Health Financial Systems JEFFERSON HEALTH CARE CENTER In Lieu of Form CMS-2540-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expires: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315231 Worksheet S Parts I, II & III Peri od. From 01/01/2021 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: То 5/5/2022 1:50 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/5/2022 Time: 1:50 pm use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 3.01 [] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[0]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11.Contractor Vendor Code 12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received: 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 JEFFERSON HEALTH CARE CENTER (315231) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1	2	SI GNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	34, 977	0	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
100.00	TOTAL	0	34, 977	0	0	100. 00

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

	Financial Systems JE ED NURSING FACILITY AND SKILLED NURSING FACILIT X INDENTIFICATION DATA	<u>FFERSON_HEALT</u> Y HEALTH_CARE		er No.: 3	15231	Period: From 01/01/ To 12/31/	/2021	u of For Workshe Part I Date/Ti 5/5/202	et S-2 me Pre	2 epared
	1.00	2.00			3.00					
	Skilled Nursing Facility and Skilled Nursing F		ex Address:							4
00		O Box:								1.0
	5	state: NJ		de: 08080)					2.0
	5	BSA Code: 1580	04 Urban/I	Rural:U						3.0
01	C	BSA Code:								3.0
		(Component Nam	e P	rovi der	Date	Payme	ent Syste	em (P,	
					CCN	Certified		0, or N)	
							V	XVIII	XIX	1
			1.00		2.00	3.00	4.00	5.00	6.00	
	SNF and SNF-Based Component Identification:								-	
00	SNF	JEFFE	RSON HEALTH C	CARE	315231	06/25/1986	N	Р	N	4.0
		CENTE							1	
00	Nursing Facility				1		1	1	1	5.0
00					1				1	6.0
00	SNF-Based HHA				ł				1	7.0
					ł					1
00	SNF-Based RHC				ļ					8.
0	SNF-Based FQHC									9.
									1	10.0
	SNF-Based OLTC								1	11.
00	SNF-Based HOSPICE								1	12.
00	SNF-Based CORF									13.
						From:		То	:	
						1.00		2.0	00	1
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2	021	12/31/	/2021	14.
	Type of Control (See Instructions)							LLC		15.
00								Y/I	N	13.
							ŀ	1. 0		1
	Turne of Europetendian Childred Numeian Essibility							1.0	10	-
~ ~	Type of Freestanding Skilled Nursing Facility						T			4
00	Is this a distinct part skilled nursing facili	ty that meets	, the require	ments se	et forth	in 42 CFR		N		16.
	section 483.5?									
00	Is this a composite distinct part skilled nurs	ing facility	that meets the	he requi	rements	set forth	in	N	I.	17.
	42 CFR section 483.5?									
00	Are there any costs included in Worksheet A th	at resulted f	rom transact	ions wit	h relat	ed		Y		18.
	organizations as defined in CMS Pub. 15-1, cha	pter 10? If	ves, complet	e Worksh	neet A-8	-1.				
	Miscellaneous Cost Reporting Information		2							1
00	If this is a low Medicare utilization cost rep	ort indicate	with a "Y"	for ves	or "N	" for no		N		19.
	If line 19 is yes, does this cost report meet							N		19.
	utilization cost report, indicate with a "Y",				i i iig u		5			' '.
	Depreciation - Enter the amount of depreciation			r tho m	athod ir	dicatod on	Linos	20 22)	d in the second s
00	Straight Line	in reported fr		i the me	stribu i fi		Lines			2 20
	5							Ι,	106, 963	
	Declining Balance								(21.
	Sum of the Year's Digits								(22.
00	Sum of line 20 through 22							1, 1	106, 963	3 23.
0.7	If depreciation is funded, enter the balance	as of the end	l of the peri	od.					(
UÜ	Were there any disposal of capital assets duri	ng the cost r								24.
			eporting per	iod? (Y/	'N)			N		
00	Was accelerated depreciation claimed on any as					nortina ner	Sho i	N		25.
00	Was accelerated depreciation claimed on any as					porting per	i od?	N N		25.
00 00	(Y/N)	sets in the c	current or any	y prior	cost re			Ν		25. 26.
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Heal th	Financial Systems	JEFFERSON HEALTH CA	RE CENTER		In Lie	u of Form CMS-	2540-10	
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3		Peri od:	Worksheet S-2		
COMPLE	X INDENTIFICATION DATA				From 01/01/2021 To 12/31/2021	Part Date/Time Pre	narod	
					10 12/31/2021	5/5/2022 1:50		
						Y/N		
42.00	42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost							
	center? Enter Y or N. If yes, check box	κ, and submit supporting :	schedule listing	g cost c	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 ac	ddress o	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 or	ganization, enter the nam	e and address of	f the ho	ome office on the	lines		
	bel ow.							
45.00	Name:	Contractor's Name:	C	Contract	or's Number:		45.00	
46.00	Street:	PO Box:					46.00	
47.00	Ci ty:	State:	Z	Zip Code	:		47.00	

	X REIMBURSEMENT QUESTI ONNAI RE	TY HEALTH CARE Prov	ider No.: 3152	From	d: 01/01/2021 12/31/2021		epared:
					Y/N	Date	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column 1, "'	(" for Yes or	"N" for N	1.00 o. For all	2.00 the date	
00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)	ly prior to the beginning the date of the change in	g of the cost n column 2. (s	see	N		1.0
			Y/N		Date 2.00	V/I 3.00	
0	Has the provider terminated participation in column 1 is yes, enter in column 2 the date 3, "V" for voluntary or "I" for involuntary.		f N	<u>,</u>	2.00	3.00	2.0
0	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home offices, d d to the provider or its 1, or members of the boa	nug				3.0
			Y/N		Туре	Date	
_	Financial Data and Reports		1.00)	2.00	3.00	
0	Column 1: Were the financial statements prep Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If Are the cost report total expenses and total	" for Audited, "C" for te copy or enter date no, see instructions.	C Y		С		4.0
	those on the filed financial statements? If reconciliation.				Y/N	Legal Oper.	0.0
					1.00	2.00	
0	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2. Is	the provider	the	N	N	6.0
0	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri	s? (Y/N) see instructions ng the cost reporting pe	5.		N N		7.0
	School and/or Allied Health Program? (Y/N) s	ee Instructions.				Y/N 1.00	
_	Bad Debts Is the provider seeking reimbursement for ba	d dobte2 (V(N) coo instru				1	
	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.			s cost rep	orting	Y N	
00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an	t collection policy chan	ge during this		-		10.0
00 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	t collection policy chan d/or coinsurance waived?	ge during this If "Y", see i	nstructi o	ns.	N N	10. C
00 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	t collection policy chan d/or coinsurance waived?	ge during this If "Y", see i	nstruction nstruction Part A	ns. s.	N N	10. 0
00 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior	t collection policy changed d/or coinsurance waived?	ge during this	nstruction Part A	ns.	N N Part B	10. C
0	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	t collection policy chan d/or coinsurance waived? cost reporting period? Description	ge during this If "Y", see i f "Y", see ir Y/N	nstruction Part A	ns. s. Date	N N Part B Y/N	10. 0 11. 0 12. 0
00 00 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and	t collection policy chan d/or coinsurance waived? cost reporting period? Description 0	ge during this If "Y", see i f "Y", see ir Y/N 1.00	nstruction Part A	ns. s. Date	N N Part B Y/N 3.00	10. (11. (12. (13. (
	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",	t collection policy chan d/or coinsurance waived? cost reporting period? Description 0	ge during this If "Y", see i f "Y", see ir Y/N 1.00 N	nstruction Part A	ns. s. Date	N N Part B Y/N 3.00	10. C 11. C 12. C 13. C 14. C
	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	t collection policy chan d/or coinsurance waived? cost reporting period? Description 0	ge during this If "Y", see i f "Y", see ir Y/N 1.00 N N	nstruction Part A	ns. s. Date	N N Part B Y/N 3.00 N	10. 0 11. 0 12. 0 13. 0 14. 0
	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for	t collection policy chan d/or coinsurance waived? cost reporting period? Description 0	ge during this If "Y", see i f "Y", see ir Y/N 1.00 N N N	nstruction Part A	ns. s. Date	N N Part B Y/N 3.00 N	9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0

Heal th	Financial Systems	JEFFERSON HEALT	H CARE CENTER		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACIL	ITY HEALTH CARE	Provi der		Period:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				From 01/01/2021 To 12/31/2021		pared: _pm
			1.	00	2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the tit	∣e∕position	AL		SOCHACKI		19.00
	held by the cost report preparer in columns	1, 2, and 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost	report	HEALTH CARE RE	SOURCES			20.00
	preparer.						
21.00	Enter the telephone number and email address	s of the cost	609-987-1440		AL. SOCHACKI @HCF	RNJ. NET	21.00
	report preparer in columns 1 and 2, respect	i vel y.					

Heal th	Financial Systems J	EFFERSON HEALTH	CARE CENTER	In Lie	u of Form CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der No.: 315231	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/5/2022 1:50	pared:
		Part B Date 4.00				
	PS&R Data	4.00				
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)					13. 00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14. 00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15. 00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
			3.00			
19. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		REPARER			19. 00
20.00	Enter the employer/company name of the cost r preparer.	report				20. 00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respective					21.00

SKI LLE	Financial Systems D NURSING FACILITY AND SKILLED NURSIN X STATISTICAL DATA	JEFFERSON HEALTH G FACILITY HEALTH CARE		F	eriod: rom 01/01/2021 o 12/31/2021		pared:
				l np	atient Days/Vis	sits	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	190	69, 350	0	-,	19, 102	1.00
2.00 3.00	NURSING FACILITY	0	0	0		0	
. 00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
00	Other Long Term Care	0	0		_		5.00
00	SNF-Based CMHC						6.00
. 00	HOSPICE	0	0	0	0 017	0	
. 00	Total (Sum of lines 1-7)	190 Inpatient D	69, 350 avs/Visits	0	8, 817 Di scharges	19, 102	8.00
		Inpatront b	4937 1131 13		bi senai ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
00		6.00	7.00	8.00	9.00	10.00	1.00
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	8, 390	36, 309	0	360	1	1.00 2.00
. 00	ICF/IID	0	0			0	3.00
00	HOME HEALTH AGENCY COST	0	0				4.00
00	Other Long Term Care	0	0				5.00
00	SNF-Based CMHC HOSPI CE		0	0	0	o	6.00 7.00
00	Total (Sum of lines 1-7)	8, 390	36, 309	0	360	1	8.00
		Di scha	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	component	11.00	12.00	13.00	14.00	15.00	
00	SKILLED NURSING FACILITY	654	1, 015	0.00			1.00
. 00	NURSING FACILITY	0	0	0.00		0.00	
00 00	ICF/IID HOME HEALTH AGENCY COST	0	0			0.00	3.00 4.00
. 00	Other Long Term Care	0	0				5.00
. 00	SNF-Based CMHC		0				6.00
. 00	HOSPI CE	0	0	0.00			
. 00	Total (Sum of lines 1-7)	654	1, 015	0.00		19, 102. 00	8.00
		Average Length of Stay		Admi s	si ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	1.00
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	35. 77 0. 00	0	379	1	283 0	1.00 2.00
00	ICF/IID	0.00	0		0	0	
00	HOME HEALTH AGENCY COST						4.00
00	Other Long Term Care	0.00				0	
00	SNF-Based CMHC	0.00	0	0	0	0	6.00
00	HOSPICE Total (Sum of lines 1-7)	0.00 35.77	0				
00		Admi ssi ons	Full Time			200	0100
	Component	Total		Nonpai d			
	Component	Total	Employees on Payroll	Workers			
		21.00	22.00	23.00	-		
00	SKILLED NURSING FACILITY	663	166.20				1.00
00	NURSING FACILITY	0	0.00				2.00
	ICF/IID HOME HEALTH AGENCY COST	0	0.00 0.00				3.00 4.00
. 00	Other Long Term Care	0	(), ()()	0.00		1	1 5.00
. 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC	0	0.00 0.00				5.00 6.00
. 00 . 00	5	0 0 663		0.00 0.00			

		JEFFERSON HEALT				u of Form CMS-2	
SNF WA	IGE INDEX INFORMATION				Period: From 01/01/2021 To 12/31/2021	5/5/2022 1:50	pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
			Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARI ES			1		I	
1.00	Total salaries (See Instructions)	9, 487, 793	0	9, 487, 79			
2.00	Physician salaries-Part A	0	0		0 0.00		2.00
3.00	Physician salaries-Part B	0	0		0 0.00		
4.00	Home office personnel	0	0		0 0.00		
5.00	Sum of lines 2 through 4	0	0	0 407 70	0 0.00		
6.00	Revised wages (line 1 minus line 5)	9, 487, 793	0	9, 487, 79			6.00 7.00
7.00	Other Long Term Care	0			0 0.00		
8.00 9.00	HOME HEALTH AGENCY COST	0			0 0.00 0 0.00		
9.00	HOSPICE	0			0 0.00		
10.00	Other excluded areas	0			0 0.00		
12.00	Subtotal Excluded salary (Sum of lines 7	0			0 0.00		
	through 11)	0					
13.00	Total Adjusted Salaries (line 6 minus line	9, 487, 793	0	9, 487, 79	345, 806. 00	27.44	13.00
	12) OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1, 658, 286	0	1, 658, 28	27, 187. 00	61.00	14.00
15.00	Contract Labor: Physician services-Part A	1, 030, 200			0 0.00		
16.00	Home office salaries & wage related costs	0	, s		0 0.00		
	WAGE-RELATED COSTS			1	0 0100	0100	
17.00	Wage-related costs core (See Part IV)	1, 972, 180	C	1, 972, 18	30		17.00
18.00	Wage-related costs other (See Part IV)	0		,	0		18.00
19.00	Wage related costs (excluded units)	0	c c		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, 972, 180	0	1, 972, 18	30		22.00
	instructions)						

Heal th	Financial Systems	JEFFERSON HEALT	H CARE CENTER		In Lie	eu of Form CMS-:	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2021 To 12/31/2021	Part III Date/Time Pre	narod
					10 12/31/2021	5/5/2022 1:50	
		Amount	Reclass. of	Adj usted		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	1	1	
1.00	Employee Benefits	0	0	(0.00		
2.00	Administrative & General	970, 126		970, 126			
3.00	Plant Operation, Maintenance & Repairs	372, 945	0	372, 945	5 15, 471. 00	24.11	3.00
4.00	Laundry & Linen Service	183, 789	0	183, 789	9 11, 065. 00	16.61	4.00
5.00	Housekeepi ng	346, 260	0	346, 260	18, 497. 00	18.72	5.00
6.00	Dietary	712, 277	0	712, 27	42, 537. 00	16.74	6.00
7.00	Nursing Administration	0	0	(0.00	0.00	7.00
8.00	Central Services and Supply	0	0	(0.00	0.00	8.00
9.00	Pharmacy	0	0	(0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	(0.00	0.00	10.00
11.00	Social Service	186, 510	0	186, 510	5, 300. 00	35.19	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	157, 362	0	157, 362	8, 917. 00	17.65	13.00
14.00	Total (sum lines 1 thru 13)	2, 929, 269					14.00
			1			1	

		FERSON HEALTH CARE CENTER		u of Form CMS-	
SNF WA	AGE RELATED COSTS	Provi der No.: 315	231 Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Pre 5/5/2022 1:50	pared:
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETIREMENT COST				
1.00	401K Employer Contributions			0	1.0
2.00	Tax Sheltered Annuity (TSA) Employer Contributi	on		0	2.0
3.00	Qualified and Non-Qualified Pension Plan Cost			208, 506	3.00
4.00	Prior Year Pension Service Cost			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Org	jani zati on)			1
5.00	401K/TSA PI an Administration fees			0	5.0
5.00	Legal /Accounting/Management Fees-Pension Plan			0	6.0
7.00	Employee Managed Care Program Administration Fe	ees		0	7.0
	HEALTH AND INSURANCE COST				
3.00	Health Insurance (Purchased or Self Funded)			750, 994	8.0
9.00	Prescription Drug Plan			0	9.0
0.00	Dental, Hearing and Vision Plan			0	10.0
1.00	Life Insurance (If employee is owner or benefic	ciary)		12, 018	11.0
2.00	Accident Insurance (If employee is owner or be	neficiary)		0	12.0
3.00	Disability Insurance (If employee is owner or I	peneficiary)		1, 052	13.0
4.00	Long-Term Care Insurance (If employee is owner	or beneficiary)		0	14. C
5.00	Workers' Compensation Insurance	5.		127, 860	15. C
6.00	Retirement Health Care Cost (Only current year,	not the extraordinary accrual req	uired by FASB 106.	0	16. C
	Non cumulative portion)	<u> </u>	5		
	TAXES				
7.00	FICA-Employers Portion Only			782, 594	17.0
8.00	Medicare Taxes - Employers Portion Only			0	18.0
9.00	Unemployment Insurance			0	19.0
20.00	State or Federal Unemployment Taxes			89, 156	20.0
	OTHER				
21.00	Executive Deferred Compensation			0	21.0
22.00	Day Care Cost and Allowances			0	22.0
23.00				0	
24.00	Total Wage Related cost (Sum of lines 1 - 23)			1, 972, 180	24.0
				Amount	
				Reported	
				1.00	
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th	Financial Systems	JEFFERSON HEALTH	I CARE CENTER		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES				Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Pre 5/5/2022 1:50	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)	. Related to	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	3, 360, 106	698, 448				1.00
2.00	Licensed Practical Nurses (LPNs)	938, 568	195, 095				2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2, 247, 516	467, 180				3.00
4.00	Total Nursing (sum of lines 1 through 3)	6, 546, 190	1, 360, 723	7, 906, 91			4.00
5.00	Physical Therapists	0	0		0 0.00		
6.00	Physical Therapy Assistants	0	0		0 0.00		6.00
7.00	Physical Therapy Aides	0	0		0 0.00		7.00
8.00	Occupational Therapists	0	0		0 0.00		
9.00	Occupational Therapy Assistants	0	0		0 0.00		
10.00	Occupational Therapy Aides	0	0		0 0.00		10.00
11.00	Speech Therapists	0	0		0 0.00	0.00	11.00
12.00	Respi ratory Therapi sts	0	0		0 0.00	0.00	12.00
13.00	Other Medical Staff	0	0		0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	0			0 0.00		14.00
15.00	Licensed Practical Nurses (LPNs)	0			0 0.00		
16. 00	Certified Nursing Assistant/Nursing Assistants/Aides	0			0 0.00		16.00
17.00	Total Nursing (sum of lines 14 through 16)	0			0 0.00		
18.00	Physical Therapists	528, 833		528, 83	3 7, 253. 00	72.91	18.00
19.00	Physical Therapy Assistants	191, 659		191, 65	9 2, 969. 00	64.55	19.00
20.00	Physical Therapy Aides	116, 080		116, 08	0 5, 804. 00	20.00	20.00
21.00	Occupational Therapists	289, 010		289, 01	0 3, 636. 00	79.49	21.00
22.00	Occupational Therapy Assistants	252, 936		252, 93	6 3, 806. 00	66.46	22.00
23.00	Occupational Therapy Aides	0			0.00	0.00	23.00
24.00	Speech Therapists	276, 585		276, 58	5 3, 719. 00	74.37	24.00
25.00	Respi ratory Therapi sts	0			0 0.00	0.00	25.00
26.00	Other Medical Staff	0			0 0.00	0.00	26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	JEFFERSON HEALTH CARE CENTER Provi der No. : 315231	Peri od:	u of Form CMS Worksheet S	
		From 01/01/2021 To 12/31/2021	Date/Time P 5/5/2022 1:	
		Group	Days	
1.00		1.00 RUX	2.00	1.00
2.00		RUL		2.00
3.00		RVX		3.00
4.00 5.00		RVL RHX		4.00 5.00
6.00		RHL		6.00
7.00		RMX		7.00
8.00		RML		8.00
9.00		RLX RUC		9.00 10.00
11.00		RUB		11.00
12.00		RUA		12.00
13.00		RVC		13.00
14. 00 15. 00		RVB RVA		14.00
16.00		RHC		16.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00		RMC		19.00
20. 00 21. 00		RMB RMA		20.00
22.00		RLB		21.00
23. 00		RLA		23.00
24.00		ES3		24.00
25. 00 26. 00		ES2 ES1		25.00 26.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00		HD2		29.00
30. 00		HD1		30.00
31.00 32.00		HC2 HC1		31.00 32.00
33.00		HB2		33.00
34.00		HB1		34.00
35.00		LE2		35.00
36. 00 37. 00		LE1 LD2		36.00 37.00
38.00		LD2 LD1		37.00
39.00		LC2		39.00
40. 00		LC1		40.00
41.00		LB2		41.00
42. 00 43. 00		LB1 CE2		42.00 43.00
44.00		CE1		44.00
45. 00		CD2		45.00
46.00		CD1		46.00
47.00 48.00		CC2 CC1		47.00 48.00
49.00		CB2		48.00
50.00		CB1		50.00
51.00		CA2		51.00
52.00		CA1		52.00
53. 00 54. 00		SE3 SE2		53.00 54.00
55.00		SE1		55.00
56. 00		SSC		56.00
57.00		SSB		57.00
58.00 59.00		SSA I B2		58.00 59.00
50. 00		I B1		60.00
61. 00		I A2		61.00
52. 00		I A1		62.00
53. 00 54. 00		BB2		63.00
64.00 65.00		BB1 BA2		64.00 65.00
66.00		BA1		66.00
67. 00		PE2		67.00
68.00		PE1		68.00
69. 00 70. 00		PD2 PD1		69.00 70.00
70.00		PD1 PC2		70.00
72.00		PC1		72.00
73.00		PB2		73.00
74.00		PB1		74.00

Health Financial Systems	JEFFERSON HEALTH CAR	E CENTER		In Lie	u of Form CMS	6-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315231	Period:	Worksheet S	-7
				From 01/01/2021 To 12/31/2021	Date/Time P 5/5/2022 1:	
				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 payments beginning 10/01/2003. Congress exp expenses. For lines 101 through 106: Enter column 2 the percentage of total expenses f line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expens (See instructions)	ected this increase to in column 1 the amoun or each category to to for yes or "N" for no	o be used t of the otal SNF if the s	for direct expense for revenue from pending refle	batient care and each category. Er Worksheet G-2, F ects increases as	related iterin Partl, sociated	
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, I	ine 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

		JEFFERSON HEALTH	CARE CENTER		In Lie	u of Form CMS-	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315231	Period: From 01/01/2021	Worksheet A	
					To 12/31/2021	Date/Time Pre 5/5/2022 1:50	
	Cost Center Description	Sal ari es	Other		1 Reclassi fi cati	Reclassi fi ed	
				+ col. 2)	ons Increase/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)		
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		2, 964, 845	2, 964, 84	5 0	2, 964, 845	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		2, 704, 045	2, 704, 02	0 0	2, 704, 043	2.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 972, 180	1, 972, 18	0 0	1, 972, 180	
4.00	00400 ADMINISTRATIVE & GENERAL	970, 126	2, 238, 873	3, 208, 99		3, 208, 999	•
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	372, 945	982, 710			1, 355, 655	•
6.00 7.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	183, 789 346, 260	49, 883 74, 315	233, 67 420, 57		233, 672 420, 575	
8.00	00800 DI ETARY	712, 277	1, 009, 470			1, 721, 747	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	2, 888	2, 88		2, 888	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	10.00
11.00	01100 PHARMACY	0	0		0 0	0	
12.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0 194 E10	0	104 55	0 0	104 EE2	
13.00 14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	186, 510	43	186, 55	0 0	186, 553 0	
15.00	01500 PATIENT ACTIVITIES	157, 362	11, 500	168, 86		168, 862	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	6, 558, 524	592, 696	7, 151, 22	0 0	7, 151, 220	1
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00 33.00	03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0		0 0	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		0 0	0	33.00
40.00	04000 RADI OLOGY	0	113, 980	113, 98	0 0	113, 980	40.00
41.00	04100 LABORATORY	0	47, 038	47, 03	8 0	47, 038	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	
43.00 44.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0	0 833, 853	833, 85	0 0	0 833, 853	
44.00	04400 PHISICAL THERAPY	0	541, 946	541, 94		541, 946	
46.00	04600 SPEECH PATHOLOGY	0	276, 585	276, 58		276, 585	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	621, 659	621, 65	0 0	621, 659	•
50.00 51.00	05100 SUPPORT SURFACES	0	0		0 0	0	
01.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			0 0	0	01.00
60.00	06000 CLI NI C	0	0		0 0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0		0 0	0	
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	35, 016				71.00
	07300 CMHC	0	0		0 0	0	
	SPECIAL PURPOSE COST CENTERS	1					
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0 0	0	
81.00 82.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF	0	0		0 0	0	
82.00	08300 HOSPI CE	0	0			0	1
89.00	SUBTOTALS (sum of lines 1-84)	9, 487, 793	12, 369, 480	21, 857, 27	3 0	21, 857, 273	•
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	367	36	0	367 0	
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
	09400 PATIENTS LAUNDRY	0	0		0 0	0	
100.00		9, 487, 793	12, 369, 847	21, 857, 64	0 0	21, 857, 640	100. 00

RECLAS	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	JEFFERSON HEALT		No.: 315231		eu of Form CMS-2 Worksheet A	
LOLAS	STATISTICAL AND ADJUSTMENT OF TATAL DALANCE U	I ENILINGES	i i ovi del	10 313231	From 01/01/2021		
					To 12/31/2021		
	Cost Center Description	Adjustments to	Net Expenses			5/5/2022 1:50	рш
			For Allocation				
		Wkst A-8)	(col. 5 +-				
			col. 6)				
		6.00	7.00	1			
	GENERAL SERVICE COST CENTERS			1			
. 00	00100 CAP REL COSTS - BLDGS & FIXTURES	-294	2, 964, 551				1.0
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	C	0				2.0
8.00	00300 EMPLOYEE BENEFITS	C	1, 972, 180	p			3.0
1.00	00400 ADMINISTRATIVE & GENERAL	-767, 711	2, 441, 288				4.0
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	C	.,	1			5.0
o. 00	00600 LAUNDRY & LINEN SERVICE	C	233, 672	1			6.0
. 00	00700 HOUSEKEEPI NG	C	420, 575	1			7.0
8.00	00800 DI ETARY	C	1, 721, 747	1			8.0
9.00	00900 NURSI NG ADMI NI STRATI ON	C	2, 888	3			9.0
0.00	01000 CENTRAL SERVICES & SUPPLY	C	0				10.0
1.00	01100 PHARMACY	C	0				11.0
2.00	01200 MEDI CAL RECORDS & LI BRARY	C	0				12.0
	01300 SOCI AL SERVI CE	C	186, 553	3			13.0
	01400 NURSING AND ALLIED HEALTH EDUCATION	C	0				14.0
5.00	01500 PATIENT ACTIVITIES	C	168, 862	2			15.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	C	7, 151, 220)			30.0
31.00	03100 NURSING FACILITY	C	0				31.0
	03200 CF/I D	C					32.0
33.00	03300 OTHER LONG TERM CARE	C	0				33.0
	ANCI LLARY SERVICE COST CENTERS						
0.00	04000 RADI OLOGY	C	113, 980)			40.0
1.00	04100 LABORATORY	C	47, 038	3			41.0
2.00	04200 I NTRAVENOUS THERAPY	C	0	p			42.0
3.00	04300 OXYGEN (INHALATION) THERAPY	C	0				43.0
4.00	04400 PHYSI CAL THERAPY	C	833, 853	1			44.0
5.00	04500 OCCUPATI ONAL THERAPY	C	541, 946	1			45. C
	04600 SPEECH PATHOLOGY	C	276, 585	1			46. C
7.00	04700 ELECTROCARDI OLOGY	C	C	1			47.0
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	C				48.0
9.00	04900 DRUGS CHARGED TO PATIENTS	C	621, 659	1			49. C
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	C	1			50. C
51.00	05100 SUPPORT SURFACES	C	C	0			51.0
	OUTPATIENT SERVICE COST CENTERS		1	1			
	06000 CLINIC	C		1			60. C
1.00	06100 RURAL HEALTH CLINIC	C	C	2			61.C
2.00							62.0
	OTHER REIMBURSABLE COST CENTERS	-	-				
	07000 HOME HEALTH AGENCY COST	C		1			70.0
	07100 AMBULANCE	C					71.0
3.00	07300 CMHC	C	C)			73.0
	SPECIAL PURPOSE COST CENTERS						
30.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. C
31.00	08100 I NTEREST EXPENSE		0				81. C
32.00	08200 UTI LI ZATI ON REVI EW - SNF		0				82.0
33.00	08300 HOSPI CE						83.0
39.00	SUBTOTALS (sum of lines 1-84)	-768,005	21, 089, 268	5			89. (
0 00	NONREI MBURSABLE COST CENTERS	-					00.
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	1			90. (
1.00	09100 BARBER AND BEAUTY SHOP		367				91.0
	09200 PHYSI CLANS PRI VATE OFFI CES			1			92.0
	09300 NONPALD WORKERS			1			93.0
	09400 PATI ENTS LAUNDRY TOTAL	-768, 005	21, 089, 635	ן .			94.0 100.0
00.00							111111

Health Financial Systems	JEFFERSON HEALTH CARE CENTER			In Lieu of Form CMS-2540-10		
RECLASSI FI CATI ONS		Provi der	No.: 315231	Period:	Worksheet A-6	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/5/2022 1:50	
			Increases			
	Cost Center	•	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
TOTALS						
	Total Reclassificati of columns 4 and 5 r equal sum of columns 9)	nust		0	0	100. 00

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

Health Financial Systems	JEFFERSON HEALTH CAR	E CENTER		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2021	Worksheet A-6)
					Date/Time Pre 5/5/2022 1:50	
	Decreases					
	Cost Center	•	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
TOTALS						
100.00				0	C	100.00

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

Heal th	Financial Systems	JEFFERSON HEALT	H CARE CENTER		In Lie	eu of Form CMS-2	2540-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315231	Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
					10 12/31/2021	5/5/2022 1:50	pareu. pm
				Acqui si ti on	S		
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1, 650, 000	0		0 0	0	
2.00	Land Improvements	745, 217	0		0 0	0	
3.00	Buildings and Fixtures	26, 059, 462	0		0 0	0	
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	551, 831	0)	0 0	0	5.00
6.00	Movable Equipment	1, 862, 101	0		0 0	0	6.00
7.00	Subtotal (sum of lines 1-6)	30, 868, 611	0		0 0	0	7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	30, 868, 611	0)	0 0	0	9.00
	Description	Endi ng Bal ance					
			Depreciated				
			Assets	-			
	T	6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		-	1			
1.00	Land	1,650,000	0				1.00
2.00	Land Improvements	745, 217	0				2.00
3.00	Buildings and Fixtures	26, 059, 462	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	551, 831	0				5.00
6.00	Movable Equipment	1, 862, 101	0				6.00
7.00	Subtotal (sum of lines 1-6)	30, 868, 611	0	2			7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	30, 868, 611	0	9			9.00

JUST	MENTS TO EXPENSES		Provi der	No.: 315231	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Date/Time Pre 5/5/2022 1:50	parec
					lassification on ch the Amount is	Worksheet A	
	Description (1)	(2) Basis For Adjustment	Amount	Cos	t Center	Line No.	
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds	В		CAP REL COST	S - BLDGS &	1.00	1.
00	(chapter 2) Trade, quantity, and time discounts (chapter		0	FIXTURES		0.00	2.
00	8) Refunds and rebates of expenses (chapter 8)		0			0,00	3.
00	Rental of provider space by suppliers (chapter 8)		0			0.00	
00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	5.
00	Television and radio service (chapter 21)		0			0.00	6.
0	Parking lot (chapter 21)		0			0.00	7.
0	Remuneration applicable to provider-based physician adjustment	A-8-2	0				8
0	Home office cost (chapter 21)		0			0.00	
00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00	
00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	0				12
00	Laundry and Linen service		0			0.00	13
00	Revenue - Employee meals		0			0.00	
00	Cost of meals - Guests		0			0.00	
00	Sale of medical supplies to other than		0			0.00	16
	patients						
00	Sale of drugs to other than patients		0			0.00	
00 00	Sale of medical records and abstracts		0			0.00	
00	Vending machines Income from imposition of interest, finance		0			0.00 0.00	
00	or penal ty charges (chapter 21)		0			0.00	20
00	Interest expense on Medicare overpayments		0			0.00	21
	and borrowings to repay Medicare						
	overpayments						
00	Utilization reviewphysicians' compensation		0	UTILIZATION	REVIEW - SNF	82.00	22
00	(chapter 21) Depreciationbuildings and fixtures			CAP REL COST	S - BLDGS &	1.00	23
00	Depreciationmovable equipment			FIXTURES CAP REL COST EQUI PMENT	S - MOVABLE	2.00	24
00	BAD DEBT EXPENSE	А	-755.345		VE & GENERAL	4.00	25
01	ADVERTI SI NG	A			VE & GENERAL	4.00	
	OTHER INCOME	В			VE & GENERAL	4.00	
03	INVESTMENT MGMT FEES LONG TERM	A			VE & GENERAL	4.00	
J. OO	Total (sum of lines 1 through 99) (Transfer		-768, 005				100

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

Health Financial Systems	JEFFERSON HEALT	H CARE CENTER		In Lie	u of Form CMS	S-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANI OFFICE COSTS			No.: 315231	Period: From 01/01/2021 To 12/31/2021	5/5/2022 1:	repared:
	Line No.	Cost (Center	Expense	e Items	
	1.00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELA	TED ORGANI ZATI ONS	6 OR	
1.00		CAP REL COSTS FIXTURES	- BLDGS &	ALLOCATED INTE	REST	1.00
2.00	0.00					2.00
3.00	0.00					3.00
4.00	0.00					4,00
5.00	0.00					5.00
6.00	0.00					6.00
7.00	0.00					7.00
8.00	0.00					8.00
9.00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	0.00					10.00
6, line 100 to Worksheet A-8, column 3, line						10.00
	Amount	Amount	Adjustments	:		
	Allowable In	Included in	(col. 4 minu			
	Cost	Wkst. A, col.	col. 5)	.5		
	0001	5				
	4,00	5.00	6,00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI				TED ORGANIZATIONS	OR	
CLAIMED HOME OFFICE COSTS:			-			
1.00	1, 805, 960	1, 805, 960		0		1.00
2.00	0	0		0		2.00
3.00	0	0		0		3.00
4.00	0	0		0		4.00
5.00	0	0		0		5.00
6.00	0	0		0		6.00
7.00	0	0		0		7.00
8.00	0	0		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	1, 805, 960	1, 805, 960		0		10.00
6, line 100 to Worksheet A-8, column 3, line	9					
12.						

Health Financial Systems	JEFFERSON HEALT	H CARE CENTER	In Lie	u of Form CMS-2	540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANI OFFICE COSTS	ZATIONS AND HOME	E Provider No.: 315231	From 01/01/2021	Worksheet A-8- Parts I-II Date/Time Prep 5/5/2022 1:50	ared:
	Symbol (1)	Name	Percentage of		
			Ownership		
	1.00	2.00	3.00		
	ZATION(S) AND/O	D HOME OFFICE.			

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	В	THOMAS JEFFERSON UNIVERSITY	0.00	1.00
		HOSPI TAL		
2.00			0.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci 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

Related Org	Related Organization(s) and/or Home Office				
		-			
Name	Percentage of	Type of Business			
	Ownershi p				
4.00	5.00	6.00	1		

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	JEFFERSON HEALTH CARE CENTER	0.00 NURSING FACILITY	1.00
2.00		0.00	2.00
3.00		0.00	3.00
4.00		0.00	4.00
5.00		0.00	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

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

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

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

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

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

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

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

Heal th	Financial Systems	JEFFERSON HEALTH	I CARE CENTER		In Lie	eu of Form CMS-:	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315231	Period: From 01/01/2021 To 12/31/2021		pared:
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFI TS	Subtotal	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS		0.0/4.551	1		1	1
1.00 2.00 3.00 4.00 5.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	2, 964, 551 0 1, 972, 180 2, 441, 288 1, 355, 655	2, 964, 551 0 70, 557 386, 879		0 0 1, 972, 180 0 201, 655 0 77, 522	2, 713, 500	•
6.00 7.00 8.00 9.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION	233, 672 420, 575 1, 721, 747 2, 888	38, 698 6, 771 128, 655 0		0 38, 203 0 71, 975 0 148, 057 0 0	499, 321 1, 998, 459 2, 888	7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0 0 0 186, 553 0	0 0 0 4, 875 0		0 0 0 0 0 0 38, 769	0 0 230, 197 0	10.00 11.00 12.00 13.00 14.00
	01500 PATIENT ACTIVITIES	168, 862	48, 313		0 32, 710		
30. 00 31. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	7, 151, 220	2, 223, 871		0 1, 363, 289 0 C	0	31.00
32.00 33.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0	0				32.00 33.00
00.00	ANCI LLARY SERVICE COST CENTERS		0				00.00
40.00	04000 RADI OLOGY	113, 980	0		0 0		•
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	47,038	0			47, 038 0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	•
44.00	04400 PHYSI CAL THERAPY	833, 853	28, 677		0 0		•
45.00	04500 OCCUPATI ONAL THERAPY	541, 946	17,030		0 0	558, 976	•
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	276, 585	2, 912			279, 497 0	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	621, 659	0		0 0	621, 659	•
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	000	0 0		0 C 0 C	-	50.00 51.00
60.00	06000 CLI NI C	0	0		0 0		
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FQHC OTHER REIMBURSABLE COST CENTERS	0	0		0 C	0	61.00 62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 C		70.00
71.00 73.00	07100 AMBULANCE 07300 CMHC	35, 016 0	0 0				71.00 73.00
	SPECIAL PURPOSE COST CENTERS			1		1	
80.00 81.00 82.00	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) NONREIMBURSABLE COST CENTERS	0 21, 089, 268	0 2, 957, 238		0 0 0 1, 972, 180	0 21, 081, 955	83.00 89.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 367	0 7, 313		0 C 0 C	7, 680	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	•
93.00 94.00	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0	0			0	
98.00	Cross Foot Adjustments	0	0		0 0	0	98.00
99.00	Negative Cost Centers	0	0		0 0	0	99.00
100.00	D TOTAL	21, 089, 635	2, 964, 551	I	0 1, 972, 180	21, 089, 635	100.00

COST /	Financial Systems LLOCATION - GENERAL SERVICE COSTS	JEFFERSON HEALTH		No.: 315231	Peri od:	u of Form CMS- Worksheet B	2340-10
C031 F	LEUGATION - GENERAL SERVICE COSTS		FIOVIDEI	10313231	From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/5/2022 1:50	epared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINI STRATI VE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINI STRATION	2, 713, 500 268, 757 45, 860 73, 732 295, 100 426	2, 088, 813 32, 241 5, 642 107, 189 0	388, 6	74 0 578, 695 0 30, 245 0 0	2, 430, 993 0	1
10.00 11.00 12.00 13.00 14.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0 0 33, 992 0	0 0 4, 062 0		0 0 0 0 0 0 0 0 0 1, 146 0 0	0 0 0 0 0	12.00 13.00
15.00	01500 PATIENT ACTIVITIES	36, 899	40, 252		0 11, 358	0	15.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	1, 585, 677	1, 852, 827	388, 6	74 522, 799	2, 430, 993	30.00
30.00	03100 NURSING FACILITY	1, 585, 677	1, 052, 027		0 0	2, 430, 993	
32.00	03200 I CF/I I D	0	C		0 0	0	
33.00	03300 OTHER LONG TERM CARE	0	0	0	0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	16, 831	C		0 0	0	40.00
41.00	04100 LABORATORY	6, 946	C		0 0	0	
42.00	04200 I NTRAVENOUS THERAPY	0	C		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	1
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	127, 365 82, 541	23, 892 14, 189		0 6, 741 0 4, 003	0	44.00
46.00	04600 SPEECH PATHOLOGY	41, 272	2, 426		0 4,003	0	
47.00	04700 ELECTROCARDI OLOGY	0	C		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	91, 797	0		0 0	0	
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0 0	0	1
01100	OUTPATIENT SERVICE COST CENTERS				0		
60.00	06000 CLI NI C	0	C		0 0	0	60.00
61.00 62.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	
02.00	06200 FOHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0)	0 0	0	70.00
71.00	07100 AMBULANCE	5, 171	C		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			1			80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	C		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	2, 712, 366	2,082,720	388, 6	74 576, 976	2, 430, 993	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	1, 134	6, 093		0 1, 719	0	1
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	C		0 0	0	
93.00	09300 NONPALD WORKERS	0	0		0 0	0	
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0			0	
		0	0		0	0	1
99.00	Negative Cost Centers	U	2, 088, 813		0 0	2, 430, 993	

		JEFFERSON HEALTH		N- 015001		eu of Form CMS-2	2540-10
CUST	ALLOCATION - GENERAL SERVICE COSTS		Provider	No.: 315231	Period: From 01/01/2021 To 12/31/2021		pared:
	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	
	GENERAL SERVICE COST CENTERS			1	-	-	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	3, 314					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	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	000000000000000000000000000000000000000				269, 397 0 0	10.00 11.00 12.00 13.00 14.00
15.00	01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	(0 (0	15.00
30.00 31.00 32.00 33.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	3, 314 0 0	((((30.00 31.00 32.00 33.00
	ANCI LLARY SERVI CE COST CENTERS			1			
40.00 41.00 42.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0 0 0					40.00 41.00 42.00
43.00 44.00 45.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY	0	(43.00 44.00 45.00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	(46.00 47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	(0 0		48.00 49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	()	0 (50.00 51.00
60.00 61.00 62.00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	(0 (0		60. 00 61. 00 62. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	(0	0 0	70.00
71.00 73.00	07100 AMBULANCE 07300 CMHC	0	(0 (0 0	71.00
80.00 81.00 82.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08200 UDSDLCE						80.00 81.00 82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 3, 314	((0 0 269, 397	
90.00 91.00 92.00 93.00 94.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CI ANS PRI VATE OFFI CES 09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		(((((91.00 92.00
94.00 98.00 99.00 100.00	Cross Foot Adjustments Negative Cost Centers	0 0 0 3, 314				0 0 0 269, 397	98.00 99.00

Heal th	Financial Systems	JEFFERSON HEALT	H CAR	RE CENTER		In Lie	u of Form CMS-	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS			Provi der	No.: 315231	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/5/2022 1:50	epared:
				R GENERAL				
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	P	<u>ERVI CE</u> ATI ENT TI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		14.00		15.00	16.00	17.00	18.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	T	1		1			1.00
2.00 3.00 4.00 5.00 6.00	00200 CAP REL COSTS - BEDGS & TEXTRES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE							2.00 3.00 4.00 5.00 6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY							7.00 8.00
9.00 10.00 11.00 12.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY							9.00 10.00 11.00 12.00
13.00 14.00 15.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES	0		338, 394	1			13.00 14.00 15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-			1			
30.00	03000 SKILLED NURSING FACILITY	0		338, 394			18, 130, 455	
31.00 32.00	03100 NURSING FACILITY 03200 ICF/IID	0		0		0 0	0	
33.00	03300 OTHER LONG TERM CARE	0		0		0 0	0	
	ANCILLARY SERVICE COST CENTERS							
40.00	04000 RADI OLOGY	0		0			130, 811	
41.00	04100 LABORATORY	0		0	53, 9		53, 984	
42.00 43.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0		0		0 0	0	
44.00	04400 PHYSI CAL THERAPY	0		0	1, 020, 5	0	1, 020, 528	
45.00	04500 OCCUPATI ONAL THERAPY	0		0	659, 7		659, 709	
46.00	04600 SPEECH PATHOLOGY	0		0	323, 8		323, 879	
47.00	04700 ELECTROCARDI OLOGY	0		0		0 0	0	
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0		0	713, 4	0 0 56 0	0 713, 456	
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		0		0 0	/13, 430	
51.00	05100 SUPPORT SURFACES	0		0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0		0		0 0	0	
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0		0)	0 0	0	61.00 62.00
02.00	OTHER REIMBURSABLE COST CENTERS							02.00
70.00	07000 HOME HEALTH AGENCY COST	0		0)	0 0	0	70.00
	07100 AMBULANCE	0		0	40, 1		40, 187	71.00
73.00	07300 CMHC	0		0)	0 0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS				-			
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE							80.00 81.00
82.00	08200 UTILIZATION REVIEW - SNF							82.00
83.00	08300 H0SPI CE	0		0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0		338, 394	21, 073, 0	09 0	21, 073, 009	89.00
00.05	NONREI MBURSABLE COST CENTERS	-	-		J	-	-	00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0	14 4	0 0	0	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES			0	16, 6		16, 626 0	
	09300 NONPAID WORKERS	0		0		0 0	0	
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	01 000 /	0 0	0	
100.00	TOTAL	0	1	338, 394	21, 089, 6	35 0	21, 089, 635	1100.00

Heal th	Financial Systems	JEFFERSON HEALTH	H CARE CENTER		In Lie	eu of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS			No.: 315231	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/5/2022 1:50	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REL BLDGS & FI XTURES	ATED COSTS MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		0	1.00	2.00	2A	3.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	0 0 0 0 0	0 70, 557 386, 879 38, 698 6, 771		0 0 0 70, 557 0 386, 879 0 38, 698 0 6, 771	0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00
13.00 14.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE 01400 NURSI NG AND ALLI ED HEALTH EDUCATI ON 01500 PATI ENT ACTI VI TI ES		128, 655 0 0 0 0 4, 875 0 48, 313		0 128, 655 0 0 0 0 0 0 0 0 0 0 0 0 0 4, 875 0 0 0 48, 313	0 0 0 0 0 0 0 0 0 0	8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
31. 00 32. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0 0	2, 223, 871 0 0 0		0 2, 223, 871 0 0 0 0 0 0 0	0 0 0 0	30. 00 31. 00 32. 00 33. 00
40.00 41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00	04000 RADI OLOGY 04100 LABORATORY 04200 INTRAVENOUS THERAPY 04200 OXYGEN (INHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS 05000 DENTAL CARE - TI TLE XI X ONLY 05100 SUPPORT SURFACES		0 0 28, 677 17, 030 2, 912 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 28, 677 0 17, 030 0 2, 912 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40.00 41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00
	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC CHUED SARLE COST CENTERS	00	0 0		0 0 0 0	0	60. 00 61. 00 62. 00
71.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	71.00
81. 00 82. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	0 2, 957, 238		0 0 0 2, 957, 238	0	•
91.00 92.00 93.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers TOTAL		0 7, 313 0 0 0 2, 964, 551		0 0 0 7, 313 0 0 0 0 0 0 0 0 0 0 0 0 0 2, 964, 551	0 0 0 0 0 0	93.00 94.00 98.00

To 12/31/2021 Date/Time Cost Center Description ADM IN STRATIVE & GENERAL PANT OPERATION. REPAILS LINEN.SERVICE HUSEKEEPING DIETARY 0 00100 CAP. REL. COSTS - BLOCS & FLATURES 0 0.0 0.00 <td< th=""><th></th><th>Financial Systems TON OF CAPITAL RELATED COSTS</th><th>JEFFERSON HEALTH</th><th></th><th>No.: 315231</th><th>Peri od:</th><th>u of Form CMS- Worksheet B</th><th></th></td<>		Financial Systems TON OF CAPITAL RELATED COSTS	JEFFERSON HEALTH		No.: 315231	Peri od:	u of Form CMS- Worksheet B	
Cost Center Description ADM IN STRATUR & GENERAL PLANT OPERATION. NMART & REPAIRS LUNDERY & LINEN SERVICE PUSEKEEPING 0 DIETARY 0 GENERAL SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 2.00 GODD CAP REL COSTS - MUNSE & FLYTURES -<						From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	epared:
ENERGY CONTRACT MAINT. MAINT. <t< th=""><th></th><th>Cost Center Description</th><th>ADMI NI STRATI VE</th><th>PLANT</th><th>LAUNDRY &</th><th>HOUSEKEEPI NG</th><th></th><th></th></t<>		Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG		
EFPALES FIFPALES C B 0 00100 CAP REL COST CENTERS 0 0 00100 CAP REL COST - BLIDGS & FIXTURES 0 0 00100 CAP REL COST - MOVABLE EQUI PMENT 0 0 00100 CAP REL COST - MOVABLE EQUI PMENT 0		· ·	& GENERAL		LINEN SERVIC	E		
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71.00 07100 AMBULANCE 134 0 0 0 73.00 07300 CMHC 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 0 0 0 0 0 81.00 08100 INTEREST EXPENSE 0 0 0 0 0 82.00 08200 UTI LI ZATI ON REVIEW - SNF 0 0 0 0 83.00 08300 HOSPICE 0 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 70, 528 392, 719 45, 970 9, 723 157, 157, 1000000000000000000000000000000000000					1	0 0	0	70 00
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89.00 SUBTOTALS (sum of lines 1-84) 70, 528 392, 719 45, 970 9, 723 157, 70, 723 NONREI MBURSABLE COST CENTERS 0								82.00
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90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0			70, 528	392, 719	45,9	/0 9,723	157, 051	89.00
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		09200 PHYSI CLANS PRI VATE OFFICES	1	1, 147			0	
93. 00 09300 NONPAI D WORKERS 0 0 0 0			0	0		0 0	0	1
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0			0	C		0 0	0	94.00
98.00 Cross Foot Adjustments 0 0		3				0 0	0	
99.00 Negative Cost Centers 0 0 0 0 0 100 0<	1		0	0		0	0	
100. 00 TOTAL 70, 557 393, 868 45, 970 9, 752 157,	00.00	TUTAL	/0, 557	393, 868	۶J 45,9	70j 9, 752	157, 051	1100.00

Heal th	Financial Systems	JEFFERSON HEALTH	H CARE CENTER		In Lie	eu of Form CMS-:	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315231	Period: From 01/01/2021 To 12/31/2021		pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	
		0.00	SUPPLY	11.00	LI BRARY	12.00	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS						4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION	11					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	(0		10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	(0 0		11.00 12.00
12.00	01300 SOCIAL SERVICE	0	(0 0		
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	(0 0		14.00
15.00	01500 PATIENT ACTIVITIES	0	(0 0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1		T		Т	
30.00	03000 SKI LLED NURSI NG FACI LI TY	11	(0 0		30.00
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D	0	(0 0		31.00 32.00
	03300 OTHER LONG TERM CARE	0	(0 0		32.00
00.00	ANCI LLARY SERVICE COST CENTERS			2		<u>, </u>	00.00
40.00	04000 RADI OLOGY	0	(0 (0 0	40.00
41.00	04100 LABORATORY	0	(D I I I I I I I I I I I I I I I I I I I	0 0		41.00
42.00	04200 INTRAVENOUS THERAPY	0	(0 0		42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	(0 0		43.00 44.00
44.00	04500 OCCUPATI ONAL THERAPY	0	(0 0		44.00
46.00	04600 SPEECH PATHOLOGY	0	(0 0	0 0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	(0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(D	0 0	0 0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	(0 0	-	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY	0	(0 0		50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVICE COST CENTERS	U U	(<u>и</u>	0 (<u> </u>	51.00
60.00	06000 CLINIC	0	(b	0 0	0 0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	(0 0		61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00 71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	(0 0		70.00
73.00	07300 CMHC	0	(
70.00	SPECIAL PURPOSE COST CENTERS			2	<u> </u>	,°	/ 0. 00
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 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	(0 0		83.00 89.00
09.00	NONREI MBURSABLE COST CENTERS	1 11	(<u>и</u>	0 (0, 544	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		91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	(<u>מ</u>	0 0	0 0	92.00
93.00	09300 NONPALD WORKERS	0	(2	0 0	-	93.00
94.00	09400 PATIENTS LAUNDRY	0	(1	0 0	0	94.00
98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0	ſ	Ś	0 0	o	98.00 99.00
100.00		11	(ó	0 0		100.00
	· · ·		-	•			

Heal th	Financial Systems	JEFFERSON HEALT	H CARE CENTER		In Lie	u of Form CMS-2	2540-10
	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315231	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/5/2022 1:50	pared:
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	OTHER GENERAL SERVI CE PATI ENT ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS	1	1	1			1 00
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 13.00\end{array}$	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 DI ETARY 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 PATIENT ACTIVITIES	0	57,054				15.00
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0 0	0		1 0 0 0 0 0 0 0 0 0	2, 889, 911 0 0 0	30. 00 31. 00 32. 00 33. 00
40.00 41.00 42.00 43.00	ANCI LLARY SERVICE COST CENTERS 04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY					438 181 0 0	40.00 41.00 42.00 43.00
44.00 45.00 46.00 47.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY			36, 60 21, 91 4, 45	08 0 8 0	36, 608 21, 918 4, 454 0	44.00
48.00 49.00 50.00 51.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0 0 0 0	0 0 0 0		0 0 7 0 0 0 0 0	0 2, 387 0 0	48.00 49.00 50.00 51.00
60. 00 61. 00 62. 00	OUTPATI ENT_SERVICE_COST_CENTERS 06000 CLINIC 06100 RURAL HEALTH_CLINIC 06200 FQHC	0			0 0 0 0	0	60. 00 61. 00 62. 00
71.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	000000000000000000000000000000000000000	0	13	0 0 44 0 0 0	0 134 0	70. 00 71. 00 73. 00
80. 00 81. 00 82. 00 83. 00 89. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0		2, 956, 03	0 0 11 0	0 2, 956, 031	80. 00 81. 00 82. 00 83. 00 89. 00
90.00 91.00 92.00 93.00 94.00 98.00 99.00 100.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers			8, 52	0 0 0 0 0 0 0 0 0 0 0 0	0 8, 520 0 0 0 0 0 0 2, 964, 551	92.00 93.00 94.00 98.00 99.00

IST A	Financial Systems LLOCATION - STATISTICAL BASIS	JEFFERSON HEALT			Period:	worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/5/2022 1:50	
		CAPI TAL REI	ATED COSTS				
			100/1015				
	Cost Center Description	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	& GENERAL	
		(SQUARE FEET)		(GROSS		(ACCUM COST)	
		(SQUARE TELT)	(SUUARE ILLI)	SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	-					
00	00100 CAP REL COSTS - BLDGS & FIXTURES	87, 562					1.
00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		87, 562				2.
00	00300 EMPLOYEE BENEFITS	0	-	.,			3.
00	00400 ADMINI STRATI VE & GENERAL	2,084					4.
00	00500 PLANT OPERATION, MAINT. & REPAIRS	11, 427				1, 820, 056	
00 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	1, 143				310, 573	6. 7.
00	00800 DI ETARY	3, 800				499, 321 1, 998, 459	
00	00900 NURSI NG ADMI NI STRATI ON	3, 800	3, 800			2, 888	
00	01000 CENTRAL SERVICES & SUPPLY	0				2,000	10.
. 00	01100 PHARMACY	0	0		0 0	0	11.
2.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	12.
8. 00	01300 SOCIAL SERVICE	144	144	186, 51	0 0	230, 197	13.
. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.
5.00	01500 PATIENT ACTIVITIES	1, 427	1, 427	157, 36	2 0	249, 885	15.
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-	1				
0. 00	03000 SKILLED NURSING FACILITY	65, 685				10, 738, 380	
. 00	03100 NURSING FACILITY	0	0		0 0	0	31.
2.00	03200 CF/I D	0	0		0 0	0	32.
8. 00	O3300 OTHER LONG TERM CARE	0	0		0 0	0	33.
	ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	112 000	40.
). 00 . 00	04000 RADI OLOGY 04100 LABORATORY				0 0 0 0	113, 980 47, 038	
2.00	04200 I NTRAVENOUS THERAPY	0				47,038	41.
. 00 . 00	04300 OXYGEN (INHALATION) THERAPY	0	0				42.
. 00	04400 PHYSI CAL THERAPY	847	-		0 0	862, 530	
5.00	04500 OCCUPATI ONAL THERAPY	503			0 0	558, 976	
. 00	04600 SPEECH PATHOLOGY	86	86		0 0	279, 497	46.
. 00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.
8.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.
0. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	621, 659	
0. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.
. 00	05100 SUPPORT SURFACES	0	0		0 0	0	51.
	OUTPATIENT SERVICE COST CENTERS	-					1
). 00	06000 CLINIC	0			0 0		60.
. 00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.
2.00	O6200 FOHC OTHER REIMBURSABLE COST CENTERS						62.
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.
	07100 AMBULANCE	0			0 0	35, 016	
. 00 . 00	07300 CMHC	0	0		0 0	0	
	SPECIAL PURPOSE COST CENTERS	-	-		-1 -	-	
0. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.
. 00	08100 INTEREST EXPENSE						81.
2. 00	08200 UTILIZATION REVIEW - SNF						82.
8.00	08300 HOSPI CE	0	0		0 0	0	
0. 00	SUBTOTALS (sum of lines 1-84)	87, 346	87, 346	9, 487, 79	3 -2, 713, 500	18, 368, 455	89.
	NONREI MBURSABLE COST CENTERS						
. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
. 00	09100 BARBER AND BEAUTY SHOP	216	216		0 0	7, 680	
. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS					0	92.
8.00 .00	09300 NUNPATD WORKERS 09400 PATIENTS LAUNDRY					0	
. 00 . 00	Cross Foot Adjustments					0	94
9.00 9.00	Negative Cost Centers						98.
, 00)2. 00	5	2, 964, 551	0	1, 972, 18	0	2, 713, 500	
.2.00	Part I)	2,704,001		1, 772, 10	Ĩ	2, , 13, 300	1.02.
3. 00		33. 856593	0. 000000	0. 20786	5	0. 147664	103
)4. 00		23.000070		3.20.00	0	70, 557	
	Part II)						
5.00	-			0.00000	0	0. 003840	105.
		1	1	1		1	1

Health Financial Systems	JEFFERSON HEALT	TH CARE CENTER		In Lie	u of Form CMS-:	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2021	Worksheet B-1	
				o 12/31/2021	Date/Time Pre 5/5/2022 1:50	
Cost Center Description	PLANT OPERATI ON,	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY (MEALS SERVED)	NURSI NG	
	MALNT. &	(PATIENT DAYS)		(WERES SERVED)	ADMINI STRATION	
	REPAI RS	l'			(DI RECT	
	(SQUARE FEET) 5.00	6.00	7.00	8.00	NURSING) 9.00	
GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	9.00	
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00 00300 EMPLOYEE BENEFITS 4. 00 00400 ADMINISTRATIVE & GENERAL						3.00 4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	74, 051					5.00
6.00 00600 LAUNDRY & LINEN SERVICE	1, 143					6.00
7.00 00700 HOUSEKEEPI NG	200	C	72, 708			7.00
8.00 00800 DI ETARY	3,800		-,		000 (00	8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON 10. 00 01000 CENTRAL SERVI CES & SUPPLY				0	203, 699 0	9.00 10.00
11. 00 01100 PHARMACY				0	0	11.00
12. 00 01200 MEDICAL RECORDS & LIBRARY	C	0	0	0	0	12.00
13.00 01300 SOCIAL SERVICE	144		144		0	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	C	-	-	-	0	14.00
15. 00 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	1, 427	0	1, 427	0	0	15.00
30. 00 03000 SKI LLED NURSI NG FACI LI TY	65, 685	36, 309	65, 685	108, 927	203, 699	30.00
31. 00 03100 NURSING FACILITY	C			0	0	31.00
32. 00 03200 I CF/I I D	C				0	32.00
33.00 O3300 OTHER LONG TERM CARE	C	C	0	0	0	33.00
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY	C	C	0	0	0	40.00
41. 00 04100 LABORATORY					0	40.00
42. 00 04200 I NTRAVENOUS THERAPY	C				0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	C		-		0	43.00
44. 00 04400 PHYSI CAL THERAPY	847		011		0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY	503		000		0	45.00 46.00
47. 00 04700 ELECTROCARDI OLOGY			0		0	40.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		-	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	C	, s	0	0	0	49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	C		-		0	50.00
51.00 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	C	0 0	0	0	0	51.00
60. 00 06000 CLINIC	C	C	0 0		0	60.00
61.00 06100 RURAL HEALTH CLINIC	C	0 0			0	61.00
62. 00 06200 FQHC						62.00
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST	C	C	0	0	0	70.00
71. 00 07100 AMBULANCE						
73.00 07300 CMHC	C	-	-	-	0	73.00
SPECIAL PURPOSE COST CENTERS			-			
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 08100 I NTEREST EXPENSE 82.00 08200 UTI LI ZATI ON REVIEW - SNF						81.00 82.00
83. 00 08300 HOSPI CE	C	o c	0	0	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	73, 835	36, 309	72, 492	108, 927	203, 699	89.00
NONREI MBURSABLE COST CENTERS	1	1	1			
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 91.00 09100 BARBER AND BEAUTY SHOP	0				0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP 92. 00 09200 PHYSI CLANS PRI VATE OFFICES	216			0	0	91.00 92.00
93. 00 09300 NONPAID WORKERS	C	, s		0	0	93.00
94.00 09400 PATIENTS LAUNDRY	C	0	0	0	0	94.00
98.00 Cross Foot Adjustments						98.00
99.00 Negative Cost Centers	2 000 012	200 474	E79 40E	2 420 002	2 214	99.00
102.00 Cost to be allocated (per Wkst. B, Part I)	2, 088, 813	388, 674	578, 695	2, 430, 993	3, 314	102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	28. 207762	10. 704619	7. 959165	22. 317635	0. 016269	103.00
104.00 Cost to be allocated (per Wkst. B,	393, 868					104.00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part	E 21007E	1 244077	0 12/12/	1 441000		105 00
105.00 Unit cost multiplier (Wkst. B, Part	5. 318875	1. 266077	0. 134126	1.441800	0.000054	105.00
				1 I		•

COST A	Financial Systems LLOCATION - STATISTICAL BASIS	JEFFERSON HEALTH			Period:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2021 To 12/31/2021	Date/Time Pre 5/5/2022 1:50	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S) 10.00	PHARMACY (COSTED REQUIS) 11.00	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 12.00	SOCIAL SERVICE (PATIENT DAYS) 13.00	NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED TI ME) 14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
14.00	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 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES					0 0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	0	C		36, 309	0	30.00
	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE					0 0 0	31.00 32.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	C		0	0	40.00
41.00	04100 LABORATORY	0	C			0	41.00
42.00 43.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	C			0	42.00 43.00
44.00	04400 PHYSI CAL THERAPY	0	C		0 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	C	0	0 0	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0				0	46.00 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	C	(0	0	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	C		-	0	50.00 51.00
01100	OUTPATIENT SERVICE COST CENTERS	· ·			,		01100
60.00		0				0	60.00
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	C		0	0	61.00 62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	C				70.00 71.00
	07300 CMHC	0	C			0	
00.00	SPECIAL PURPOSE COST CENTERS	1		1			
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00 89.00	08300 HOSPICE	0	C	1		0	
69.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	<u> </u>	C.	<u>y</u> (50, 309	0	69.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C			0	90.00
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRIVATE OFFICES	0	C			0	91.00 92.00
93.00	09300 NONPAI D WORKERS	0	C		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	C	0	0 0	0	94.00
98.00 99.00	Cross Foot Adjustments Negative Cost Centers						98.00 99.00
102.00	Cost to be allocated (per Wkst. B,	0	C	0	269, 397	0	102. 00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000	7. 419565	0.00000	103. 00
104.00	Cost to be allocated (per Wkst. B,	0	C	(6, 544		104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 180231	0. 000000	105 00
100.00	UNIT COST MULTIPITEL (WKSL. D, Part	0.000000	0.000000	1 0.00000	0. 100231	0.000000	100.00

	n Financial Systems ALLOCATION - STATISTICAL BASIS	JEFFERSON HEALTH	Provi der No.: 315231	Peri od:	u of Form CMS-2540 Worksheet B-1
				From 01/01/2021 To 12/31/2021	Date/Time Prepare
				10 12/01/2021	5/5/2022 1:50 pm
	Cost Center Description	OTHER GENERAL SERVI CE PATI ENT ACTI VI TI ES (PATI ENT DAYS) 15. 00			
	GENERAL SERVICE COST CENTERS				
14.00					1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.
15.00		36, 309			15.
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	36, 309			30.
31. 00 32. 00 33. 00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0			30. 31. 32. 33.
10 00	ANCI LLARY SERVI CE COST CENTERS	0			40
41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS 05000 DENTAL CARE - TITLE XIX ONLY				40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51.
50.00	06000 CLINIC	0			60.
61.00 62.00	06100 RURAL HEALTH CLINIC	0			61. 62.
	07000 HOME HEALTH AGENCY COST	0			70.
	07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	0			71. 73.
80. 00 81. 00 82. 00 83. 00 89. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 36, 309			80. 81. 82. 83. 89.
90.00 91.00 92.00 93.00 94.00 98.00 99.00 102.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 338, 394			90. 91. 92. 93. 94. 98. 99. 102.
103.00 104.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,				103. 104.
105.00	Part II) D Unit cost multiplier (Wkst. B, Part II)	1. 571346			105.

Health Financial Systems JEFFERSON HEALTH CARE CENTE	R	In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provid		Period:	Worksheet C	
		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/5/2022 1:50	
Cost Center Description	Total (from	Total Charges		
	Wkst. B, Pt I,		di vi ded by	
	col . 18)		col . 2	
	1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS				
40. 00 04000 RADI OLOGY	130, 81			
41.00 04100 LABORATORY	53, 984	47,038		
42. 00 04200 I NTRAVENOUS THERAPY		0	0.000000	
43.00 04300 0XYGEN (INHALATION) THERAPY	(0 0	0.00000	
44. 00 04400 PHYSI CAL THERAPY	1, 020, 528		0. 796826	
45. 00 04500 OCCUPATI ONAL THERAPY	659, 709			
46.00 04600 SPEECH PATHOLOGY	323, 879	537, 794		
47.00 04700 ELECTROCARDI OLOGY	(0 0	0.000000	
48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	(0 0	0.000000	
49.00 04900 DRUGS CHARGED TO PATIENTS	713, 450	660, 417	1.080311	•
50.00 05000 DENTAL CARE - TITLE XIX ONLY	(0 0	0.000000	•
51.00 05100 SUPPORT SURFACES	(0 0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS		1		
60. 00 06000 CLINIC	(0 0	0.000000	
61.00 06100 RURAL HEALTH CLINIC				61.00
62. 00 06200 FQHC				62.00
71.00 07100 AMBULANCE	40, 18			•
100. 00 Total	2, 942, 554	3, 830, 042		100. 00

Health Financial Systems	JEFFERSON HEALT				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315231	Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021		narod
				10 12/31/2021	5/5/2022 1:50	
		Title	XVIII (1)	Skilled Nursing		
				Facility		
		Health Care Pr	rogram Charge	s Health Care	Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B		Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	<u>Column 3)</u> 1,00	2.00	3.00	4,00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPA		2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	TILNI COST					-
40. 00 04000 RADI OLOGY	9. 310391	14, 050		0 130, 811	0	40.00
41. 00 04100 LABORATORY	1, 147668			0 53, 984		1
42.00 04200 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0. 796826	833, 107		0 663, 841	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 525671	809, 399		0 425, 478	0	45.00
46.00 04600 SPEECH PATHOLOGY	0. 602236	167, 056		0 100, 607	0	46.00
47.00 04700 ELECTROCARDI OLOGY	0. 000000	0		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 PATIENTS	1. 080311	429, 845		0 464, 366	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	1. 147675			0	0	71.00
100.00 Total (Sum of lines 40 - 71)		2, 300, 495		0 1, 839, 087	0	100.00
(1) Far title V and VIV use selumne 1 2 and 4 ar						

(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	JEFFERSON HEALT	H CARE CENTER		In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/5/2022 1:50	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description						
					1.00	
PART II - APPORTIONMENT OF VACCINE COST						
1.00 Drugs charged to patients - ratio of c			t C, column 3,	line 49)	1.080311	1.00
2.00 Program vacci ne charges (From your rec					0	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	viders, transf	er this amoun [.]	t to Worksheet	0	3.00
E, Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of		Part A Nursing	
	(From Wkst. B,	(From Wkst. B,		Cost (From Wkst. D Part	& Allied Health Costs	
	18 Part 1, COL		Costs to Tota		for Pass	
	18	14)	Costs - Part		Through (Col.	
		14)	(Col. 2 / Col		3 x Col. 4)	
					5 X COI. 4)	
	1,00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
ANCI LLARY SERVI CE COST CENTERS						
40. 00 04000 RADI OLOGY	130, 811	C	0.00000	0 130, 811	0	40.00
41.00 04100 LABORATORY	53, 984	C	0. 00000	53, 984	0	41.00
42.00 04200 I NTRAVENOUS THERAPY	0	C	0. 00000	0 0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	C	0. 00000	0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	1, 020, 528	C	0. 00000	663, 841	0	44.00
45.00 04500 OCCUPATI ONAL THERAPY	659, 709	C	0. 00000	0 425, 478	0	45.00
46.00 04600 SPEECH PATHOLOGY	323, 879	C	0. 00000		0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	C	0. 00000		0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0. 00000		0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	713, 456	C	0. 00000			49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	C	0. 00000		0	50.00
51.00 05100 SUPPORT SURFACES	0	C	0. 00000		0	51.00
100.00 Total (Sum of lines 40 - 52)	2, 902, 367	C		1, 839, 087	0	100. 00

MPUTATION OF INPATIENT ROUTINE COSTS		Provi der No.: 315231	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre	parec
		Title XVIII	Skilled Nursing	5/5/2022 1:50 PPS	pm
			Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	INPATIENT DAYS				-
00	Inpatient days including private room days			36, 309	1 1.0
00	Private room days			30, 307	
00	Inpatient days including private room days applicable to	the Program		8, 817	
00	Medically necessary private room days applicable to the			0,017	
00	Total general inpatient routine service cost			18, 130, 455	
00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			10, 130, 433	J.
00	General inpatient routine service charges			17, 828, 454	16.
00	General inpatient routine service cost/charge ratio (Li	ne 5 divided by line 6)		1.016939	
00	Enter private room charges from your records			0	
00	Average private room per diem charge (Private room charge	es line 8 divided by private	room days. line	0.00	
	2)	, · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·		
0. 00	Énter semi-private room charges from your records			0	10.
. 00					
	semi-private room days)	C C	5		
2.00	Average per diem private room charge differential (Line	9 minus line 11)		0.00	12.
3.00	Average per diem private room cost differential (Line 7	times line 12)		0.00	13.
1.00	Private room cost differential adjustment (Line 2 times	line 13)		0	14.
5.00	General inpatient routine service cost net of private ro	oom cost differential (Line 5	minus line 14)	18, 130, 455	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
	Adjusted general inpatient service cost per diem (Line 1	5 divided by line 1)		499.34	
	Program routine service cost (Line 3 times line 16)			4, 402, 681	17
. 00	Medically necessary private room cost applicable to prog			0	18
0. 00	Total program general inpatient routine service cost (L			4, 402, 681	
. 00	Capital related cost allocated to inpatient routine serv line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		t II column 18,	2, 889, 911	20
. 00	Per diem capital related costs (Line 20 divided by line	e 1)		79.59	21
. 00	Program capital related cost (Line 3 times line 21)			701, 745	22
	Inpatient routine service cost (Line 19 minus line 22)			3, 700, 936	23
. 00	Aggregate charges to beneficiaries for excess costs (Fr			0	1
. 00	Total program routine service costs for comparison to th	ne cost limitation (Line 23 mi	nus line 24)	3, 700, 936	25
					26
	Inpatient routine service cost limitation (Line 3 times			1	27
	Reimbursable inpatient routine service costs (Line 22 pl	us the lesser of line 25 or		1	28
	(Transfer to Worksheet E, Part II, line 4) (See instruct	ions)			1

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	36, 309	1.00
2.00	Program inpatient days (see instructions)	8, 817	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. 242832	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Т

Heal th	Financial Systems JEFFERSON HEALT	H CARE CENTER	In Lie	u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provi der No.: 315231	Peri od:	Worksheet E	
			From 01/01/2021	Part I	
			To 12/31/2021	Date/Time Pre 5/5/2022 1:50	
		Title XVIII	Skilled Nursing	PPS	pili
		in the xurri	Facility	115	
			, idoinity		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIM	BURSEMENT			
1.00	Inpatient PPS amount (See Instructions)			5, 327, 135	1.00
2.00	Nursing and Allied Health Education Activities (pass throug	h payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			5, 327, 135	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			654, 259	5.00
6.00	Allowable bad debts (From your records)			101, 834	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See in	istructions)		101, 834	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			66, 192	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)			4, 739, 068	11.00
12.00	Interim payments (See instructions)			4, 704, 091	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 sequestration	n		0	
14.55	Demonstration payment adjustment amount after sequestration	1		0	14.55
14.75	Sequestration for non-claims based amounts (see instruction	is)		0	
14.99	Sequestration amount (see instructions)			0	14.99
	Balance due provider/program (see Instructions)			34, 977	
16.00	Protested amounts (Nonallowable cost report items in accord			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LES	SER OF COST OR CHARGES - T	ITLE XVIII ONLY		
17.00	Ancillary services Part B			0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)			0	19.00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00
22.00	Primary payor amounts			0	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 in	istructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)			0	24.02
	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.00
26.00	Interim payments (See instructions)			0	26.00
27.00	Tentative adjustment			0	27.00 28.00
28.00	Other Adjustments (See instructions) Specify			-	
28.50	Demonstration payment adjustment amount before sequestration			0	28.50
28.55	Demonstration payment adjustment amount after sequestration	I		0	28.55
28.99	Sequestration amount (see instructions)			0	28.99 29.00
	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accor	dance with CMS Rub 15 2 c	oction 115 2	0	
30.00	In orested amounts (nonarrowable cost report ritellis) In accor	uance with thoms rub. 13-2, S	CCTUTITID. Z	0	30.00

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315231	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Pre 5/5/2022 1:50	pare
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Tabel interim promote and to provide	1.00	2.00 4,756,4	3.00	4.00	1
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		4, 756, 4	0	0	
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					-
01	ADJUSTMENTS TO PROVIDER			0	0	3
)1)2	ADJUSTMENTS TO PROVIDER			0	0	
)2)3				0	0	
)4				0	0	
)5				0	0	
	Provider to Program			-1		
0	ADJUSTMENTS TO PROGRAM	08/31/2021	52, 4	02	0	1 3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-52, 4	02	0	3
	- 3.98)				_	
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		4, 704, 0	91	0	4
	TO BE COMPLETED BY CONTRACTOR					
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
	Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	
)2				0	0	
)3	Provider to Program			0	0	5
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	
99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	
	- 5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER		34, 9	77	0	
)2	PROVIDER TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		4, 739, 0		0	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		Period: From 01/01/2021 To 12/31/2021	Worksheet G Date/Time Pre 5/5/2022 1:50	parec
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Accesto	1.00	2.00	3.00	4.00	
	AssetsCURRENT ASSETS					1
D	Cash on hand and in banks	-5, 509, 308		0 0	0	1.
C	Temporary investments	0		0 0	0	
2	Notes receivable	0		0 0	0	
)	Accounts recei vabl e Other recei vabl es	6, 244, 274		0 0	0	
5	Less: allowances for uncollectible notes and accounts	-2, 389, 407		0 0	0	
	recei vabl e	,				
C	Inventory	0		0 0	0	
))	Prepaid expenses	212, 319		0 0	0	
))0	Other current assets Due from other funds	856, 923		0 0	0	1
00	TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	-585, 199		0 0	0	
	FIXED ASSETS			-1 -1		1
00	Land	1, 650, 000		0 0	0	
00	Land improvements	745, 217		0 0	0	
00	Less: Accumulated depreciation	-83, 043			0	
00 00	Buildings Less Accumulated depreciation	26, 059, 462 -3, 130, 430		0 0	0	
00	Leasehold improvements	-3, 130, 430		0 0	0	
00	Less: Accumulated Amortization	0		0 0	0	
00	Fixed equipment	0		0 0	0	19
00	Less: Accumulated depreciation	0		0 0	0	
00	Automobiles and trucks	0		0 0	0	21
00 00	Less: Accumulated depreciation Major movable equipment	0 819, 135		0 0	0	
00	Less: Accumulated depreciation	019, 135			0	
00	Minor equipment - Depreciable	0		0 0	0	1
	Minor equipment nondepreciable	0		0 0	0	
00	Other fixed assets	0		0 0	0	
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	26, 060, 341		0 0	0	28
00	OTHER ASSETS Investments	187, 508		0 0	0	29
00	Deposits on Leases	107, 500		0 0	0	
00	Due from owners/officers	-3, 365, 010		0 0	0	
00	Other assets	-81, 382		0 0	0	32
00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-3, 258, 884		0 0	0	
00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	22, 216, 258		0 0	0	34
	CURRENT LIABILITIES					1
00	Accounts payable	756, 244		0 0	0	35
00	Salaries, wages, and fees payable	15, 000		0 0	0	
	Payroll taxes payable	389, 580		0 0	0	1 .
	Notes & loans payable (Short term)	0		0 0	0	
00 00	Deferred income Accelerated payments	0		0 0	0	39
00	Due to other funds	0		o o	0	
00	Other current liabilities	13, 953, 684		o o	0	42
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	15, 114, 508		0 0	0	43
~~	LONG TERM LIABILITIES					·
00 00	Mortgage payable Notes payable	0			0	
00	Unsecured Loans	0			0	
00	Loans from owners:	0		0 0	0	
00	Other long term liabilities	0		0 0	0	48
	OTHER (SPECIFY)	0		0 0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		0 0	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	15, 114, 508		0 0	0	51
00	CAPI TAL ACCOUNTS General fund balance	7, 101, 750				52
00	Specific purpose fund	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
00						
	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58)	7, 101, 750		0 0	0	59

Heal th	Financial Systems	JEFFERSON HEALTH	I CARE CENTER		In Lie	eu of Form CMS-2	2540-10
STATEM	IENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315231	Period: From 01/01/2021 To 12/31/2021		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	2.00	4.00	E 00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 18.\ 00\\ \end{array}$	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) ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	1.00 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 14,640,084 -7,538,336 7,101,748 2 7,101,750			0 0 0 0 0 0 0 0 0 0 0 0	$\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\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ $
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		7, 101, 750		0		19.00
		Endowment Fund	PI ant	Fund			
1.00		6.00	7.00	8.00			1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	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) ROUNDING	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 sheet (Line 11 - line 18)	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 JEFFERSON HEALTH CA	RE CENTER			In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315231		riod: om 01/01/2021 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/5/2022 1:50	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		17, 828, 4	54		17, 828, 454	1.00
2.00	NURSING FACILITY			0		0	2.00
3.00	ICF/IID			0		0	3.00
4.00	OTHER LONG TERM CARE			0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		17, 828, 4	54		17, 828, 454	5.00
	All Other Care Services		1				
6.00	ANCI LLARY SERVI CES		3, 830, 1	35	0	3, 830, 135	6.00
7.00	CLINIC				0	0	7.00
8.00	HOME HEALTH AGENCY COST				0	0	8.00
9.00	AMBULANCE				0	0	9.00
10.00	RURAL HEALTH CLINIC				0	0	10.00
10. 10	FQHC				0	0	10. 10
	CMHC				0	0	11.00
	HOSPICE			0	0	0	12.00
	ROUTINE CHARGES / BED HOLD		19, 3		0	19, 390	13.00
14.00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3 Worksheet G-3, Line 1)	to	21, 677, 9	79	0	21, 677, 979	14.00
	Cost Center Description						
					1.00	2.00	
	PART II - OPERATING EXPENSES						
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					21, 857, 640	1.00
2.00	Add (Specify)				0		2.00
3.00					0		3.00
4.00					0		4.00
5.00					0		5.00
6.00					0		6.00
7.00					0		7.00
8.00	Total Additions (Sum of lines 2 - 7)					0	8.00
9.00	Deduct (Specify)				0		9.00
10.00					0		10.00
11.00					0		11.00
12.00					0		12.00
13.00					0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			1		0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)					21, 857, 640	15.00

Heal th	Financial Systems	JEFFERSON HEALTH CA	RE CENTER	In Lie	u of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSE	S	Provi der No.: 315231	Peri od:	Worksheet G-3	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/5/2022 1:50	
	· · · · · · · · · · · · · · · · · · ·				57572022 1.50	pin
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Par	t I, col. 3, line 1	4)		21, 677, 979	1.00
2.00	Less: contractual allowances and discounts or	n patients accounts			7, 525, 072	2.00
3.00	Net patient revenues (Line 1 minus line 2)				14, 152, 907	3.00
4.00	Less: total operating expenses (From Workshee	et G-2, Part II, li	ne 15)		21, 857, 640	4.00
5.00	Net income from service to patients (Line 3 m	minus 4)			-7, 704, 733	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				159, 393	7.00
8.00	Revenues from communications (Telephone and	Internet 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				1, 482	11.00
12.00					0	12.00
	Revenue from laundry and linen service				4, 500	13.00
	Revenue from meals sold to employees and gues	sts			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical sup		n patients		0	16.00
17.00	Revenue from sale of drugs to other than pati				0	17.00
18.00	Revenue from sale of medical records and abst	tracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19.00
20.00	5	nteen			0	20.00
21.00	5				0	21.00
22.00	Rental of skilled nursing space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	BARBER BEAUTY				1, 022	24.00
24.50	COVI D-19 PHE Fundi ng				0	24.50
25.00					166, 397	25.00
26.00	Total (Line 5 plus line 25)				-7, 538, 336	26.00
27.00	Other expenses (specify)				0	27.00
28.00					0	28.00
29.00					0	29.00
	Total other expenses (Sum of lines 27 - 29)				0	30.00
31.00	Net income (or loss) for the period (Line 26	minus line 30)			-7, 538, 336	31.00