THIS REPORT IS REQUIRED BY LAW (42 USC 1395g 42 CFR.200(B)). COMPLETION OF THIS REPORT IS VIEWED AS A CONDITION OF YOUR PROVIDER AGREEMENT.

FORM APPROVED
OMB NO. 0938-0758
EXPIRES: 11/30/2024

HOSPICE AGENCY	Period:	Run Date Time: 1/1/2024 1:51 pm
Provider CCN: 055555	From: 01/01/2022	MCRIF32 **1984-14**
	To: 12/31/2022	Version: 5.12.177.1

HOSPICE COST AND DATA REPORT

Worksheet S
Parts I, II

PART I - COST REPORT STATUS

			1	ECR DATE 2	ECR TIME 3	
Provider use only	1	Electronically prepared cost report	X			1
	2	Manually prepared cost report				2
	3	Number of times cost report has been amended				3
	4	Medicare utilization	F			4
Contractor use only	5	Cost report status [1] As Submitted [2] Reserved [3] Reserved [4] Reserved [5] Amended	1			5
	6	Date received				6
	7	Contractor number	06014			7
	8	First cost report for this provider CCN				8
	9	Last cost report for this provider CCN				9
	10	Reserved				10
	11	Contractor vendor code	4			11
	12	Reserved				12

PART II - CERTIFICATION

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 PROVIDER(S)

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 HOSPICE AGENCY, 055555 {Provider Name(s) and Provider CCN(s)} for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and that, 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 1		CHECKBOX 2	ELECTRONIC SIGNATURE 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	Signature Date				4

HOSPICE AGENCY	Period:	Run Date Time: 1/1/2024 1:51 pm
Provider CCN: 055555	From: 01/01/2022	MCRIF32 **1984-14**
	To: 12/31/2022	Version: 5.12.177.1

HOSPICE IDENTIFICATION DATA

Worksheet S-1
Parts I-III

PART I - IDENTIFICATION DATA

		1.00								
1.00	Name	HOSPICE AGENCY								1.00
		1.00		2.00		3.00				
2.00	Street address			P.O. Box:						2.00
3.00	City			State:	CA	ZIP Code:				3.00
4.00	County	SONOMA								4.00
		1.00	2.00							
5.00	CCN	055555								5.00
6.00	Date hospice began operation	10/01/2017								6.00
		Title XVIII - Medicare	Title XIX - Medicaid							
7.00	Certification date	10/01/2017	10/01/2017							7.00
		From	To							
8.00	Cost reporting period	01/01/2022	12/31/2022							8.00
				1.00		2.00		3.00		
Malpractice Insurance Information										
9.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y						9.00
10.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1						10.00
				Premiums		Paid Losses		Self Insurance		
11.00	Amounts of malpractice premiums, paid losses, and self-insurance			1		0		1		11.00
12.00	Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N						12.00
						Y/N		HO/CO Number		
						1.00		2.00		
Home Office / Chain Organization Information										
13.00	Are HO/CO costs (as defined in CMS Pub. 15-1, §2150ff) claimed? Enter "Y" for yes or "N" for no in col. 1. If yes, enter the home office number in col. 2. (see instructions)					Y		HO HB0533		13.00
		1.00								
14.00	HO/CO name	HOME OFFICE								14.00
		1.00		2.00		3.00				
15.00	HO/CO Street address	123 MAIN STREET		HO/CO P.O. Box:						15.00
16.00	HO/CO City	LOS ANGELES		HO/CO State:	CA	HO/CO ZIP Code	92612			16.00
		1.00								
17.00	HO/CO contractor name	NORIDIAN								17.00
18.00	HO/CO contractor number	01001								18.00
								1.00		
Other Information										
19.00	Type of control (see instructions)							6		19.00
20.00	Number of CBSAs where Medicare covered services were provided during the cost reporting period							2		20.00
21.00	List each CBSA code where Medicare covered hospices services were provided during the cost reporting period (line 21 contains the first code)							42220		21.00
21.01	CBSA #2							42034		21.01

PART II - STATISTICAL DATA

		UNDUPLICATED DAYS				
		Title XVIII - Medicare	Title XIX - Medicaid	Other	Total	
		1.00	2.00	3.00	4.00	
30.00	Continuous Home Care	1	0	0	1	30.00
31.00	Routine Home Care	82,987	1,180	2,730	86,897	31.00
32.00	Inpatient Respite Care	8	0	0	8	32.00
33.00	General Inpatient Care	224	46	12	282	33.00
34.00	Total Hospice Days	83,220	1,226	2,742	87,188	34.00

PART III - CONTRACTED STATISTICAL DATA

		UNDUPLICATED DAYS				
		Title XVIII - Medicare	Title XIX - Medicaid	Other	Total	
		1.00	2.00	3.00	4.00	
40.00	Inpatient Respite Care	8	0	0	8	40.00
41.00	General Inpatient Care	224	46	12	282	41.00

HOSPICE AGENCY	Period:	Run Date Time:	1/1/2024 1:51 pm
	From: 01/01/2022	MCRIF32	**1984-14**
Provider CCN: 055555	To: 12/31/2022	Version:	5.12.177.1

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
ROUTINE HOME CARE

Worksheet A-2

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	SUBTOTAL	ADJUSTMENTS	TOTAL (col. 5 +- col. 6)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25.00	INPATIENT CARE-CONTRACTED								25.00
26.00	PHYSICIAN SERVICES	0	1,079,179	**1,079,179**	0	**1,079,179**	0	**1,079,179**	26.00
27.00	NURSE PRACTITIONER	0	0	**0**	0	**0**	0	**0**	27.00
28.00	REGISTERED NURSE	4,358,287	365,570	**4,723,857**	0	**4,723,857**	0	**4,723,857**	28.00
29.00	LPN/LVN	174,332	0	**174,332**	0	**174,332**	0	**174,332**	29.00
30.00	PHYSICAL THERAPY	0	0	**0**	0	**0**	0	**0**	30.00
31.00	OCCUPATIONAL THERAPY	0	0	**0**	0	**0**	0	**0**	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	**0**	0	**0**	0	**0**	32.00
33.00	MEDICAL SOCIAL SERVICES	1,292,541	0	**1,292,541**	0	**1,292,541**	0	**1,292,541**	33.00
34.00	SPIRITUAL COUNSELING	317,081	0	**317,081**	0	**317,081**	0	**317,081**	34.00
35.00	DIETARY COUNSELING	0	0	**0**	0	**0**	0	**0**	35.00
36.00	COUNSELING - OTHER	0	0	**0**	0	**0**	0	**0**	36.00
37.00	HOSPICE AIDE AND HOMEMAKER SERVICES	1,050,224	0	**1,050,224**	0	**1,050,224**	0	**1,050,224**	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	652,660	**652,660**	0	**652,660**	0	**652,660**	38.00
39.00	PATIENT TRANSPORTATION	0	2,859	**2,859**	0	**2,859**	0	**2,859**	39.00
40.00	IMAGING SERVICES	0	0	**0**	0	**0**	0	**0**	40.00
41.00	LABS AND DIAGNOSTICS	0	2,196	**2,196**	0	**2,196**	0	**2,196**	41.00
42.00	MEDICAL SUPPLIES - NON-ROUTINE	0	415,701	**415,701**	0	**415,701**	0	**415,701**	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	**0**	0	**0**	0	**0**	42.50
43.00	OUTPATIENT SERVICES	0	0	**0**	0	**0**	0	**0**	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	**0**	0	**0**	0	**0**	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	**0**	0	**0**	0	**0**	45.00
46.00	OTHER PATIENT CARE SVC (SPECIFY)	0	0	**0**	0	**0**	0	**0**	46.00
100.00	TOTAL	**7,192,465**	**2,518,165**	**9,710,630**	**0**	**9,710,630**	**0**	**9,710,630**	100.00

* Transfer the amount in column 7 to Wkst. B, col. 0, line 51.

HOSPICE AGENCY	Period:	Run Date Time: 1/1/2024 1:51 pm
Provider CCN: 055555	From: 01/01/2022	MCRIF32 **1984-14**
	To: 12/31/2022	Version: 5.12.177.1

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **Worksheet A**

			SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	SUBTOTAL	ADJUSTMENTS	TOTAL (col. 5 +- col. 6)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	0100	CAP REL COSTS-BLDG & FIXT		294,790	**294,790**	0	**294,790**	0	**294,790**	1.00
2.00	0200	CAP REL COSTS-MVBLE EQUIP		203,355	**203,355**	0	**203,355**	0	**203,355**	2.00
3.00	0300	EMPLOYEE BENEFITS DEPARTMENT	0	1,383,372	**1,383,372**	0	**1,383,372**	2,733,293	**4,116,665**	3.00
4.00	0400	ADMINISTRATIVE & GENERAL	5,589,946	4,538,804	**10,128,750**	146,951	**10,275,701**	-1,422,493	**8,853,208**	4.00
5.00	0500	PLANT OPERATION & MAINTENANCE	0	146,951	**146,951**	-146,951	**0**	0	**0**	5.00
6.00	0600	LAUNDRY & LINEN SERVICE	0	0	**0**	0	**0**	0	**0**	6.00
7.00	0700	HOUSEKEEPING	0	0	**0**	0	**0**	0	**0**	7.00
8.00	0800	DIETARY	0	0	**0**	0	**0**	0	**0**	8.00
9.00	0900	NURSING ADMINISTRATION	0	0	**0**	0	**0**	0	**0**	9.00
10.00	1000	ROUTINE MEDICAL SUPPLIES	0	0	**0**	0	**0**	0	**0**	10.00
11.00	1100	MEDICAL RECORDS	0	0	**0**	0	**0**	0	**0**	11.00
12.00	1200	STAFF TRANSPORTATION	0	219,292	**219,292**	0	**219,292**	0	**219,292**	12.00
13.00	1300	VOLUNTEER SERVICE COORDINATION	199,255	0	**199,255**	0	**199,255**	0	**199,255**	13.00
14.00	1400	PHARMACY	0	765,694	**765,694**	0	**765,694**	0	**765,694**	14.00
15.00	1500	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	**0**	0	**0**	0	**0**	15.00
16.00	1600	OTHER GENERAL SERVICE (SPECIFY)	0	0	**0**	0	**0**	0	**0**	16.00
17.00	1700	PATIENT/RESIDENTIAL CARE SERVICES								17.00
DIRECT PATIENT CARE SERVICE COST CENTERS										
25.00	2500	INPATIENT CARE-CONTRACTED		149,371	**149,371**	0	**149,371**	0	**149,371**	25.00
26.00	2600	PHYSICIAN SERVICES	0	1,082,792	**1,082,792**	0	**1,082,792**	0	**1,082,792**	26.00
27.00	2700	NURSE PRACTITIONER	0	0	**0**	0	**0**	0	**0**	27.00
28.00	2800	REGISTERED NURSE	4,374,365	366,919	**4,741,284**	0	**4,741,284**	0	**4,741,284**	28.00
29.00	2900	LPN/LVN	174,938	0	**174,938**	0	**174,938**	0	**174,938**	29.00
30.00	3000	PHYSICAL THERAPY	0	0	**0**	0	**0**	0	**0**	30.00
31.00	3100	OCCUPATIONAL THERAPY	0	0	**0**	0	**0**	0	**0**	31.00
32.00	3200	SPEECH/LANGUAGE PATHOLOGY	0	0	**0**	0	**0**	0	**0**	32.00
33.00	3300	MEDICAL SOCIAL SERVICES	1,297,775	0	**1,297,775**	0	**1,297,775**	0	**1,297,775**	33.00
34.00	3400	SPIRITUAL COUNSELING	318,168	0	**318,168**	0	**318,168**	0	**318,168**	34.00
35.00	3500	DIETARY COUNSELING	0	0	**0**	0	**0**	0	**0**	35.00
36.00	3600	COUNSELING - OTHER	0	0	**0**	0	**0**	0	**0**	36.00
37.00	3700	HOSPICE AIDE AND HOMEMAKER SERVICES	1,053,647	0	**1,053,647**	0	**1,053,647**	0	**1,053,647**	37.00
38.00	3800	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	652,660	**652,660**	0	**652,660**	0	**652,660**	38.00
39.00	3900	PATIENT TRANSPORTATION	0	2,859	**2,859**	0	**2,859**	0	**2,859**	39.00
40.00	4000	IMAGING SERVICES	0	0	**0**	0	**0**	0	**0**	40.00
41.00	4100	LABS AND DIAGNOSTICS	0	2,196	**2,196**	0	**2,196**	0	**2,196**	41.00
42.00	4200	MEDICAL SUPPLIES - NON-ROUTINE	0	415,701	**415,701**	0	**415,701**	0	**415,701**	42.00
42.50	4250	DRUGS CHARGED TO PATIENTS	0	0	**0**	0	**0**	0	**0**	42.50
43.00	4300	OUTPATIENT SERVICES	0	0	**0**	0	**0**	0	**0**	43.00
44.00	4400	PALLIATIVE RADIATION THERAPY	0	0	**0**	0	**0**	0	**0**	44.00
45.00	4500	PALLIATIVE CHEMOTHERAPY	0	0	**0**	0	**0**	0	**0**	45.00
46.00	4600	OTHER PATIENT CARE SVC (SPECIFY)	0	0	**0**	0	**0**	0	**0**	46.00
NONREIMBURSABLE COST CENTERS										
60.00	6000	BEREAVEMENT PROGRAM	378,104	0	**378,104**	0	**378,104**	0	**378,104**	60.00
61.00	6100	VOLUNTEER PROGRAM	0	0	**0**	0	**0**	0	**0**	61.00
62.00	6200	FUNDRAISING	0	0	**0**	0	**0**	0	**0**	62.00
63.00	6300	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	**0**	0	**0**	0	**0**	63.00
64.00	6400	PALLIATIVE CARE PROGRAM	0	0	**0**	0	**0**	0	**0**	64.00
65.00	6500	OTHER PHYSICIAN SERVICES	0	0	**0**	0	**0**	0	**0**	65.00
66.00	6600	RESIDENTIAL CARE	0	0	**0**	0	**0**	0	**0**	66.00
67.00	6700	ADVERTISING	0	0	**0**	0	**0**	0	**0**	67.00
68.00	6800	TELEHEALTH/TELEMONITORING	0	0	**0**	0	**0**	0	**0**	68.00
69.00	6900	THRIFT STORE	0	0	**0**	0	**0**	0	**0**	69.00
70.00	7000	NURSING FACILITY ROOM & BOARD		2,078,266	**2,078,266**	0	**2,078,266**	-2,078,266	**0**	70.00
71.00	7100	OTHER NONREIMBURSABLE (SPECIFY)	0	0	**0**	0	**0**	0	**0**	71.00
100.00		TOTAL	**13,386,198**	**12,303,022**	**25,689,220**	**0**	**25,689,220**	**-767,466**	**24,921,754**	100.00

* Transfer the amounts in column 7 to Wkst. B, col. 0, line as appropriate.
** See instructions. Do not transfer the amounts in col. 7 to Wkst. B.

HOSPICE AGENCY	Period:	Run Date Time:	1/1/2024 1:51 pm
	From: 01/01/2022	MCRIF32	**1984-14**
Provider CCN: 055555	To: 12/31/2022	Version:	5.12.177.1

RECLASSIFICATIONS

Worksheet A-6

	Increases				Decreases					
	Cost Center	Wkst. A Line #	Salary	Other	Cost Center	Wkst. A Line #	Salary	Other	LOC WS Ind.	
	2.00	3.00	4.00	4.01	5.00	6.00	7.00	7.01	8.00	
A - RECLASSIFY PLANT OPERATIONS										
1.00	ADMINISTRATIVE & GENERAL	4.00	0	146,951	PLANT OPERATION & MAINTENANCE	5.00	0	146,951		1.00
100.00	**Total reclassifications**		**0**	**146,951**			**0**	**146,951**		100.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 4.01, 7 and 7.01 to Wkst. A, col. 4, lines as appropriate.

HOSPICE AGENCY	Period:	Run Date Time: 1/1/2024 1:51 pm
	From: 01/01/2022	MCRIF32 **1984-14**
Provider CCN: 055555	To: 12/31/2022	Version: 5.12.177.1

ADJUSTMENTS TO EXPENSES

Worksheet A-8

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Descriptions (1)	Basis for Adjustment (2)	Amount	Cost Center	Line No.	LOC WS Indicator	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income on restricted funds (chapter 2)		0		0.00	0	1.00
2.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	2.00
3.00	Adjustment resulting from transactions with related organizations (chapter 10) and home office costs (chapter 21)	A-8-1	1,327,322				3.00
4.00	Revenue - employee and guest meals	B	0	DIETARY	8.00		4.00
5.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	0	ADMINISTRATIVE & GENERAL	4.00		5.00
6.00	Bad debts included on trial balance	A	0		0.00	0	6.00
7.00	Patient personal purchases		0		0.00	0	7.00
8.00	Depreciation - buildings and fixtures		0	CAP REL COSTS-BLDG & FIXT	1.00		8.00
9.00	Depreciation - movable equipment		0	CAP REL COSTS-MVBLE EQUIP	2.00		9.00
10.00	Revenue - State-redirected room and board	B	-2,078,266	NURSING FACILITY ROOM & BOARD	70.00		10.00
11.00	MEALS & ENTERTAINMENT	A	-7,722	ADMINISTRATIVE & GENERAL	4.00	0	11.00
11.01	ADVERTISING	A	-8,800	ADMINISTRATIVE & GENERAL	4.00	0	11.01
11.02			0		0.00	0	11.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Wkst. A, col. 6, line 100.)		**-767,466**				50.00

(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.
(3) Additional adjustments may be made on lines 11 through 49 and subscripts thereof.

HOSPICE AGENCY	Period:	Run Date Time: 1/1/2024 1:51 pm
Provider CCN: 055555	From: 01/01/2022	MCRIF32 **1984-14**
	To: 12/31/2022	Version: 5.12.177.1

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Worksheet A-8-1
Part I

PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

	Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Net Adjustments (col. 4 minus col. 5)	LOC WS Indicator	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	1,483,656	2,928,597	-1,444,941	0	1.00
2.00	3.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE COSTS	2,733,293	0	2,733,293	0	2.00
3.00	4.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	38,970	0	38,970	0	3.00
4.00	0.00			0	0	0	0	4.00
5.00	0.00			0	0	0	0	5.00
6.00	0.00			0	0	0	0	6.00
7.00	0.00			0	0	0	0	7.00
8.00	0.00			0	0	0	0	8.00
9.00	0.00			0	0	0	0	9.00
10.00	**TOTALS (sum of lines 1-9). Transfer col. 6, line 10 to Wkst A-8, col. 2, line 3)**			**4,255,919**	**2,928,597**	**1,327,322**		10.00

* Transfer amounts in col. 6, lines 1 through 9 (and subscripts as appropriate) to Wkst. A, col. 6, lines as indicated in col. 1. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Wkst. A, col. 1 and/or col. 2, report the amount allowable in col. 4 above.

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 PARTII OF THIS WORKSHEET.

This information is used by the Centers for Medicare and Medicaid Services and its 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under Title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	B		0.00	HOSPITAL	0.00	HEALTH SYSTEM	1.00
2.00	B		0.00	HOSPITAL	0.00	HEALTH SYSTEM	2.00
3.00			0.00		0.00		3.00
4.00			0.00		0.00		4.00
5.00			0.00		0.00		5.00
6.00			0.00		0.00		6.00
7.00			0.00		0.00		7.00
8.00			0.00		0.00		8.00
9.00			0.00		0.00		9.00
10.00			0.00		0.00		10.00

(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 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.

G. Other (financial or non-financial) specify:		

HOSPICE AGENCY	Period:	Run Date Time: 1/1/2024 1:51 pm
	From: 01/01/2022	MCRIF32 **1984-14**
Provider CCN: 055555	To: 12/31/2022	Version: 5.12.177.1

COST ALLOCATION **Worksheet B**

	Cost Center Description	NET EXPENSES FOR ALLOC.	CAP REL COSTS-BLDG & FIXT	CAP REL COSTS-MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		0	1.00	2.00	3.00	3A	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS												
1.00	CAP REL COSTS-BLDG & FIXT	294,790	294,790									1.00
2.00	CAP REL COSTS-MVBLE EQUIP	203,355		203,355								2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4,116,665	0	0	4,116,665							3.00
4.00	ADMINISTRATIVE & GENERAL	8,853,208	294,790	203,355	1,719,082	11,070,435	11,070,435					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	0	0	0			6.00
7.00	HOUSEKEEPING	0	0	0	0	0	0	0	0	0		7.00
8.00	DIETARY	0	0	0	0	0	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	219,292	0	0	0	219,292	175,265	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	199,255	0	0	61,277	260,532	208,226	0	0	0	0	13.00
14.00	PHARMACY	765,694	0	0	0	765,694	611,968	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0			0	0		0		17.00
LEVEL OF CARE												
50.00	CONTINUOUS HOME CARE	96			25	121	97					50.00
51.00	ROUTINE HOME CARE	9,710,630			2,211,899	11,922,529	9,528,882					51.00
52.00	INPATIENT RESPITE CARE	1,735	0	0	198	1,933	1,545	0	0	0	0	52.00
53.00	GENERAL INPATIENT CARE	178,930	0	0	7,905	186,835	149,325	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS												
60.00	BEREAVEMENT PROGRAM	378,104	0	0	116,279	494,383	395,127	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	0	0		0		61.00
62.00	FUNDRAISING	0	0	0	0	0	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	0	0		0		68.00
69.00	THRIFT STORE	0	0	0	0	0	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD	0										70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	0	0	0	0	0	71.00
100.00	NEGATIVE COST CENTER	0	0	0	0	0	0	0	0	0	0	100.00
101.00	TOTAL	**24,921,754**	**294,790**	**203,355**	**4,116,665**	**24,921,754**	**11,070,435**	**0**	**0**	**0**	**0**	101.00

HOSPICE AGENCY	Period:	Run Date Time: 1/1/2024 1:51 pm
Provider CCN: 055555	From: 01/01/2022	MCRIF32 **1984-14**
	To: 12/31/2022	Version: 5.12.177.1

COST ALLOCATION **Worksheet B**

	Cost Center Description	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (SPECIFY)	PATIENT/RESIDENTIAL CARE SERVICES	TOTAL	
		9.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS												
1.00	CAP REL COSTS-BLDG & FIXT											1.00
2.00	CAP REL COSTS-MVBLE EQUIP											2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT											3.00
4.00	ADMINISTRATIVE & GENERAL											4.00
5.00	PLANT OPERATION & MAINTENANCE											5.00
6.00	LAUNDRY & LINEN SERVICE											6.00
7.00	HOUSEKEEPING											7.00
8.00	DIETARY											8.00
9.00	NURSING ADMINISTRATION	0										9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0									10.00
11.00	MEDICAL RECORDS	0	0	0								11.00
12.00	STAFF TRANSPORTATION	0	0	0	394,557							12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	468,758						13.00
14.00	PHARMACY	0	0	0	0	0	1,377,662					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	0	0				15.00
16.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	0	0	0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES								0	0		17.00
LEVEL OF CARE												
50.00	CONTINUOUS HOME CARE	0	0	0	4	0	0	0	0		**222**	50.00
51.00	ROUTINE HOME CARE	0	0	0	393,240	34,792	1,377,662	0	0		**23,257,105**	51.00
52.00	INPATIENT RESPITE CARE	0	0	0	36	0	0	0	0	0	**3,514**	52.00
53.00	GENERAL INPATIENT CARE	0	0	0	1,277	104	0	0	0	0	**337,541**	53.00
NONREIMBURSABLE COST CENTERS												
60.00	BEREAVEMENT PROGRAM	0			0	39,383	0	0	0		**928,893**	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	0	0	0		**0**	61.00
62.00	FUNDRAISING	0			0	4,147	0	0	0		**4,147**	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	0	0	0		**0**	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	0	0	0		**0**	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	0	0	0		**0**	65.00
66.00	RESIDENTIAL CARE	0			0	0	0	0	0	0	**0**	66.00
67.00	ADVERTISING	0			0	0	0	0	0		**0**	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	0	0	0		**0**	68.00
69.00	THRIFT STORE	0			0	0	0	0	0		**0**	69.00
70.00	NURSING FACILITY ROOM & BOARD										**0**	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	390,332	0	0	0		**390,332**	71.00
100.00	NEGATIVE COST CENTER	0	0	0	0	0	0	0	0	0	**0**	100.00
101.00	TOTAL	**0**	**0**	**0**	**394,557**	**468,758**	**1,377,662**	**0**	**0**	**0**	**24,921,754**	101.00

HOSPICE AGENCY	Period:	Run Date Time: 1/1/2024 1:51 pm
	From: 01/01/2022	MCRIF32 **1984-14**
Provider CCN: 055555	To: 12/31/2022	Version: 5.12.177.1

CALCULATION OF PER DIEM COST **Worksheet C**

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. B, col 18, line 50)			**222**	1.00
2.00	Total unduplicated days (Wkst. S-1, col. 4, line 30)			**1**	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			**222.00**	3.00
4.00	Unduplicated program days (Wkst. S-1, col. as appropriate, line 30)	1	0		4.00
5.00	Program cost (line 3 times line 4)	222	0		5.00
ROUTINE HOME CARE					
6.00	Total cost (Wkst. B, col. 18, line 51)			**23,257,105**	6.00
7.00	Total unduplicated days (Wkst. S-1, col. 4, line 31)			**86,897**	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			**267.64**	8.00
9.00	Unduplicated program days (Wkst. S-1, col. as appropriate, line 31)	82,987	1,180		9.00
10.00	Program cost (line 8 times line 9)	22,210,641	315,815		10.00
INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. B, col. 18, line 52)			**3,514**	11.00
12.00	Total unduplicated days (Wkst. S-1, col. 4, line 32)			**8**	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			**439.25**	13.00
14.00	Unduplicated program days (Wkst. S-1, col. as appropriate, line 32)	8	0		14.00
15.00	Program cost (line 13 times line 14)	3,514	0		15.00
GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. B, col. 18, line 53)			**337,541**	16.00
17.00	Total unduplicated days (Wkst. S-1, col. 4, line 33)			**282**	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			**1,196.95**	18.00
19.00	Unduplicated program days (Wkst. S-1, col. as appropriate, line 33)	224	46		19.00
20.00	Program cost (line 18 times line 19)	268,117	55,060		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			**23,598,382**	21.00
22.00	Total unduplicated days (Wkst. S-1, col. 4, line 34)			**87,188**	22.00
23.00	Average cost per diem (line 21 divided by line 22)			**270.66**	23.00

Main Report