPY 0.000000 0 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66, 370 0 114, 141 0 45.00 04500 OCUPATI ONAL THERAPY 0.684923 74, 530 0 51, 047 0	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS 0.000000 0	
Column 3) Column 3) 1.00 2.00 3.00 4.00 5.00 PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0.000000 0 0 0 41.00 04100 LABORATORY 0.000000 0 0 0 0 42.00 04200 INTRAVENOUS THERAPY 0.000000 0 0 0 0 43.00 04400 PHYSI CAL THERAPY 1.263033 0 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66, 370 0 114, 141 0 45.00 04500 OCCUPATI ONAL THERAPY 0.684923 74, 530 0 51, 047 0	
PART I CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS 0.000000 0 0 0 0 40.00 04000 RADIOLOGY 0.000000 0 0 0 0 41.00 04100 LABORATORY 1.263067 0 0 0 0 42.00 04200 INTRAVENOUS THERAPY 0.000000 0 0 0 43.00 04300 OX400 PHYSI CAL THERAPY 1.263033 0 0 0 45.00 04500 OCUPATI ONAL THERAPY 0.684923 74,530 0 51,047 0	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS 0.000000 0 <td< td=""><td></td></td<>	
ANCI LLARY SERVICE COST CENTERS 40.00 04000 RADI 0LOGY 0.000000 0 0 0 41.00 04100 LABORATORY 0.263067 0 0 0 0 42.00 04200 INTRAVENOUS THERAPY 0.000000 0 0 0 0 43.00 04300 XYGEN (I NHALATI 0N) THERAPY 1.263033 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66, 370 0 114, 141 0 45.00 04500 OCUPATI 0NAL THERAPY 0.684923 74, 530 0 51, 047 0	
40. 00 04000 RADI OLOGY 0.00000 0 <td></td>	
41.00 04100 LABORATORY 1.263067 0 0 0 42.00 04200 INTRAVENOUS THERAPY 0.000000 0 0 0 43.00 04300 0XYGEN (INHALATION) THERAPY 1.263033 0 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66,370 0 114,141 0 45.00 04500 OCUPATI ONAL THERAPY 0.684923 74,530 0 51,047 0	40.00
42.00 04200 INTRAVENOUS THERAPY 0.000000 0 0 0 43.00 04300 0XYGEN (INHALATION) THERAPY 1.263033 0 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66,370 0 114,141 0 45.00 04500 OCUPATI ONAL THERAPY 0.684923 74,530 0 51,047 0	41.00
43.00 04300 0XYGEN (I NHALATI ON) THERAPY 1.263033 0 0 0 44.00 04400 PHYSI CAL THERAPY 1.719772 66, 370 0 114, 141 0 45.00 04500 OCCUPATI ONAL THERAPY 0.684923 74, 530 0 51, 047 0	42.00
44. 00 04400 PHYSI CAL THERAPY 1. 719772 66, 370 0 114, 141 0 45. 00 04500 OCCUPATI ONAL THERAPY 0. 684923 74, 530 0 51, 047 0	43.00
45. 00 04500 OCCUPATI ONAL THERAPY 0. 684923 74, 530 0 51, 047 0	44.00
	45.00
46. 00 04600 SPEECH PATHOLOGY 1. 753539 16, 450 0 28, 846 0	46.00
47. 00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0	47.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 000000 0 0 0 0	48.00
49. 00 04900 DRUGS CHARGED TO PATI ENTS 1. 413069 0 0 0 0	49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0. 000000 0 0	50.00
51.00 05100 SUPPORT SURFACES 0.000000 0 0 0 0	51.00
OUTPATIENT SERVICE COST CENTERS	
60. 00 06000 CLINIC 0. 000000 0 0 0 0	60.00
	61.00
	62.00
	71.00
100.00 Total (Sum of lines 40 - 71) 157, 350 0 194, 034 0 1 (1) For title V and VIV use selemes 1 - 2 and 4 calu	00.00

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

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

Health Financial Systems	GATEWAY CAR	E CENTER		In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315177	Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description						
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00Drugs charged to patients - ratio of co2.00Program vaccine charges (From your reco3.00Program costs (Line 1 x line 2) (TitleE, Part I, line 18)	rds, or the PS&	aR)			1. 413069 743 1, 050	1.00 2.00 3.00
Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	(From Wkst. B,		I I, Col. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH						-
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY			0.0000		0	40,00
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY 43. 00 04300 0XYGEN (I NHALATI ON) THERAPY 44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 0CCUPATI ONAL THERAPY 45. 00 04600 SPEECH PATHOLOGY	9, 521 0 3, 198 439, 744 199, 923 120, 647		0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000	00 0 00 0 00 0 00 114, 141 00 51, 047	0 0 0 0	41.00 42.00 43.00
47. 00 04700 ELECTROCARDIOLOGY 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 51. 00 05100 SUPPORT SURFACES 100. 00 Total (Sum of lines 40 - 52)	0 33, 260 78, 024 0 0 884, 317		0. 00000 0. 00000 0. 00000 0. 00000 0. 00000		0 0 0 0 0	47.00 48.00 49.00 50.00

Health Financial Systems GATEW. COMPUTATION OF INPATIENT ROUTINE COSTS		Provider No.: 315177	Peri od: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Pre 5/24/2024 11:	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				1
. 00	Inpatient days including private room days			54, 487	1.00
. 00	Private room days			0	2.00
. 00	Inpatient days including private room days applicable to th	e Program		2, 158	3.00
. 00	Medically necessary private room days applicable to the Pro	gram		0	4.00
. 00	Total general inpatient routine service cost			14, 676, 532	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
. 00	General inpatient routine service charges			15, 591, 041	6.00
. 00	General inpatient routine service cost/charge ratio (Line	5 divided by line 6)		0.941344	7.0
8.00	Enter private room charges from your records			0	8.0
. 00	Average private room per diem charge (Private room charges 2)	line 8 divided by private	room days, line	0.00	9.0
0.00	Enter semi-private room charges from your records			0	10.0
1. 00	Average semi-private room per diem charge (Semi-private ro semi-private room days)	om charges line 10, divide	d by	0.00	11.0
2.00	Average per diem private room charge differential (Line 9 m	inus line 11)		0.00	12.0
3.00	Average per diem private room cost differential (Line 7 tim	es line 12)		0.00	13.0
4.00	Private room cost differential adjustment (Line 2 times lin	e 13)		0	14. C
5.00	General inpatient routine service cost net of private room PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus line 14)	14, 676, 532	15. C
6.00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		269.36	16.0
7.00	Program routine service cost (Line 3 times line 16)	-		581, 279	17. C
8.00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18.0
9.00	Total program general inpatient routine service cost (Line	17 plus line 18)		581, 279	19. (
0. 00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	896, 041	20.0
1. 00	Per diem capital related costs (Line 20 divided by line 1)			16.45	21.0
2.00	Program capital related cost (Line 3 times line 21)			35, 499	22.0
3.00	Inpatient routine service cost (Line 19 minus line 22)			545, 780	23.0
4.00	Aggregate charges to beneficiaries for excess costs (From			0	1 - · · ·
	Total program routine service costs for comparison to the c	ost limitation (Line 23 mi	nus line 24)	545, 780	25.0
	Enter the per diem limitation (1)				26.0
	Inpatient routine service cost limitation (Line 3 times the				27.0
8. 00	Reimbursable inpatient routine service costs (Line 22 plus		line 27)		28. (
	(Transfer to Worksheet E, Part II, line 4) (See instruction	s) • used for title V and or t			I .

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	54, 487	1.00
2.00	Program inpatient days (see instructions)	2, 158	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. 039606	4.00
	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

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Ieal th Financi al Systems GATEWAY COMPUTATION OF INPATIENT ROUTINE COSTS GATEWAY		Provider No.: 315177	Period: From 01/01/2023	Worksheet D-1 Parts I-II	
			To 12/31/2023	Date/Time Pre 5/24/2024 11:	
		Title XIX	Skilled Nursing Facility	Cost	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS]
. 00	Inpatient days including private room days			54, 487	1.0
. 00	Private room days			0	2.0
. 00	Inpatient days including private room days appl	licable to the Program		47, 193	3.0
. 00	Medically necessary private room days applicabl	le to the Program		0	4. C
. 00	Total general inpatient routine service cost			14, 676, 532	5.C
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
. 00	General inpatient routine service charges			15, 591, 041	
. 00	General inpatient routine service cost/charge i	ratio (Line 5 divided by line 6)		0. 941344	7.0
. 00	Enter private room charges from your records			0	8.0
. 00	Average private room per diem charge (Private 1 2)	room charges line 8 divided by private	room days, line	0.00	9.
0. 00	0 Enter semi-private room charges from your records				10.0
1. 00	Average semi-private room per diem charge (Ser semi-private room days)		ed by	286.14	11. (
2.00	Average per diem private room charge differenti	ial (Line 9 minus line 11)		0.00	12.0
3.00	Average per diem private room cost differential	l (Line 7 times line 12)		0.00	13.0
4.00	Private room cost differential adjustment (Line	e 2 times line 13)		0	14.
5.00	General inpatient routine service cost net of p PROGRAM INPATIENT ROUTINE SERVICE COSTS	private room cost differential (Line 5	minus line 14)	14, 676, 532	15.
6.00	Adjusted general inpatient service cost per die	em (line 15 divided by line 1)		269.36	16 (
	Program routine service cost (Line 3 times lin			12, 711, 906	
	Medically necessary private room cost applicabl			0	18.
	Total program general inpatient routine service			12, 711, 906	-
	Capital related cost allocated to inpatient rou		rt II column 18	896, 041	
0.00	line 30 for SNF; line 31 for NF, or line 32 for			0,0,011	20.
1.00	Per diem capital related costs (Line 20 divide			16.45	21.
	Program capital related cost (Line 3 times lin			776, 325	
	Inpatient routine service cost (Line 19 minus			11, 935, 581	
	Aggregate charges to beneficiaries for excess of			0	
	Total program routine service costs for compari		inus line 24)	11, 935, 581	
	Enter the per diem limitation (1)			0.00	
	Inpatient routine service cost limitation (Line	e 3 times the per diem limitation line	26) (1)	0	27.
	Reimbursable inpatient routine service costs (I (Transfer to Worksheet E, Part II, line 4) (See	Line 22 plus the lesser of line 25 or		12, 711, 906	

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		1
1.00	Total SNF inpatient days	54, 487	1.00
2.00	Program inpatient days (see instructions)	47, 193	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. 866133	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

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Heal th	Financial Systems GATEWAY CA	ARE CENTER	In Lie	u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provi der No.: 315177	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prep 5/24/2024 11:	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REI	MBURSEMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)			1, 368, 286	1.00
2.00	Nursing and Allied Health Education Activities (pass throu	ugh payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)	5 1 5 7		1, 368, 286	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			270, 800	5.00
6.00	Allowable bad debts (From your records)			312, 252	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See i	nstructions)		71, 595	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			202, 964	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			1, 300, 450	11.00
12.00	Interim payments (See instructions)			1, 307, 307	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestrati	on		0	14.50
14.55	Demonstration payment adjustment amount after sequestration			0	14.55
14.75	Sequestration for non-claims based amounts (see instruction	ons)			
14.99	Sequestration amount (see instructions)			21, 950	
15.00				-32, 866	15.00
16.00	Protested amounts (Nonallowable cost report items in accor			0	16.00
17 00	PART B - ANCI LLARY SERVICE COMPUTATION OF REIMBURSEMENT LE	SSER OF COST OR CHARGES - I	TILE XVIII ONLY	0	17 00
17.00	Ancillary services Part B			0	17.00 18.00
18.00 19.00	Vaccine cost (From Wkst D, Part II, line 3) Total reasonable costs (Sum of lines 17 and 18)			1, 050 1, 050	
20.00	Medicare Part B ancillary charges (See instructions)			743	
20.00	Cost of covered services (Lesser of Line 19 or Line 20)			743	
22.00	Primary payor amounts			,43	22.00
23.00	Coinsurance and deductibles			0	23.00
24.00	Allowable bad debts (From your records)			0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see i	nstructions)		0	24.0
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)			743	
26.00	Interim payments (See instructions)			654	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50	Demonstration payment adjustment amount before sequestrati	on		0	28.50
28.55	Demonstration payment adjustment amount after sequestration			0	28.55
28. 99	Sequestration amount (see instructions)			15	28.99
29.00	Balance due provider/program (see instructions)			74	29.00
	Protested amounts (Nonallowable cost report items) in acco	ordance with CMS Pub 15-2 s	ection 115 2	0	30.00

	2	CARE CENTER			u of Form CMS-2	2540-
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX O	NLY Provider 1	No.: 315177	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part II Date/Time Pre 5/24/2024 11:	pareo
		Titl	e XIX	Skilled Nursing		15 ai
				Facility		
					1.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1.00	
. 00	Inpatient ancillary services (see Instructions)				0	1 1.
. 00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II	line 5)			0	
. 00	Outpatient services	,			0	
. 00	Inpatient routine services (see instructions)				12, 711, 906	
. 00	Utilization reviewphysicians' compensation (from provid	der records)			0	1
. 00	Cost of covered services (Sum of Lines 1 - 5)	,			12, 711, 906	6.
. 00	Differential in charges between semiprivate accommodation	ns and less than s	semi pri vate	accommodations	0	7.
3. 00	SUBTOTAL (Line 6 minus line 7)		·		12, 711, 906	8.
. 00	Primary payor amounts				0	9.
0. 00	Total Reasonable Cost (Line 8 minus line 9)				12, 711, 906	10.
	REASONABLE CHARGES					
1.00	Inpatient ancillary service charges				0	11.
	Outpatient service charges				0	
	Inpatient routine service charges				0	
	Differential in charges between semiprivate accommodation	ns and less than s	semi pri vate	accommodations	0	
5.00	Total reasonable charges				0	15
	CUSTOMARY CHARGES	<u> </u>				
	Aggregate amount actually collected from patients liable				0	
7.00	Amounts that would have been realized from patients liabl had such payment been made in accordance with 42 CFR 413.		services o	n a charge basis	0	17
8. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)	13(0)			0.000000	18.
	Total customary charges (see instructions)				0.000000	
7.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				0	1 1 1
0.00	Cost of covered services (see Instructions)				0	20
1.00	Deducti bl es				0	
	Subtotal (Line 20 minus line 21)				0	
3.00	Coinsurance				0	
4.00	Subtotal (Line 22 minus line 23)				0	24
	Allowable bad debts (from your records)				0	25
6.00	Subtotal (sum of lines 24 and 25)				0	26
7.00	Unrefunded charges to beneficiaries for excess costs erro	oneously collected	based on c	orrection of	0	27
8.00	Recovery of excess depreciation resulting from provider	termination or a c	lecrease in	program	0	28
0.00	utilization			5. 5 <u>9</u> . dili	0	1 20
9.00	Other Adjustments (see instructions) Specify				0	29
	Amounts applicable to prior cost reporting periods result if minus, enter amount in parentheses)	ting from disposit	tion of depr	eciable assets (0	
1. 00	Subtotal (Line 26 plus or minus lines 29, and 30, minus	lines 27 and 20)			0	31
	Interim payments	11103 Z7 and 20)			0	
3.00	Balance due provider/program (Line 31 minus line 32) (ind	dicate overnavment	ts in parent	heses) (see	0	
5. 50	Instructions)				0	1 33.

			No.: 315177	Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XVIII	Skilled Nursing Facility		
		Inpatien	nt Part A		T B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		1, 075, 5 264, 2		654 0	1.(
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04 05				0	0	3.
55	Provider to Program			0	0	5
50	ADJUSTMENTS TO PROGRAM	07/19/2023	32, 4	.91	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-32, 4	.91	0	3
00	- 3.98) Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		1, 307, 3	07	654	4
	TO BE COMPLETED BY CONTRACTOR		I			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
1	Program to Provi der TENTATI VE TO PROVI DER				0	-
)1)2	TENTATIVE TO PROVIDER			0	0	5 5
)2				0	0	5
-	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52 99	Subtatal (Sum of Linac E 01 E 40 minus sum of Lines E 50			0	0	5 5
9	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			U	0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVI DER			0	74	6
)2	PROVIDER TO PROGRAM		32, 8		0	6
00	Total Medicare program liability (see instructions)		1, 274, 4		728	7
			Contra	actor Name	Contractor	
				1.00	Number 2.00	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der	F	eriod: rom 01/01/2023	Worksheet G	
y)		Concerned Frend		o 12/31/2023	Date/Time Pre 5/24/2024 11:	
		General Fund	Purpose Fund	Endowment Fund	Plant Fund	
	Assets	1.00	2.00	3.00	4.00	+
	CURRENT ASSETS	T		1		1
0	Cash on hand and in banks	1, 019, 659	0	0	0	
0	Temporary investments Notes receivable	0	0	0	0	
0	Accounts receivable	2,971,800	-	0	0	
0	Other recei vabl es	-788, 901	0	0	0	
0	Less: allowances for uncollectible notes and accounts	0	0	0	0	
_	recei vabl e					
0	Inventory Prepaid expenses	-242, 120		0	0	
0	Other current assets	1, 542, 930		0	0	
00	Due from other funds	0	0	0	0	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4, 503, 368	0	0	0) 1
	FI XED ASSETS	-	-			4.
00	Land	0			0	
00 00	Land improvements Less: Accumulated depreciation	0	0		0	
00	Buildings	0	0	0	0	
00	Less Accumulated depreciation	0	0	0	0	
00	Leasehold improvements	1, 975, 458		0	0	1
00	Less: Accumulated Amortization	-1, 444, 168		0	0	
00	Fixed equipment Less: Accumulated depreciation	0	0	0	0	
00 00	Automobiles and trucks	0	0	0	0	
00	Less: Accumulated depreciation	0	0	0	0	
00	Major movable equipment	1, 524, 057	0	0	0	
00	Less: Accumulated depreciation	-1, 517, 863	0	0	0	2
00	Minor equipment - Depreciable	0	0	0	0	
00	Minor equipment nondepreciable	0	0	0	0	
00 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	537, 484	0		0	
00	OTHER ASSETS		0	<u> </u>	0	1 2
00	Investments	0	0	0	0	0 2
00	Deposits on Leases	0	0	0	0	3 3
00	Due from owners/officers	0	0	0	0	
00	Other assets	14,005		0	0	
00 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32) TOTAL ASSETS (Sum of lines 11, 28, and 33)	14, 005 5, 054, 857	0		0	
00	Liabilities and Fund Balances	0,001,007	0			ľ
	CURRENT LI ABI LI TI ES					
00	Accounts payable	0	0		0	
00	Salaries, wages, and fees payable	-30, 233			0	
00	Payroll taxes payable Notes & Loans payable (Short term)	-9, 597	0	Ŭ	0 0	
00 00	Deferred income	0		0	0	
00	Accel erated payments	0			0	4
00	Due to other funds	0	0	0	0	4
00	Other current liabilities	5, 502, 658			0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	5, 462, 828	0	0	0	4
00	LONG TERM LI ABI LI TI ES	0	0	0	0	0 4
00	Mortgage payable Notes payable	0			0	
00	Unsecured Loans	0	0	-	0	
00	Loans from owners:	0	0	Ő	0	
00	Other long term liabilities	0	0	0	0	
	OTHER (SPECIFY)	0	0	0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	Б 440 000	0		0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS	5, 462, 828	0	U U	0	1 2
00	General fund balance	-407, 971				5
00	Specific purpose fund		0			5
00	Donor created - endowment fund balance - restricted			0		5
00	Donor created - endowment fund balance - unrestricted			0		5
00	Governing body created - endowment fund balance			0	~	5
00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
00	replacement, and expansion				0	5
		1				-
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-407, 971	()	01	0) 5

Heal th	Financial Systems	GATEWAY CAR	E CENTER		In Li	eu of Form CMS-	2540-10
	IENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315177	Period: From 01/01/2023 To 12/31/2023	3 Date/Time Pre 5/24/2024 11:	pared: <u>13 am</u>
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) CAPTIAL Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17)	265, 088 0 0 0 0 0 0 0 0 0 0 0	2:00 819, 118 -1, 492, 177 -673, 059 265, 088 -407, 971		0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-407, 971		1	0	19.00
		Endowment Fund		Fund			
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) CAPTIAL	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	0 0 0 0 0	0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems	GATEWAY CARE CE	NTER			In Lie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315177	Peri Froi To		Worksheet G-2 Parts I-II Date/Time Pre 5/24/2024 11:	pared:
	Cost Center Description			Inpati ent		Outpati ent	Total	
				1.00		2.00	3.00	
	PART I - PATIENT REVENUES							
	General Inpatient Routine Care Services							
1.00	SKILLED NURSING FACILITY			15, 591, 04	41		15, 591, 041	1.00
2.00	NURSING FACILITY				0		0	2.00
3.00					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, 591, 04	41		15, 591, 041	5.00
0.00	All Other Care Services	11105 1 17		10,071,0		I	10, 071, 011	0.00
6.00	ANCI LLARY SERVICES			713, 54	43	0	713, 543	6.00
7.00				,10,0-	13	0	, 13, 343	7.00
8.00	HOME HEALTH AGENCY COST					0	0	8.00
9.00	AMBULANCE					0	0	9,00
7.00 10.00	RURAL HEALTH CLINIC					0	0	10.00
						0		
10.10	FQHC					0	0	10.10
11.00	CMHC				~	0	0	11.00
	HOSPI CE				0	0	0	12.00
13.00	OTHER (SPECIFY)				0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (1 Worksheet G-3, Line 1)	Fransfer column 3	to	16, 304, 58	84	0	16, 304, 584	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	ne 100)			1	1	17, 459, 473	1.00
2.00	Add (Specify)	ne 100)				0	17,437,473	2.00
2.00	Add (Specify)					0		3.00
3.00 4.00						0		3.00 4.00
4.00 5.00						0		
						0		5.00
6.00						0		6.00
7.00						0		7.00
8.00	Total Additions (Sum of lines 2 - 7)						0	8.00
9.00	Deduct (Specify)					0		9.00
10.00						0		10.00
11.00						0		11.00
12.00						0		12.00
13.00						0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)						0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8,	minus line 14)					17, 459, 473	15.00

Heal th	Financial Systems	GATEWAY CARE CE	ENTER	In Lie	u of Form CMS-2	2540-10		
STATEM	STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315177 Period:							
	From 01/01/2023							
	To 12/31/2023							
					5/24/2024 11:			
				-	1.00			
1.00	Total patient revenues (From Wkst. G-2, Part	I, col. 3, line 1	4)		16, 304, 584	1.00		
2.00	Less: contractual allowances and discounts on	patients accounts	i		479, 065	2.00		
3.00	Net patient revenues (Line 1 minus line 2)				15, 825, 519	3.00		
4.00	Less: total operating expenses (From Worksheet	: G-2, Part II, li	ne 15)		17, 459, 473	4.00		
5.00	Net income from service to patients (Line 3 mi	nus 4)			-1, 633, 954	5.00		
	Other income:							
6.00	Contributions, donations, bequests, etc				0	6.00		
7.00	Income from investments				3, 729	7.00		
8.00	Revenues from communications (Telephone and I	nternet service)			0	8.00		
9.00	Revenue from television and radio service				0	9.00		
10.00	Purchase di scounts				0	10.00		
11.00	Rebates and refunds of expenses				0	11.00		
12.00	5				0	12.00		
13.00	Revenue from laundry and linen service				0	13.00		
14.00	Revenue from meals sold to employees and guest	S			0	14.00		
15.00	J				0	15.00		
16.00			n patients		0	16.00		
17.00	5 1				0	17.00		
18.00	Revenue from sale of medical records and abstr				0	18.00		
19.00					0	19.00		
	Revenue from gifts, flower, coffee shops, cant	een			0	20.00		
	Rental of vending machines				0	21.00		
22.00	0				0	22.00		
23.00	Governmental appropriations				0	23.00		
24.00	OTHER REV MISC				5,001	24.00		
24.01					133, 047	24. 01 24. 50		
24.50 25.00	COVID-19 PHE Funding Total other income (Sum of lines 6 - 24)				0 141, 777	24.50 25.00		
25.00 26.00						25.00 26.00		
26.00	Total (Line 5 plus line 25) Other expenses (specify)				-1, 492, 177 0	26.00		
27.00	Utilei experises (speci i y)				0	27.00		
28.00					0	28.00		
	Total other expenses (Sum of lines 27 - 29)				0	30.00		
	Net income (or loss) for the period (Line 26 m	ninus line 30)			-1, 492, 177			
51.00	Incernical (or ross) for the period (Line 20 h	indo inte 50)		I	-1,472,177	51.00		

GATEWAY CARE CENTER, LLC (a limited liability company)

FINANCIAL STATEMENTS YEAR ENDED DECEMBER 31, 2023

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INDEPENDENT AUDITORS' REPORT

To the Members of Gateway Care Center, LLC

Opinion

We have audited the accompanying financial statements of Gateway Care Center, LLC (a limited liability company), which comprise the balance sheet as of December 31, 2023, and the related statements of operations and members' equity, and cash flows for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Gateway Care Center, LLC as of December 31, 2023, and the results of its operations and its cash flows for the year then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Gateway Care Center, LLC and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Gateway Care Center, LLC's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Gateway Care Center, LLC's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Gateway Care Center, LLC's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Grand Sonnesschins UP

November 13, 2024

GATEWAY CARE CENTER, LLC (a limited liability company) BALANCE SHEET DECEMBER 31, 2023

ASSETS Current assets		
Cash and cash equivalents (note 2)	\$	844,526
Cash - restricted (note 2)		168,128
Accounts receivable - net of allowance for doubtful accounts of \$552,000		2,515,927
Prepaid expenses and other		273,079
Due from landlord (note 6)		1,500,000
Total current assets		5,301,660
Property and equipment - net (note 3)		537,484
Security deposits		12,975
TOTAL ASSETS	\$_	5,852,119
LIABILITIES AND MEMBERS' EQUITY		
Current liabilities		
Accounts payable	\$	2,573,756
Accrued expenses		363,648
Accrued withheld taxes		31,454
Due to private and third-party payors		878,539
Patients' funds payable		125,117
Total current liabilities		3,972,514
Due to member (note 11)		1,800,202
Total liabilities		5,772,716
Members' equity		79,403
TOTAL LIABILITIES AND MEMBERS' EQUITY	\$	5,852,119

GATEWAY CARE CENTER, LLC (a limited liability company) STATEMENTS OF OPERATIONS AND MEMBERS' EQUITY YEAR ENDED DECEMBER 31, 2023

Revenues	\$ 15,851,184
Operating expenses	 17,359,716
Loss from operations	(1,508,532)
Non-operating revenue	
Interest income	 3,729
NET LOSS	(1,504,803)
Members' equity - December 31, 2022	 1,384,206 (120,597)
Members' equity contributed	 200,000
MEMBERS' EQUITY - DECEMBER 31, 2023	\$ 79,403

GATEWAY CARE CENTER, LLC (a limited liability company) STATEMENT OF CASH FLOWS YEAR ENDED DECEMBER 31, 2023

Cash flows from operating activities		
Net loss	\$	(1,504,803)
Adjustments to reconcile net loss		
to net cash used in operating activities:		
Depreciation		77,720
Increase in assets		
Accounts receivable		(240,550)
Prepaid expenses and others		(150,700)
Increase (decrease) in liabilities		
Accounts payable		639,564
Accrued expenses and withheld taxes		94,594
Due to private and third-party payors		215,049
Patients' funds payable		(18,324)
Net cash used in operating activities		(887,450)
Cash flows from financing activities		
Loan to landlord		(1,000,000)
Loan from members		1,800,202
Member's equity contributed		200,000
Net cash provided financing activities		1,000,202
Net increase in cash, restricted cash, and cash equivalents		112,752
Cash, restricted cash, and cash equivalents - December 31, 2022		899,902
CASH, RESTRICTED CASH AND	<u>_</u>	1.010 (54
CASH EQUIVALENTS - DECEMBER 31, 2023	\$_	1,012,654

NOTE 1 – FORMATION AND DESCRIPTION OF BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization and business – Gateway Care Center LLC ("the Company") was formed in the State of New Jersey on May 31, 2002, without a finite life. The Company is licensed to operate a skilled nursing facility consisting of 178 beds in Eatontown, New Jersey. The Company substantially earns all of its revenue by providing in-house skilled nursing care to residents who live in the skilled nursing facility. The members of the Company are generally protected from liability for acts and obligations of the Company. The Company leases land, building, and rights to its license in Eatontown, New Jersey, from a related entity.

Basis of accounting – The books and records of the Company are maintained on the accrual basis in accordance with accounting principles generally accepted in the United States of America ("GAAP").

Cash equivalents – Cash equivalents represent short-term investments with original maturity dates of three months or less.

Restricted cash-patient funds – The Company adopted Financial Accounting Standards Board ("FASB") standard "ASU-2016-18, Statement of Cash Flows (Topic 230): Restricted Cash." This standard requires that restricted cash and restricted cash equivalents be included in beginning and ending cash and cash equivalents on the statement of cash flows.

Trade accounts receivable – Trade accounts receivable are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a charge to earnings and a credit to a valuation allowance based on its assessment of the current status of individual accounts. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to trade accounts receivable. The valuation allowance increased by approximately \$56,000 at December 31, 2023.

Property and equipment – Property and equipment are stated at cost. Depreciation is computed by the straight-line method over the estimated useful lives of the assets. Expenditures for maintenance and repairs are charged to operations as incurred. Significant renovations and replacements which improve and extend the life of assets are capitalized.

Income taxes – The Company is treated as a partnership for federal and state income tax purposes and does not incur income taxes. Instead, its earnings and losses are included in the personal returns of the members and taxed depending on their personal tax situations. The financial statements do not reflect a provision for income taxes. The policy of the Company is to record interest expense and penalties related to income taxes in operating expense. For the year ended December 31, 2023, there was no income tax related interest or penalty expenses and no accrued interest and penalties.

In 2020 the State of New Jersey passed Business Alternative Income Tax ("BAIT") Act. This law allowed LLCs to pay tax due on partnership earnings instead of on the individual owner's return. The tax rates are graduated and range from 5.675% to 10.9% of earnings. The Company did not record any New Jersey State BAIT income tax during 2023.

NOTE 1 – FORMATION AND DESCRIPTION OF BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Leases – The Company adopted ASC-842 Leases. With adoption, the Company determined, which contracts conveyed the Company a right to control identified property, plant, or equipment for a period of time in exchange for consideration were deemed to be leases. The Company classified these contracts as Right-of-Use ("ROU") assets. ROU assets and lease liabilities are recognized based on the present value of lease payments over the lease term with lease expense recognized on a straight-line basis.

Lease agreements may contain rent escalation clauses, rent holidays, or certain landlord incentives, including tenant improvement allowances. ROU assets include amounts for scheduled rent increases and may be reduced by lease incentive amounts. Using the transition approach, the Company elected to use the following practical expedients and, therefore, did not reassess any of the following: (1) whether any expired or existing contracts are or contain leases, (2) the lease classification of expired or existing operating leases and recorded them as operating leases and all existing leases that were classified as capital leases as financing leases, and (3) initial direct costs for any existing leases.

With implementation, the Company also elected the following practical expedients of (1) using the Company's implicit borrowing rate (if available at the time of the lease origination); or (2) using a risk-free discount rate (US Treasury Rate) for the lease-derived ROU assets. ROU assets were treated separately from non-lease components of all asset classes. For leases utilizing the risk-free rate expedient, the Company elected to use a period comparable with that of the lease term, as an accounting policy election for all leases. The Company also made an accounting policy election to not record ROU assets or lease liabilities for leases with an initial term of 12 months or less and will recognize payments for such leases in its Statements of Earnings on a straight-line basis over the lease term. There were no residual value guarantees in any of the leases. The Company used hindsight in determining the lease term.

Estimates – The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Revenues – The Company's revenue is derived primarily from providing healthcare services to its patients. Revenues are recognized when services are provided to the patients at the amount that reflects the consideration to which the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare and other insurers, in exchange for providing patient care. The healthcare services are primarily for routine services in exchange for a contractual agreed-upon amount or rate. Routine services are treated as a single performance obligation satisfied over time as services are rendered. As such, patient care services represent a bundle of services that are not capable of being distinct. Additionally, there may be ancillary services which are not included in the daily rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

NOTE 1 – FORMATION AND DESCRIPTION OF BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Revenue recognized from healthcare services are adjusted for estimates of variable consideration to arrive at the transaction price. The Company determines the transaction price based on contractually agreed-upon amounts or rate, adjusted for estimates of variable consideration. The Company uses the expected value method in determining the variable component that should be used to arrive at the transaction price, using contractual agreements and historical reimbursement experience within each payor type. The amount of variable consideration which is included in the transaction price may be constrained, and is included in the net revenue only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. If actual amounts of consideration ultimately received differ from the Company's estimates, the Company adjusts these estimates, which would affect net service revenue in the period such variances become known.

Advertising – Advertising costs, except for costs associated with direct-response advertising, are charged to operations when incurred. The costs of direct-response advertising are capitalized and amortized over the period during which future benefits are expected to be received.

Guaranteed payments to members – Guaranteed payments to members that are intended as compensation for services rendered are accounted for as expenses of the Company rather than as allocations of the Company's earnings. Guaranteed payments that are intended as payments of interest on capital accounts are not accounted for as expenses of the Company, but rather, as part of the allocation of net earnings.

Government Grants – In 2022, the Company adopted ASU-2022-10, Government Assistance (Topic 832) Disclosures by Business entities about Government Assistance. The Company's accounting policy for government grants is to follow International Accounting Standards # 20 - Accounting for Government Grants and Disclosure of Government Assistance.

Subsequent events – The Company has reviewed for subsequent events and transactions for potential recognition and disclosure in the financial statements through November 13, 2024, the date the financial statements were available to be issued. No subsequent events were noted.

NOTE 2 - CASH, RESTRICTED CASH, AND CASH EQUIVALENTS

The balance in cash, restricted cash, and cash equivalents at December 31, 2023, consists of the following:

Operating cash Restricted cash – patient funds	\$ 844,526 168,128
Total cash, restricted cash, and cash equivalents	\$ <u>1,012,654</u>

NOTE 3 – PROPERTY AND EQUIPMENT

Property and equipment at December 31, 2023, are summarized as follows:

	Life	
	(Years)	
Furniture and equipment	5-7	\$ 1,975,458
Improvements	10-15	<u>1,524,057</u>
		3,499,515
Less accumulated depreciation		<u>2,962,031</u>
_		\$ 537,484

Depreciation expense was \$77,720 for the year.

NOTE 4 – REVENUE

Approximately 6% of revenues were derived from billings to the New Jersey Department of Health for stays by Medicaid patients.

Approximately 9% of revenues were derived from billings to the Federal government for stays by Medicare patients covered by Part A and for services provided which are covered by Medicare Part B.

Approximately 73% of revenues were derived from billings to managed care organizations ("MCO") for stays by Medicaid patients.

Effective July 2014, the New Jersey Department of Human Services changed its reimbursement methodology to a MCO system. The Company entered into contracts with state approved MCO's that will be paying for all new Medicaid admissions. All subsequent rates are negotiated between the Company and each MCO.

The Company owns solar panels which produce electricity that it sells to outside parties. Total revenue from the sale of electricity in 2023 was \$133,047.

NOTE 5 – CONCENTRATION OF CREDIT RISK

The Company maintains its cash balances at various financial institutions. At December 31, 2023, accounts at the institutions are insured by the Federal Deposit Insurance Corporation ("FDIC") up to \$250,000. At December 31, 2023, there were approximately \$2,012,000 of uninsured amounts.

The Company had approximately 9% of its receivables due from the New Jersey Department of Health and 26% of its receivables due from MCO for stays by Medicaid patients.

Approximately 6% of the revenues during the year were derived from billings to the Federal government for stays by Medicare patients covered by Part A and for services provided which are covered by Medicare Part B, respectively.

NOTE 6 – RELATED-PARTY TRANSACTIONS

The Company leases its facility from a related entity on a month-to-month basis. The lease provides for a monthly rent of \$130,000 plus all real estate taxes and operating expenses and any additional rent as determined by the parties. The balance due from the landlord was \$1,500,000 at December 31, 2023. Aggregate rent was \$2,407,139 for year ended December 31, 2023, which included \$197,139 in real estate taxes, and \$650,000 in additional rent.

The Company paid \$800,000 in management fees for the year, to an entity that is owned by the members of the Company. There were no balance due at December 31, 2023.

NOTE 7 – ADVERTISING

Advertising expense was \$43,749 for the year. There were no direct response advertising costs either capitalized or expensed. The Company's policy is to expense indirect advertising costs as incurred.

NOTE 8 – CONTRACTED SERVICES

A substantial number of the facility services are contracted from outside companies.

NOTE 9 – RESTRICTED CASH

The Company is required to maintain restricted patient funds accounts for its residents in a separate restricted account. The amount must at all times be equal to or exceed the aggregate of all outstanding obligations for patient funds.

NOTE 10 – ECONOMIC DEPENDENCY

The Company purchased a substantial portion of its services from one company, totaling approximately \$550,000 for the year. The balances due to this company and included in accounts payable at December 31, 2023, was approximately \$18,000.

NOTE 11 – DUE TO MEMBERS

Due to members amounted to \$1,800,202 at December 31, 2023. The balance is non-interest-bearing and will not be repaid in 2024.

NOTE 12 – CONTINGENCIES

Revenues are based on current billings. Certain adjustments may be made in subsequent periods as a result of audits or appeals, the final results of which are not determinable as of the date of the financial statements. Such adjustments, if any, will be reflected in revenues in the period in which ascertained.

The Company has two corporate credit cards which they can use for corporate purchases. The first credit card has an unlimited spending limit and no balance due included in accounts payable at December 31, 2023, the second card has a spending limit of \$39,800. At December 31, 2023, the credit card had a balance due of \$9,393 included in accounts payable.

At times, the Company is involved in various lawsuits and subject to certain contingencies in the normal course of business. Management vigorously defends any claims that are asserted.

The Company is contingently liable as a co-borrower on a mortgage of the related landlord. The mortgage was fully recorded on the related company's books. At December 31, 2023, the amount owed on this mortgage was \$8,129,843. The fixed interest rate on this mortgage was 4.25%. Substantially all the Company's assets are pledged as collateral on this mortgage. The mortgage is subject to certain covenants, which the Company and the related party were in compliance with at December 31, 2023.

The New Jersey Department of Health is currently in the process of revising the methodology used to calculate the Medicaid reimbursement rate paid to the Company. The effect of these revisions on future operations cannot be determined at this time.



INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION

To the Members of Gateway Care Center, LLC

We have audited the financial statements of Gateway Care Center, LLC (a limited liability company) as of and for the year ended December 31, 2023, and our report thereon dated November 13, 2024, which expressed an unmodified opinion on those financial statements, appears on page one. Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information contained in the statements of revenues, operating expenses, patient days, and payroll and benefits is presented for purposes of additional analysis of the financial statements, rather than to present the financial position, results of operations, and cash flows of the individual companies, and it is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements themselves, and other records used to prepare the financial statements or to the financial statements themselves, and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Grand Sonnerschine LLP

November 13, 2024

GATEWAY CARE CENTER, LLC (a limited liability company) SUPPLEMENTARY INFORMATION REVENUES YEAR ENDED DECEMBER 31, 2023

				Per Patient Day
Medicaid	\$	1,024,331	\$	269.63
Medicaid - managed care		11,507,871		269.09
Private and Insurance		1,089,834		303.66
Medicare - Part A		1,308,437		609.43
Medicare - Part A bad debt		(112,385)		(52.35)
Hospice	_	594,873		271.63
Total current year	_	15,412,961	\$_	282.85
Therapy Miscellaneous Sale of electricity	-	300,173 5,003 133,047 438,223		
TOTAL REVENUES	\$_	15,851,184		

GATEWAY CARE CENTER, LLC (a limited liability company) SUPPLEMENTARY INFORMATION OPERATING EXPENSES YEAR ENDED DECEMBER 31, 2023

				Per
DIDECT DATIENT CADE COST				Patient
DIRECT PATIENT CARE COST				Day
Direct routine patient care costs Salaries - RN	\$	961 950	\$	15.87
- LPN	Φ	864,850 1,279,468	Φ	23.48
- LFN - CNA		1,279,408		23.48 18.84
Employee benefits		631,097		10.04
Contracted nursing		1,337,370		24.54
Contracted nurshig	_		•	
		5,139,323	•	94.31
Routine patient care costs - not directly reported				
Medical supplies		201,259		3.69
Oxygen		3,080		0.06
OTC Drugs		40,424		0.74
	_	244,763		4.49
TOTAL DIRECT PATIENT CARE COST		5,384,086		98.80
ANCILLARY PATIENT CARE COSTS				
Radiology and laboratory		7,538		0.14
Salaries Therapy		323,379		5.93
Employee benefits		64,362		1.18
RX Drugs		48,144		0.88
Ambulance services		31,865		0.58
TOTAL ANCILLARY		,	•	
PATIENT CARE COSTS	_	475,288		8.71
INDIRECT PATIENT CARE COSTS				
Workforce related costs - patient care				
Salaries - Nursing supervisor		435,024		7.98
- DON and ADON		153,144		2.81
- MDS Cordinator		842,459		15.46
Employee benefits	_	254,258		4.67
	_	1,684,885		30.92

GATEWAY CARE CENTER, LLC (a limited liability company) SUPPLEMENTARY INFORMATION OPERATING EXPENSES YEAR ENDED DECEMBER 31, 2023

			Per Patient Day
Patient support services			
Food (including supplements) \$	565,118	\$	10.37
Salaries - Dietary	932,436		17.11
Employee benefits	185,583		3.41
Dietary supplies	60,513		1.11
Salaries - Housekeeping and laundry	457,900		8.40
Employee benefits	91,136		1.67
Housekeeping and laundry supplies	158,452		2.91
Salaries - Social services	79,976		1.47
Employee benefits	15,918		0.29
Salaries Recreation	684,376		12.56
Employee benefits	136,212		2.50
Recreation supplies and services	40,604		0.75
Medical director	40,750		0.75
Fire drill	4,262		0.08
Garbage disposal	39,463		0.72
Landscaping/snow removal	19,984		0.37
Exterminating	13,483	_	0.25
	3,526,166		64.72
TOTAL INDIRECT			
PATIENT CARE COSTS	5,211,051	-	95.64
ADMINISTRATIVE AND OPERATING COSTS			
Property operating costs			
Salaries - Maintenance	120,016		2.20
Employee benefits	23,887		0.44
Maintenance supplies and services	162,782		2.99
Gas	93,217		1.71
Electric	90,504		1.66
Water and sewer	99,593		1.83
Cable	35,614		0.65
Telephone	16,345		0.30
Real estate tax	197,139		3.62
Property insurance	29,555		0.54
	868,652	- ·	15.94

See independent auditors' report on supplementary information.

GATEWAY CARE CENTER, LLC (a limited liability company) SUPPLEMENTARY INFORMATION OPERATING EXPENSES YEAR ENDED DECEMBER 31, 2023

			Per Patient Day
Administrative & operating costs			
Salaries - Administrator \$	152,467	\$	2.80
Employee benefits	30,346		0.56
Salaries - Office	669,379		12.28
Employee benefits	133,227		2.44
Office supplies and expenses	65,876		1.21
Data processing	56,370		1.03
Management fees	800,000		14.68
Insurance	78,130		1.43
Accounting	55,538		1.02
Legal	38,679		0.71
Advertising	11,005		0.20
Travel	48,318		0.89
Consulting	134,546		2.47
License, dues and seminars	11,205		0.21
Other A&O costs	14,071	_	0.26
	2,299,157	_	42.19
TOTAL ADMINISTRATIVE AND OPERATING COSTS	3,167,809	-	58.13
CAPITAL COSTS			
Rent	2,210,000		40.56
Depreciation	77,720		1.43
Equipment lease	8,821		0.16
TOTAL CAPITAL COSTS	2,296,541	-	42.15
	<u> </u>	-	
NON-ALLOWABLE COSTS			
Medicaid assessment tax	704,556		12.93
Bad debt expense	56,361		1.03
Marketing	32,744		0.60
Non-allowable miscellaneous	800	_	0.01
TOTAL NON-ALLOWABLE COSTS	794,461	-	14.57
TOTAL OPERATING EXPENSES \$	17,329,236	\$	318.00

GATEWAY CARE CENTER, LLC (a limited liability company) SUPPLEMENTARY INFORMATION PATIENT DAYS YEAR ENDED DECEMBER 31, 2023

		Percent of
		Total
Skilled nursing facility		
Medicaid	3,799	6.97%
Medicaid - managed care	42,766	78.48%
Medicare	2,147	3.94%
Private and Insurance	3,589	6.59%
Hospice	2,190	4.02%
TOTAL PATIENT DAYS	54,491	100.00%

Percent occupancy - 178 beds

83.87%

GATEWAY CARE CENTER, LLC (a limited liability company) SUPPLEMENTARY INFORMATION SCHEDULES OF PAYROLL AND BENEFITS YEAR ENDED DECEMBER 31, 2023

			Per Patient Day
SALARIES			
RN	\$	864,850 \$	5 15.87
LPN		1,279,468	23.48
CNA		1,026,538	18.84
Therapy		323,379	5.93
Nursing administratod		435,024	7.98
MDS Cordinator		842,459	15.46
Dietary		932,436	17.11
Housekeeping		457,900	8.4
Social services		79,976	1.47
Maintenance		120,016	2.2
Recreation		684,376	12.56
Administrator		152,467	2.8
Office	_	669,379	12.28
TOTAL SALARIES	\$ _	7,868,268	<u> </u>
EMPLOYEE BENEFITS			
Payroll taxes	\$	709,874	
Employee benefits		666,049	
Worker's compensation		220,583	
TOTAL EMPLOYEE BENEFITS	\$ =	1,596,506	
TOTAL EMPLOYEE BENEFITS AS A PERCENT OF SALARIES	=	20.29%	