This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0022

HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 33-7165	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-II Date/Time Prepared: 9/9/2020 11:41 am

Contractor Use Only:

[ ] Audited [ ] Desk Reviewed Date Received: Contractor No.: [ ] Initial [ ] Final [ ] Re-opened

PART I - CERTIFICATION

Check applicable box

[X] Electronic filed cost report
[ ] Manually submitted cost report

Date: 9/9/2020
Time: 11:41 am

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 THE 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 Home Health Agency Cost Report and the Balance Sheet and Statement of Revenue and Expenses prepared by SULLIVAN COUNTY HOME HEALTH CARE - 33-7165 (Provider name(s) and number(s)) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019, 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.

[ ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)_____
Chief Financial Officer or Administrator

_____
Title

_____
Date

PART II - SETTLEMENT SUMMARY

		TITLE XVIII		
		Part A	Part B	
		1.00	2.00	
1.00	HOME HEALTH AGENCY	0	0	1.00
2.00	HOME HEALTH-BASED CORF			2.00
3.00	HOME HEALTH-BASED CMHC		0	3.00
3.50	HOME HEALTH-BASED RHC		0	3.50
3.60	HOME HEALTH-BASED FQHC		0	3.60
4.00	TOTAL	0	0	4.00

"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 0938-0022. The time required to complete this information collection is estimated to average 227 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports 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.

HOME HEALTH AGENCY COMPLEX IDENTIFICATION DATA | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 | Date/Time Prepared: 9/9/2020 11:41 am

	1.00	2.00	3.00	
	Home Health Agency Complex Address:			
1.00	Street: 50 COMMUNITY LANE	P.O. Box: 590		1.00
1.01	City: LIBERTY	State: NY	Zip Code: 12754	1.01

		Component	Provider CCN	Date	
		1.00	2.00	3.00	
	Home Health Agency Component Identification				
2.00	Home Health Agency	SULLIVAN COUNTY HOME HEALTH CARE	337165	01/01/1969	2.00
3.00	HHA-based CORF				3.00
3.50	HHA-based Hospice				3.50
4.00	HHA-based CMHC				4.00
5.00	HHA-based RHC				5.00
6.00	HHA-based FQHC				6.00

		From:	To:	
		1.00	2.00	
7.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	7.00
			1.00	
8.00	Type of control (see instructions)		12	8.00
9.00	If this a low or no Medicare utilization cost report, enter "L" for Low or "N" for No Medicare Utilization.			9.00
	Depreciation: Enter the amount of depreciation reported in this HHA for the methods indicated.			
10.00	Straight Line		22,408	10.00
11.00	Declining Balance		0	11.00
12.00	Sum of the Years' Digits		0	12.00
13.00	Sum of lines 10, 11 and 12		22,408	13.00
14.00	Were there any disposals of capital assets during this cost reporting period?		N	14.00
15.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period?		N	15.00
16.00	Was accelerated depreciation claimed on assets acquired on or after August l, l970 (See PRM 15-1, Chapter l)?		N	16.00
17.00	If depreciation is funded, enter the balance at end of period.		0	17.00
18.00	Did the provider cease to participate in the Medicare program at the end of the period to which this cost report applies (See PRM 15-1, Chapter 1)?		N	18.00
19.00	Was there substantial decrease in health insurance proportion of allowable costs from prior cost reporting periods (See PRM 15-1, Chapter 1)?		N	19.00
20.00	Does the provider qualify as a small HHA (see 42 CFR 413.24(d))?		N	20.00
21.00	Does the HHA qualify as a nominal charge provider (see 42 CFR 409.3)?		N	21.00
22.00	Does the HHA contract with outside suppliers for physical therapy services?		Y	22.00
22.01	Does the HHA contract with outside suppliers for occupational therapy services?		Y	22.01
22.02	Does the HHA contract with outside suppliers for speech therapy services?		Y	22.02

		Part A	Part B	
		1.00	2.00	
	If this facility contains a non-public provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption.			
23.00	HHA	Y	Y	23.00
25.00	CMHC		N	25.00
			1.00	
26.00	If the HHA componentized (or fragmented) its administrative and general service costs, indicate whether option one or option two is being utilized. (See Section 3214) (Enter "1" for option one and "2" for option two)		0	26.00
27.00	List amounts of malpractice premiums and paid losses:			27.00
27.01	Premiums		12,012	27.01
27.02	Paid Losses		0	27.02
27.03	Self Insurance		0	27.03
28.00	Are malpractice premiums and/or paid losses reported in other than the Administrative and General cost center? If yes, submit a supporting schedule listing cost centers and amounts contained therein.		N	28.00
29.00	If you are part of a chain organization, enter "Y" for yes and enter the name and address of the home office, otherwise, enter "N" for no.		N	29.00

	1.00	2.00	3.00	
29.01	Home Office Name:	Home Office No.:	Contractor No.:	29.01
29.02	Street:	P.O. Box:	Contractor Name:	29.02
29.03	City:	State:	Zip Code:	29.03

HOME HEALTH AGENCY REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2-1 | Date/Time Prepared: 9/9/2020 11:41 am

		Y/N	Date	V/I	
		1.00	2.00	3.00	
	General Instruction: For all column 1 responses, enter "Y" for YES or "N" for NO. Enter all dates in the format (mm/dd/yyyy)				
	COMPLETED BY ALL HHAs				
	Provider Organization and Operation				
1.00	Has the HHA changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is yes, enter the date of the change in column 2. (see instructions)	N			1.00
2.00	Has the HHA terminated participation in the Medicare program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. (see instructions)	N			2.00
3.00	Is the HHA involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If column 1 is yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation.	N			5.00

		Y/N	
		1.00	
	Bad Debts		
6.00	Is the HHA or HHA-based entities seeking reimbursement for bad debts? If yes, see instructions.	N	6.00
7.00	If line 6 is yes, did the HHA's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	7.00
8.00	If line 6 is yes, were patient coinsurance amounts waived? If yes, see instructions.	N	8.00

		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Report Data				
9.00	Was the cost report prepared using the PS&R Report only? If column 1 is yes, enter the paid-through date of the PS&R Report used in column 2. (see instructions)		Y	08/25/2020	9.00
10.00	Was the cost report prepared using the PS&R Report for totals and the HHA's records for allocation? If column 1 is yes, enter the paid-through date in column 2. (see instructions)		N		10.00
11.00	If line 9 or 10 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.		N		11.00
12.00	If line 9 or 10 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		12.00
13.00	If line 9 or 10 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		13.00
14.00	Was the cost report prepared only using the HHA's records? If yes, see instructions.		N		14.00

	1.00	2.00	3.00	
	Cost Report Preparer Contact Information			
15.00	First name: MARILYN	Last name: BONFIGLIO	Title: FISCAL ADMINISTRATIVE OFFICER	15.00
16.00	Employer: SULLIVAN COUNTY PUBLIC HEALTH			16.00
17.00	Phone number: (845) 292-5910 EXT. 2247	E-mail Address: MARILYN.BONFIGLIO@CO.SULLIVAN.NY.US		17.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Parts I - IV | Date/Time Prepared: 9/9/2020 11:41 am

	Description	County	Title XVIII Visits	Title XVIII Patients	Other Visits	Other Patients	Total Visits	Total Patients	
		0	1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - STATISTICAL DATA								
1.00	Skilled Nursing		3,974	576	2,891	584	6,865	1,160	1.00
2.00	Physical Therapy		2,628	446	1,452	291	4,080	737	2.00
3.00	Occupational Therapy		455	83	151	29	606	112	3.00
4.00	Speech Pathology		54	8	26	8	80	16	4.00
5.00	Medical Social Service		340	96	195	54	535	150	5.00
6.00	Home Health Aide		1,035	110	315	42	1,350	152	6.00
7.00	All Other Services				1	0	1	0	7.00
8.00	Total Visits		8,486		5,031		13,517		8.00
9.00	Home Health Aide Hours		0		0		0		9.00
10.00	Unduplicated Census Count - Full Cost Reporting Period			576.00		588.00		1,164.00	10.00

		Number of Hours in Normal Work Week	Staff	Contract	Total	
		0	1.00	2.00	3.00	
11.00	Administrator and Assistant Administrator(s)	35.00	1.76	0.00	1.76	11.00
12.00	Director and Assistant Director(s)		0.31	0.00	0.31	12.00
13.00	Other Administrative Personnel		11.03	0.00	11.03	13.00
14.00	Direct Nursing Service		13.46	0.00	13.46	14.00
15.00	Nursing Supervisor		3.83	0.00	3.83	15.00
16.00	Physical Therapy Service		0.00	1.45	1.45	16.00
17.00	Physical Therapy Supervisor		0.00	0.00	0.00	17.00
18.00	Occupational Therapy Service		0.00	0.15	0.15	18.00
19.00	Occupational Therapy Supervisor		0.00	0.00	0.00	19.00
20.00	Speech Pathology Service		0.00	0.01	0.01	20.00
21.00	Speech Pathology Supervisor		0.00	0.00	0.00	21.00
22.00	Medical Social Service		0.82	0.02	0.84	22.00
23.00	Medical Social Supervisor		0.00	0.00	0.00	23.00
24.00	Home Health Aide		1.77	0.00	1.77	24.00
25.00	Home Health Aide Supervisor		0.00	0.00	0.00	25.00
26.00	LTHHCP AND OTHER		1.49	0.00	1.49	26.00
27.00	CLINIC (EPIDEMIOLOGY)		7.06	0.00	7.06	27.00

		1.00	1.01	
28.00	Enter the total number of MSAs in column 1 and/or CBSAs in column 2 where Medicare covered services were provided during the cost reporting period.	0	1	28.00

		MSA Codes	CBSA Codes	
		1.00	1.01	
29.00	List all MSA and CBSA codes in which Medicare covered home health services were provided during the cost reporting period (line 29 contains the first code):	0	99933	29.00

		Full Episodes without Outliers	Full Episodes with Outliers	LUPA Episodes	PEP Only Episodes	SCIC within a PEP	SCIC Only Episodes	Totals	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
30.00	Skilled Nursing Visits	3,183	490	224	77	0	0	3,974	30.00
31.00	Skilled Nursing Visit Charges	557,025	85,750	39,025	13,475	0	0	695,275	31.00
32.00	Physical Therapy Visits	2,352	173	39	65	0	0	2,629	32.00
33.00	Physical Therapy Visit Charges	294,000	21,625	4,750	8,000	0	0	328,375	33.00
34.00	Occupational Therapy Visits	395	50	2	8	0	0	455	34.00
35.00	Occupational Therapy Visit Charges	49,375	6,250	250	1,000	0	0	56,875	35.00
36.00	Speech Pathology Visits	48	6	0	0	0	0	54	36.00
37.00	Speech Pathology Visit Charges	6,000	750	0	0	0	0	6,750	37.00
38.00	Medical Social Service Visits	214	112	5	9	0	0	340	38.00
39.00	Medical Social Service Visit Charges	26,750	14,000	625	1,125	0	0	42,500	39.00
40.00	Home Health Aide Visits	767	251	0	17	0	0	1,035	40.00
41.00	Home Health Aide Visit Charges	46,691	17,100	0	1,096	0	0	64,887	41.00
42.00	Total Visits (Sum of lines 30,32,34,36,38,40)	6,959	1,082	270	176	0	0	8,487	42.00
43.00	Other Charges	0	0	0	0	0	0	0	43.00
44.00	Total Charges (Sum of lines 31,33,35,37,39,41,43)	979,841	145,475	44,650	24,696	0	0	1,194,662	44.00
45.00	Total Number of Episodes	518		96	12	0	0	626	45.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Parts I - IV | Date/Time Prepared: 9/9/2020 11:41 am

		Full Episodes without Outliers	Full Episodes with Outliers	LUPA Episodes	PEP Only Episodes	SCIC within a PEP	SCIC Only Episodes	Totals	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
46.00	Total Number of Outlier Episodes		33		1	0	0	34	46.00
47.00	Total Non-Routine Medical Supply Charges	28,672	7,003	2,410	125	0	0	38,210	47.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 9/9/2020 11:41 am

		SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION (See Instructions)	CONTRACTED PURCHASED SERVICES	OTHER COSTS	TOTAL	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT			0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0		22,408	22,408	2.00
3.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	229,710	229,710	3.00
4.00	TRANSPORTATION	0	0	0	0	0	0	4.00
5.00	ADMINISTRATIVE AND GENERAL	493,321	274,781	479	32,479	334,630	1,135,690	5.00
	HHA REIMBURSABLE SERVICES							
6.00	SKILLED NURSING CARE	1,031,139	574,347	2,900	0	18,548	1,626,934	6.00
7.00	PHYSICAL THERAPY	0	0	0	329,661	0	329,661	7.00
8.00	OCCUPATIONAL THERAPY	0	0	0	42,042	0	42,042	8.00
9.00	SPEECH PATHOLOGY	0	0	0	3,360	0	3,360	9.00
10.00	MEDICAL SOCIAL SERVICES	53,987	30,071	4,672	1,860	0	90,590	10.00
11.00	HOME HEALTH AIDE	81,413	45,347	7,901	0	1,675	136,336	11.00
12.00	SUPPLIES	0	0	0	0	37,252	37,252	12.00
13.00	DRUGS	0	0	0	0	0	0	13.00
13.20	COST OF ADMINISTERING VACCINES	0	0	0	0	0	0	13.20
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	HOME DIALYSIS AIDE SERVICES	0	0	0	0	0	0	15.00
16.00	RESPIRATORY THERAPY	0	0	0	0	0	0	16.00
17.00	PRIVATE DUTY NURSING	0	0	0	0	0	0	17.00
18.00	CLINIC	32,262	17,970	557	11,070	121,477	183,336	18.00
19.00	HEALTH PROMOTION ACTIVITIES	512,782	285,621	2,355	0	72,862	873,620	19.00
20.00	DAY CARE PROGRAM	0	0	0	0	0	0	20.00
21.00	HOME DELIVERED MEALS PROGRAM	0	0	0	0	0	0	21.00
22.00	HOMEMAKER	0	0	0	0	0	0	22.00
23.00	OTHER	36,274	20,205	899	84,561	24,122	166,061	23.00
	SPECIAL PURPOSE COST CENTERS							
24.00	CORF							24.00
25.00	HOSPICE	0	0	0	0	0	0	25.00
26.00	CMHC	0	0	0	0	0	0	26.00
27.00	RHC	0	0	0	0	0	0	27.00
28.00	FQHC	0	0	0	0	0	0	28.00
29.00	TOTAL	2,241,178	1,248,342	19,763	505,033	862,684	4,877,000	29.00
30.00	If you want the system to distribute your benefits based on salary, enter total benefits:	0						30.00

		RECLASSIFICATION (Fr. Wks. A-4)	RECLASSIFIED TRIAL BALANCE (Cols. 6 + 7)	ADJUSTMENTS	EXPENSES FOR COST ALLOCATION (Col. 8 + 9)		
		7.00	8.00	9.00	10.00		
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	-324	-324		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,408	-3,650	18,758		2.00
3.00	PLANT OPERATION & MAINTENANCE	0	229,710	0	229,710		3.00
4.00	TRANSPORTATION	0	0	0	0		4.00
5.00	ADMINISTRATIVE AND GENERAL	0	1,135,690	-340,645	795,045		5.00
	HHA REIMBURSABLE SERVICES						
6.00	SKILLED NURSING CARE	0	1,626,934	0	1,626,934		6.00
7.00	PHYSICAL THERAPY	0	329,661	0	329,661		7.00
8.00	OCCUPATIONAL THERAPY	0	42,042	0	42,042		8.00
9.00	SPEECH PATHOLOGY	0	3,360	0	3,360		9.00
10.00	MEDICAL SOCIAL SERVICES	0	90,590	0	90,590		10.00
11.00	HOME HEALTH AIDE	0	136,336	0	136,336		11.00
12.00	SUPPLIES	0	37,252	0	37,252		12.00
13.00	DRUGS	0	0	0	0		13.00
13.20	COST OF ADMINISTERING VACCINES	0	0	0	0		13.20
14.00	DME	0	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	HOME DIALYSIS AIDE SERVICES	0	0	0	0		15.00
16.00	RESPIRATORY THERAPY	0	0	0	0		16.00
17.00	PRIVATE DUTY NURSING	0	0	0	0		17.00
18.00	CLINIC	0	183,336	0	183,336		18.00
19.00	HEALTH PROMOTION ACTIVITIES	0	873,620	0	873,620		19.00
20.00	DAY CARE PROGRAM	0	0	0	0		20.00
21.00	HOME DELIVERED MEALS PROGRAM	0	0	0	0		21.00
22.00	HOMEMAKER	0	0	0	0		22.00
23.00	OTHER	0	166,061	0	166,061		23.00
	SPECIAL PURPOSE COST CENTERS						
24.00	CORF						24.00
25.00	HOSPICE	0	0	0	0		25.00
26.00	CMHC	0	0	0	0		26.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 9/9/2020 11:41 am

		RECLASSIFICATION (Fr. Wks. A-4)	RECLASSIFIED TRIAL BALANCE (Cols. 6 + 7)	ADJUSTMENTS	EXPENSES FOR COST ALLOCATION (Col. 8 + 9)		
		7.00	8.00	9.00	10.00		
27.00	RHC	0	0	0	0		27.00
28.00	FQHC	0	0	0	0		28.00
29.00	TOTAL	0	4,877,000	-344,619	4,532,381		29.00
30.00	If you want the system to distribute your benefits based on salary, enter total benefits:						30.00

RECLASSIFICATIONS

Provider CCN: 33-7165

Period: From 01/01/2019 To 12/31/2019

Worksheet A-4

Date/Time Prepared: 9/9/2020 11:41 am

	Increase			Decrease			
	Cost Center	Line No.	Amount (2)	Cost Center	Line No.	Amount (2)	
	2.00	3.00	4.00	5.00	6.00	7.00	
	TOTALS						
100.00	Total Reclassifications (Sum of column 4 must equal sum of column 7)		0			0	100.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, column 7, line as appropriate.

ADJUSTMENTS TO EXPENSES

Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-5 | Date/Time Prepared: 9/9/2020 11:41 am

	Description (1)	(2) Basis/Code	Amount	Expense Classification on Worksheet A To/From Which The Amount is to be Adjusted: Cost Center	Line No.	
		1.00	2.00	3.00	4.00	
1.00	Excess funds generated from operations, other than net income	B	-3,650	CAP REL COSTS-MVBLE EQUIP	2.00	1.00
2.00	Trade, quantity, time and other discounts on purchases (Chap. 8)	B	0		0.00	2.00
3.00	Rebates and refunds of expenses (Chap. 8)	B	0		0.00	3.00
4.00	Home office costs (Chap. 21)	A	0		0.00	4.00
5.00	Adjustments resulting from transaction with related organization (Chap. 10)	From Wks A-6	-340,645			5.00
6.00	Sale of medical records and abstracts	B	0		0.00	6.00
7.00	Income from imposition of interest, finance or penalty charges (Chap. 21)	B	-324	CAP REL COSTS-BLDG & FIXT	1.00	7.00
8.00	Sale of medical and surgical supplies to other than patients	A	0		0.00	8.00
9.00	Sale of Drugs to other than patients	A	0		0.00	9.00
10.00	Physical therapy adjustment (Chap. 14)	From Wks A-8-3	0	PHYSICAL THERAPY	7.00	10.00
10.01	Occupational therapy adjustment (Chap. 14)	From Wks A-8-3	0	OCCUPATIONAL THERAPY	8.00	10.01
10.02	Speech pathology adjustment (Chap. 14)	From Wks A-8-3	0	SPEECH PATHOLOGY	9.00	10.02
11.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	A	0		0.00	11.00
12.00	Lobbying Activities	A	0		0.00	12.00
13.00			0		0.00	13.00
14.00			0		0.00	14.00
15.00			0		0.00	15.00
16.00			0		0.00	16.00
17.00			0		0.00	17.00
18.00			0		0.00	18.00
19.00			0		0.00	19.00
20.00			0		0.00	20.00
21.00	TOTAL (Sum of lines 1-20)		-344,619			21.00

(1) Description - All line references in this column pertain to the Provider Reimbursement Manual, Part I.
(2) Basis for adjustment (See Instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - If cost cannot be determined

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	Provider CCN: 33-7165	Period: From 01/01/2019 To 12/31/2019	Worksheet A-6 Date/Time Prepared: 9/9/2020 11:41 am

			1.00
	A. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? (If yes, complete Parts B and C)		YES

		Location And Amount Included On Worksheet A, Column 8				
		Line No.	Cost Center	Expense Items	Amount	
		1.00	2.00	3.00	4.00	
	B. Costs incurred and adjustments required as a result of transactions with related organizations or claimed home office costs:					
1.00		3.00	PLANT OPERATION & MAINTENANCE	UTILITIES/MAINTENANCE	229,710	1.00
2.00		5.00	ADMINISTRATIVE AND GENERAL	INDIRECT COST ALLOCATION	607,735	2.00
3.00		0.00			0	3.00
4.00	TOTALS (Sum of lines 1-3)(Transfer col. 6, lines 1-3 to Wkst A, Col. 9, lines as appropriate) (Transfer col. 6, line 4 to Wkst. A-5, col. 2, line 5)				837,445	4.00

		Amount Allowable in Cost	Net Adjustments (col. 4 minus col. 5)		
		5.00	6.00		
	B. Costs incurred and adjustments required as a result of transactions with related organizations or claimed home office costs:				
1.00		229,710	0		1.00
2.00		267,090	340,645		2.00
3.00		0	0		3.00
4.00	TOTALS (Sum of lines 1-3)(Transfer col. 6, lines 1-3 to Wkst A, Col. 9, lines as appropriate) (Transfer col. 6, line 4 to Wkst. A-5, col. 2, line 5)	496,800	340,645		4.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	Provider CCN: 33-7165	Period: From 01/01/2019 To 12/31/2019	Worksheet A-6 Date/Time Prepared: 9/9/2020 11:41 am

		Symbol (1)	Name	Address	Percent Owned by Provider	
		1.00	2.00	3.00	4.00	
	C. Interrelationship of provider to related organization(s):					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the provider to furnish the information requested on Part C of this worksheet.

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

1.00		G	SULLIVAN COUNTY	MONTICELLO, NY	0.00	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
	G. Other (financial or non-financial) specify:					

(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.

		Percent Ownership of Provider	Type of Business		
		5.00	6.00		
	C. Interrelationship of provider to related organization(s):				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the provider to furnish the information requested on Part C of this worksheet.

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

1.00		100.00	GOVERNMENT		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
	G. Other (financial or non-financial) specify:				

(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.

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE

Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 | Date/Time Prepared: 9/9/2020 11:41 am

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00	6.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE							
1.00	Land	8,000	0	0	0	0	8,000	1.00
2.00	Land Improvements	0	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	2,220,525	0	0	0	0	2,220,525	3.00
4.00	Building Improvements	20,538	0	0	0	0	20,538	4.00
5.00	Fixed Equipment	443,983	3,066	0	3,066	0	447,049	5.00
6.00	Movable Equipment	232,062	0	0	0	27,470	204,592	6.00
7.00	Total	2,925,108	3,066	0	3,066	27,470	2,900,704	7.00

COST ALLOCATION-GENERAL SERVICE COST | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B | Date/Time Prepared: 9/9/2020 11:41 am

	Cost Center Description	NET EXPENSES FOR COST ALLOCATION (FR. WKST A, COL 10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	3.00	4.00	4A	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-324	-324	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,758		18,758	0	0	0	2.00
3.00	PLANT OPERATION & MAINTENANCE	229,710	0	0	229,710	0	0	3.00
4.00	TRANSPORTATION	0	0	0	0	0	0	4.00
5.00	ADMINISTRATIVE AND GENERAL	795,045	0	6,672	81,714	0	883,431	5.00
	HHA REIMBURSABLE SERVICES							
6.00	SKILLED NURSING CARE	1,626,934	0	5,083	62,246	0	1,694,263	6.00
7.00	PHYSICAL THERAPY	329,661	0	0	0	0	329,661	7.00
8.00	OCCUPATIONAL THERAPY	42,042	0	0	0	0	42,042	8.00
9.00	SPEECH PATHOLOGY	3,360	0	0	0	0	3,360	9.00
10.00	MEDICAL SOCIAL SERVICES	90,590	0	0	0	0	90,590	10.00
11.00	HOME HEALTH AIDE	136,336	0	285	3,487	0	140,108	11.00
12.00	SUPPLIES	37,252	0	0	0	0	37,252	12.00
13.00	DRUGS	0	0	0	0		0	13.00
13.20	COST OF ADMINISTERING VACCINES	0	0	0	0		0	13.20
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	HOME DIALYSIS AIDE SERVICES	0	0	0	0	0	0	15.00
16.00	RESPIRATORY THERAPY	0	0	0	0	0	0	16.00
17.00	PRIVATE DUTY NURSING	0	0	0	0	0	0	17.00
18.00	CLINIC	183,336	0	0	0	0	183,336	18.00
19.00	HEALTH PROMOTION ACTIVITIES	873,620	0	3,393	41,551	0	918,564	19.00
20.00	DAY CARE PROGRAM	0	0	0	0	0	0	20.00
21.00	HOME DELIVERED MEALS PROGRAM	0	0	0	0	0	0	21.00
22.00	HOMEMAKER	0	0	0	0	0	0	22.00
23.00	OTHER	166,061	0	3,325	40,712	0	210,098	23.00
	SPECIAL PURPOSE COST CENTERS							
24.00	CORF	0	0	0	0	0	0	24.00
25.00	HOSPICE	0	0	0	0	0	0	25.00
26.00	CMHC	0	0	0	0	0	0	26.00
27.00	RHC	0	0	0	0	0	0	27.00
28.00	FQHC	0	0	0	0	0	0	28.00
29.00	TOTAL	4,532,381	0	18,758	229,710	0	4,532,705	29.00

COST ALLOCATION-GENERAL SERVICE COST | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B | Date/Time Prepared: 9/9/2020 11:41 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	TOTAL		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			2.00
3.00	PLANT OPERATION & MAINTENANCE	0			3.00
4.00	TRANSPORTATION	0			4.00
5.00	ADMINISTRATIVE AND GENERAL	883,431			5.00
	HHA REIMBURSABLE SERVICES				
6.00	SKILLED NURSING CARE	410,154	2,104,417		6.00
7.00	PHYSICAL THERAPY	79,806	409,467		7.00
8.00	OCCUPATIONAL THERAPY	10,178	52,220		8.00
9.00	SPEECH PATHOLOGY	813	4,173		9.00
10.00	MEDICAL SOCIAL SERVICES	21,930	112,520		10.00
11.00	HOME HEALTH AIDE	33,918	174,026		11.00
12.00	SUPPLIES	9,018	46,270		12.00
13.00	DRUGS	0	0		13.00
13.20	COST OF ADMINISTERING VACCINES	0	0		13.20
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	HOME DIALYSIS AIDE SERVICES	0	0		15.00
16.00	RESPIRATORY THERAPY	0	0		16.00
17.00	PRIVATE DUTY NURSING	0	0		17.00
18.00	CLINIC	44,383	227,719		18.00
19.00	HEALTH PROMOTION ACTIVITIES	222,370	1,140,934		19.00
20.00	DAY CARE PROGRAM	0	0		20.00
21.00	HOME DELIVERED MEALS PROGRAM	0	0		21.00
22.00	HOMEMAKER	0	0		22.00
23.00	OTHER	50,861	260,959		23.00
	SPECIAL PURPOSE COST CENTERS				
24.00	CORF	0	0		24.00
25.00	HOSPICE	0	0		25.00
26.00	CMHC	0	0		26.00
27.00	RHC	0	0		27.00
28.00	FQHC	0	0		28.00
29.00	TOTAL	883,431	4,532,705		29.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/9/2020 11:41 am

	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	TRANS-PORTATION (MILEAGE)	RECONCIL-IATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	7,115						1.00
2.00	CAP REL COSTS-MVBLE EQUIP		7,115					2.00
3.00	PLANT OPERATION & MAINTENANCE	0	0	7,115				3.00
4.00	TRANSPORTATION	0	0	0	0			4.00
5.00	ADMINISTRATIVE AND GENERAL	2,531	2,531	2,531	0	-883,431	3,649,274	5.00
	HHA REIMBURSABLE SERVICES							
6.00	SKILLED NURSING CARE	1,928	1,928	1,928	0	0	1,694,263	6.00
7.00	PHYSICAL THERAPY	0	0	0	0	0	329,661	7.00
8.00	OCCUPATIONAL THERAPY	0	0	0	0	0	42,042	8.00
9.00	SPEECH PATHOLOGY	0	0	0	0	0	3,360	9.00
10.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	90,590	10.00
11.00	HOME HEALTH AIDE	108	108	108	0	0	140,108	11.00
12.00	SUPPLIES	0	0	0	0	0	37,252	12.00
13.00	DRUGS	0	0	0		0	0	13.00
13.20	COST OF ADMINISTERING VACCINES	0	0	0		0	0	13.20
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	HOME DIALYSIS AIDE SERVICES	0	0	0	0	0	0	15.00
16.00	RESPIRATORY THERAPY	0	0	0	0	0	0	16.00
17.00	PRIVATE DUTY NURSING	0	0	0	0	0	0	17.00
18.00	CLINIC	0	0	0	0	0	183,336	18.00
19.00	HEALTH PROMOTION ACTIVITIES	1,287	1,287	1,287	0	0	918,564	19.00
20.00	DAY CARE PROGRAM	0	0	0	0	0	0	20.00
21.00	HOME DELIVERED MEALS PROGRAM	0	0	0	0	0	0	21.00
22.00	HOMEMAKER	0	0	0	0	0	0	22.00
23.00	OTHER	1,261	1,261	1,261	0	0	210,098	23.00
	SPECIAL PURPOSE COST CENTERS							
24.00	CORF	0	0	0	0	0	0	24.00
25.00	HOSPICE	0	0	0	0	0	0	25.00
26.00	CMHC	0	0	0	0	0	0	26.00
27.00	RHC	0	0	0	0	0	0	27.00
28.00	FQHC	0	0	0	0	0	0	28.00
29.00	TOTAL	7,115	7,115	7,115	0	-883,431	3,649,274	29.00
30.00	Cost To Be Allocated (Per Wkst B)	-324	18,758	229,710	0		883,431	30.00
31.00	Unit Cost Multiplier	0.000000	2.636402	32.285313	0.000000		0.242084	31.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Parts I - V Date/Time Prepared: 9/9/2020 11:41 am

	Cost Per Visit Computation - Patient Services	From Wkst B, Col. 6, Line:	Total Cost	Total Visits	Average Cost Per Visit (Cols 2 / 3) (1)	
		1.00	2.00	3.00	4.00	
	PART I - AGGREGATE AGENCY COST PER VISIT COMPUTATION					
1.00	Skilled Nursing	6.00	2,104,417	6,865	306.54	1.00
2.00	Physical Therapy	7.00	409,467	4,080	100.36	2.00
3.00	Occupational Therapy	8.00	52,220	606	86.17	3.00
4.00	Speech Pathology	9.00	4,173	80	52.16	4.00
5.00	Medical Social Services	10.00	112,520	535	210.32	5.00
6.00	Home Health Aide Services	11.00	174,026	1,350	128.91	6.00
7.00	Total (Sum of lines 1-6)		2,856,823	13,516		7.00

(1) Compute the average cost per visit one time for each discipline (column 4, lines 1 through 6) for the entire home health agency.

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Parts I - V Date/Time Prepared: 9/9/2020 11:41 am

CBSA 1

	Total Medicare Patient Service Cost Computation - CBSA 99933	From Wkst. C, Part I, Col. 4, Line:	Average Cost Per Visit	Medicare Program Visits: Part A	Medicare Program Visits: Part B Not Subject to Deductibles & Coinsurance	Medicare Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Medicare Services: Part A	
		0	4.00	5.00	6.00	7.00	8.00	
	PART II - COMPUTATION OF THE AGGREGATE MEDICARE COST AND THE AGGREGATE OF THE MEDICARE LIMITATION (2)							
1.00	Skilled Nursing	1.00	306.54	0	3,974		0	1.00
2.00	Physical Therapy	2.00	100.36	0	2,629		0	2.00
3.00	Occupational Therapy	3.00	86.17	0	455		0	3.00
4.00	Speech Pathology	4.00	52.16	0	54		0	4.00
5.00	Medical Social Services	5.00	210.32	0	340		0	5.00
6.00	Home Health Aide Services	6.00	128.91	0	1,035		0	6.00
7.00	Total (Sum of lines 1-6)			0	8,487		0	7.00

	Total Medicare Patient Service Cost Computation - CBSA 99933	Program Cost Limits	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	
		4.00	5.00	6.00	7.00	8.00	9.00	
	Limitation							
8.00	Skilled Nursing							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide Services							13.00
14.00	Total (Sum of lines 8-13)							14.00

(2) Complete Worksheet C, Part II once for each MSA/CBSA where Medicare covered services were furnished during the cost reporting period.

	Total Medicare Patient Service Cost Computation - CBSA 99933	Cost of Medicare Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Medicare Services: Part B Subject to Deductibles & Coinsurance	Total (Sum of Cols 8 & 9)	
		9.00	10.00	11.00	
	PART II - COMPUTATION OF THE AGGREGATE MEDICARE COST AND THE AGGREGATE OF THE MEDICARE LIMITATION (2)				
1.00	Skilled Nursing	1,218,190		1,218,190	1.00
2.00	Physical Therapy	263,846		263,846	2.00
3.00	Occupational Therapy	39,207		39,207	3.00
4.00	Speech Pathology	2,817		2,817	4.00
5.00	Medical Social Services	71,509		71,509	5.00
6.00	Home Health Aide Services	133,422		133,422	6.00
7.00	Total (Sum of lines 1-6)	1,728,991		1,728,991	7.00

	Total Medicare Patient Service Cost Computation - CBSA 99933	Subject to Deductibles & Coinsurance	Total (Sum of Cols 8 & 9)	
		10.00	11.00	
	Limitation			
8.00	Skilled Nursing			8.00
9.00	Physical Therapy			9.00
10.00	Occupational Therapy			10.00
11.00	Speech Pathology			11.00
12.00	Medical Social Services			12.00
13.00	Home Health Aide Services			13.00
14.00	Total (Sum of lines 8-13)			14.00

(2) Complete Worksheet C, Part II once for each MSA/CBSA where Medicare covered services were furnished during the cost reporting period.

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Parts I - V Date/Time Prepared: 9/9/2020 11:41 am

	Other Patient Services	From Wkst B, Col. 6, Line:	Total Cost	Total Charges from HHA Record	Ratio (Cols 2 / 3)	Medicare Covered Charges: Part A	Medicare Covered Charges: Part B Not Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - SUPPLIES AND DRUGS COST COMPUTATION							
15.00	Cost of Medical Supplies	12.00	46,270	50,011	0.925196	0	38,210	15.00
16.00	Cost of Drugs	13.00	0	0	0.000000		0	16.00
16.20	Cost of Administrating Vaccines	13.20	0	0	0.000000			16.20

		MSA/CBSA Code (3)	Medicare Program Unduplicated Census Count For Each MSA/CBSA Pre 10/1/2000 (4)	Per Beneficiary Annual Limitation Per MSA/Non-MSA CBSA/Non-CBSA (From your Contractor)	Cost of Medicare Services: Part A	Part B: Not Subject to Deductibles & Coinsurance	Part B: Subject to Deductibles & Coinsurance	
		0	1.00	2.00	3.00	4.00	5.00	
	PART IV - COMPARISON OF THE LESSER OF THE AGGREGATE MEDICARE COST, THE AGGREGATE OF THE MEDICARE COST PER VISIT LIMITATION AND THE AGGREGATE PER BENEFICIARY COST LIMITATION							
17.00	Total Cost of Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, lines 1-6 (exculsive of subscripts))				0	1,728,991		17.00
18.00	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))				0	35,352		18.00
19.00	Total (Sum of lines 17 and 18).				0	1,764,343		19.00
20.00	Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 &11, respectively, line 14)							20.00
21.00	Cost of Medical Supplies (From Part III, cols. 8 & 9, line 15)							21.00
22.00	Total (Sum of lines 20 and 21)							22.00
23.00	Per Beneficiary Cost Limitation for MSA/CBSA:							23.00
24.00	Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof)							24.00

		From Wkst. C, Part I, Col. 4, Line:	Average Cost Per Visit	Part B - Subject to Deductibles and Coinsurance: Medicare Program Visits for Services Before 1/1/1998	Medicare Program Costs for Services Before 1/1/1998	Medicare Program Visits for Services 1/1/1998 - 12/31/1998	Medicare Program Visits for Services 1/1/1999 - 9/30/2000	
		1.00	2.00	3.00	4.00	5.00	5.01	
	PART V - OUTPATIENT THERAPY REDUCTION COMPUTATION							
25.00	Physical Therapy	2.00	100.36	0	0	0	0	25.00
26.00	Occupational Therapy	3.00	86.17	0	0	0	0	26.00
27.00	Speech Pathology	4.00	52.16	0	0	0	0	27.00
28.00	Total (Sum of lines 25-27)			0	0	0	0	28.00

(3) The MSA/CBSA codes flow from Worksheet S-3, Part III, line 29 and subscripts as indicated.
(4) The sum of column 1, line 24 must equal Worksheet S-3, Part I, column 2, line 10.01

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Parts I - V Date/Time Prepared: 9/9/2020 11:41 am

	Other Patient Services	Medicare Covered Charges	Cost of Services				
		Part B		Part B			
		Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		7.00	8.00	9.00	10.00		
	PART III - SUPPLIES AND DRUGS COST COMPUTATION						
15.00	Cost of Medical Supplies	0	0	35,352	0		15.00
16.00	Cost of Drugs	0		0	0		16.00
16.20	Cost of Administrating Vaccines	0		0	0		16.20
		Total (Sum of Cols 3 & 4)					
		6.00					
	PART IV - COMPARISON OF THE LESSER OF THE AGGREGATE MEDICARE COST, THE AGGREGATE OF THE MEDICARE COST PER VISIT LIMITATION AND THE AGGREGATE PER BENEFICIARY COST LIMITATION						
17.00	Total Cost of Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, lines 1-6 (exculsive of subscripts))	1,728,991					17.00
18.00	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))	35,352					18.00
19.00	Total (Sum of lines 17 and 18).	1,764,343					19.00
20.00	Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 &11, respectively, line 14)						20.00
21.00	Cost of Medical Supplies (From Part III, cols. 8 & 9, line 15)						21.00
22.00	Total (Sum of lines 20 and 21)						22.00
23.00	Per Beneficiary Cost Limitation for MSA/CBSA:						23.00
24.00	Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof)						24.00
		Part B - Subject to Deductibles and Coinsurance					
		Medicare Program Visits for Services on or After 10/1/2000	Medicare Program Costs for Services 1/1/1998 - 12/31/1998	Application of the Reasonable Cost Reduction	Reasonable Costs Net of Adjustments		
		5.02	6.00	7.00	8.00		
	PART V - OUTPATIENT THERAPY REDUCTION COMPUTATION						
25.00	Physical Therapy	0	0	0	0		25.00
26.00	Occupational Therapy	0	0	0	0		26.00
27.00	Speech Pathology	0	0	0	0		27.00
28.00	Total (Sum of lines 25-27)	0	0	0	0		28.00

(3) The MSA/CBSA codes flow from Worksheet S-3, Part III, line 29 and subscripts as indicated.
(4) The sum of column 1, line 24 must equal Worksheet S-3, Part I, column 2, line 10.01

CALCULATION OF REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D | Date/Time Prepared: 9/9/2020 11:41 am

	Description	Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	Part I - Computation of the Lesser of Reasonable Cost or Customary Charges				
	Reasonable Cost of Title XVIII - Part A & B Services				
1.00	Reasonable Cost of Services (See Instructions)	0	0	0	1.00
2.00	Cost of Services, RHC & FQHC			0	2.00
3.00	Sum of Lines 1 and 2	0	0	0	3.00
4.00	Total charges for title XVIII - Part A and Part B Services - Pre 10/1/2000				4.00
4.01	Total charges for title XVIII - Part A and Part B Services - Post 9/30/2000		0	0	4.01
	Customary Charges				
5.00	Amount actually collected from patients liable for payment for services on a charge basis (From your records)	0	0	0	5.00
6.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	6.00
7.00	Ratio of line 5 to line 6 (Not to exceed 1.000000)	1.000000	1.000000	1.000000	7.00
8.00	Total customary charges - title XVIII (Multiply line 7 by line 4 for column 1)(Multiply line 7 by the sum of lines 4 & 4.01 for columns 2 & 3, respectively)(See Instructions)	0	0	0	8.00
9.00	Excess of total customary charges over total reasonable cost (Complete only if line 8 exceeds line 3)	0	0	0	9.00
10.00	Excess of reasonable costs over customary charges (Complete only if line 3 exceeds line 8)	0	0	0	10.00
11.00	Primary Payer Amounts	0	0	0	11.00

	Description	Part A Services	Part B Services	
		1.00	2.00	
	Part II - Computation of Reimbursement Settlement			
12.00	Total reasonable cost (See Instructions)	0	0	12.00
12.01	Total PPS Payment - Full Episodes without Outliers	0	1,290,513	12.01
12.02	Total PPS Payment - Full Episodes with Outliers	0	124,039	12.02
12.03	Total PPS Payment - LUPA Episodes	0	44,067	12.03
12.04	Total PPS Payment - PEP only Episodes	0	19,435	12.04
12.05	Total PPS Payment - SCIC within a PEP Episode	0	0	12.05
12.06	Total PPS Payment - SCIC Only Episodes	0	0	12.06
12.07	Total PPS Outlier Payment - Full Episodes with Outliers	0	0	12.07
12.08	Total PPS Outlier Payment - PEP Only Episodes	0	0	12.08
12.09	Total PPS Outlier Payment - SCIC within a PEP Episode	0	0	12.09
12.10	Total PPS Outlier Payment - SCIC Only Episodes	0	0	12.10
12.11	Total Other Payments	0	0	12.11
12.12	DME Payments	0	0	12.12
12.13	Oxygen Payment	0	0	12.13
12.14	Prosthetics and Orthotics Payment	0	0	12.14
13.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	13.00
14.00	Subtotal (Sum of lines 12-12.14 minus line 13)	0	1,478,054	14.00
15.00	Excess reasonable cost (from line 10)	0	0	15.00
16.00	Subtotal (Line 14 minus line 15)	0	1,478,054	16.00
17.00	Coinsurance billed to Medicare patients (From your records)		0	17.00
18.00	Net cost (Line 16 minus line 17)	0	1,478,054	18.00
19.00	Reimbursable bad debts (From your records)	0	0	19.00
20.00	Pneumococcal Vaccine		0	20.00
21.00	Total Costs - Current cost reporting period (See Instructions)	0	1,478,054	21.00
22.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets	0	0	22.00
23.00	Recovery of excess depreciation resulting from agencies' termination or a decrease in Medicare utilization	0	0	23.00
24.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit	0	0	24.00
25.00	Total Cost before sequestration and other adjustments (line 21 plus/minus line 22 minus sum of lines 23 and 24)	0	1,478,054	25.00
25.50	OTHER ADJUSTMENTS (SPECIFY)	0	0	25.50
25.99	POST SEQ DEMO REDUCTION	0	0	25.99
26.00	Sequestration Adjustment (See Instructions)	0	29,561	26.00
27.00	Amount reimbursable after sequestration and other adjustments (Line 25 plus line 25.50 minus line 26)	0	1,448,493	27.00
28.00	Total interim payments (From Worksheet D-1, line 4)	0	1,448,493	28.00
28.50	Tentative settlement (For contractor use only)	0	0	28.50
29.00	Balance due HHA/Medicare program (Line 27 minus line 28)(Indicate overpayments in brackets)	0	0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pin. 15-2, section 115.2	0	0	30.00
31.00	Balance due HHA/Medicare Program (Line 29 minus line 30)(Indicate overpayments in brackets)	0	0	31.00

ANALYSIS OF PAYMENTS TO HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 9/9/2020 11:41 am

	Description	Part A mm/dd/yyyy	Part A Amount	Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,448,493	1.00
2.00	Interim payments payable on individual bills either submitted or to be submitted to the contractor, for services rendered in the cost report period. If none, write "NONE" or enter a zero.		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none write "NONE" or enter a zero. (1)					3.00
3.01	PROGRAM TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
3.50	PROVIDER TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49, minus sum of lines 3.50-3.98)		0		0	3.99
4.00	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 and 3.99)(Transfer to Wkst D, Part II, column as appropriate, line 28)		0		1,448,493	4.00
	To be Completed by Contractor					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5.01	PROGRAM TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
5.50	PROVIDER TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	SUBTOTAL (Sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determine net settlement amount (balance due) based on the cost report (See Instructions)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare Program Liability (See Instructions)		0		1,448,493	7.00

	Description		Contractor Number	Date: Month, Day, Year	
		0	1.00	2.00	
8.00	Name of Contractor	National Government Services, Inc.	06001		8.00

Signature of Authorized Person: _____

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

BALANCE SHEET (To be completed by all providers maintaining fund type accounting records. Nonproprietary providers not maintaining fund type accounting records, should complete the "General Fund" column only.)

Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet F | Date/Time Prepared: 9/9/2020 11:41 am

	ASSETS (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	342,503	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes Receivable	0	0	0	0	3.00
4.00	Accounts Receivable	982,459	0	0	0	4.00
5.00	Other Receivables	557,663	0	0	0	5.00
6.00	Less: Allowance for uncollectible notes and accounts receivable	-18,513	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid Expenses	26,463	0	0	0	8.00
9.00	OTHER CURRENT ASSETS	50	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,890,625	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	8,000	0	0	0	12.00
13.00	Land Improvements	0	0	0	0	13.00
14.00	Less: Accumulated Depreciation	0	0	0	0	14.00
15.00	Buildings	2,220,525	0	0	0	15.00
16.00	Less: Accumulated Depreciation	-2,220,525	0	0	0	16.00
17.00	Leasehold Improvements	20,538	0	0	0	17.00
18.00	Less: Accumulated Depreciation	-20,538	0	0	0	18.00
19.00	Fixed equipment	447,049	0	0	0	19.00
20.00	Less: Accumulated Depreciation	-419,444	0	0	0	20.00
21.00	Automobiles and trucks	204,592	0	0	0	21.00
22.00	Less: Accumulated Depreciation	-201,043	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Less: Accumulated Depreciation	0	0	0	0	24.00
25.00	Minor equipment nondepreciable	0	0	0	0	25.00
26.00	OTHER FIXED ASSETS	0	0	0	0	26.00
27.00	Total fixed assets (sum of lines 12-26)	39,154	0	0	0	27.00
	OTHER ASSETS					
28.00	Investments	0	0	0	0	28.00
29.00	Deposits on leases	0	0	0	0	29.00
30.00	Due from owners/officers	0	0	0	0	30.00
31.00	OTHER ASSETS	0	0	0	0	31.00
32.00	Total other assets (sum of lines 28-31)	0	0	0	0	32.00
33.00	Total assets (sum of lines 11, 27, and 32)	1,929,779	0	0	0	33.00
	LIABILITIES AND FUND BALANCE (Omit Cents)					
	CURRENT LIABILITIES					
34.00	Accounts payable	250,688	0	0	0	34.00
35.00	Salaries, wages, & fees payable	900,893	0	0	0	35.00
36.00	Payroll taxes payable	0	0	0	0	36.00
37.00	Notes & loans payable (short term)	0	0	0	0	37.00
38.00	Deferred income	0	0	0	0	38.00
39.00	Accelerated payments	0	0	0	0	39.00
40.00	Due to other funds	0	0	0	0	40.00
41.00	OTHER (SPECIFY)	21,116,816	0	0	0	41.00
42.00	Total current liabilities (sum of lines 34-41)	22,268,397	0	0	0	42.00
	LONG TERM LIABILITIES					
43.00	Mortgage payable	0	0	0	0	43.00
44.00	Notes payable	0	0	0	0	44.00
45.00	Unsecured loans	0	0	0	0	45.00
46.00	Loans from owners - prior to 7/1/66	0	0	0	0	46.00
47.00	Loans from owners - on or after 7/1/66	0	0	0	0	47.00
48.00	OTHER (SPECIFY)	0	0	0	0	48.00
49.00	Total long term liabilities (sum of lines 43-48)	0	0	0	0	49.00
50.00	Total liabilities (sum of lines 42 and 49)	22,268,397	0	0	0	50.00
	CAPITAL ACCOUNTS					
51.00	General fund balance	-20,338,618				51.00
52.00	Specific purpose fund balance		0			52.00
53.00	Donor created - Endowment fund balance - restricted			0		53.00
54.00	Donor created - Endowment fund balance - unrestricted			0		54.00
55.00	Governing body created - Endowment fund balance			0		55.00
56.00	Plant fund balance - Invested in plant				0	56.00
57.00	Plant fund balance - Reserve for plant improvement, replacement and expansion				0	57.00
58.00	Total fund balances (sum of lines 51 thru 57)	-20,338,618	0	0	0	58.00
59.00	Total liabilities and fund balances (sum of lines 50 and 58)	1,929,779	0	0	0	59.00

STATEMENT OF REVENUE AND OPERATING EXPENSES | Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet F-1 | Date/Time Prepared: 9/9/2020 11:41 am

		1.00	2.00	
1.00	Total patient revenues	3,976,087		1.00
2.00	Less: Allowances and discounts on patients' accounts	0		2.00
3.00	Net patient revenues (Line 1 minus line 2)		3,976,087	3.00
4.00	Operating expenses (From Worksheet A, column 6, line 29)	4,877,000		4.00
	Additions to operating expenses (Specify)			
5.00		2,055,671		5.00
6.00		0		6.00
7.00		0		7.00
8.00		0		8.00
9.00		0		9.00
10.00		0		10.00
	Subtractions to operating expenses (Specify)			
11.00		0		11.00
12.00		0		12.00
13.00		0		13.00
14.00		0		14.00
15.00		0		15.00
16.00		0		16.00
17.00	Less total operating expenses (net of lines 4-16)		6,932,671	17.00
18.00	Net income from service to patients (Line 3 minus line 17)		-2,956,584	18.00
	Other Income:			
19.00	Contributions, donations, bequests, etc.	0		19.00
20.00	Income from investments	0		20.00
21.00	Purchase discounts	0		21.00
22.00	Rebates and refunds of expenses	0		22.00
23.00	Sale of Medical and Nursing Supplies to other than patients	0		23.00
24.00	Sale of durable medical equipment to other than patients	0		24.00
25.00	Sale of drugs to other than patients	0		25.00
26.00	Sale of medical records and abstracts	0		26.00
	Other Revenues (Specify)			
27.00		0		27.00
28.00		0		28.00
29.00		0		29.00
30.00		0		30.00
31.00		0		31.00
32.00	Total Other Income (Sum of lines 19 thru 31)		0	32.00
33.00	Net Income or Loss for the period (Line 18 plus line 32)		-2,956,584	33.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 33-7165 | Period: From 01/01/2019 To 12/31/2019 | Worksheet F-2 | Date/Time Prepared: 9/9/2020 11:41 am

		General Fund		Special Purpose Fund		Endowment Fund		
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Fund balances at beginning of period		-17,382,034		0		0	1.00
2.00	Net income (loss) (from Wkst. F-1, line 33)		-2,956,584					2.00
3.00	Total (sum of line 1 and line 2)		-20,338,618		0		0	3.00
	Additions (Credit Adjustments)(Specify)							
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	Total Additions (sum of line 4-8)		0		0		0	9.00
10.00	Subtotal (line 3 plus line 9)		-20,338,618		0		0	10.00
	Deductions (Debit Adjustments)(Specify)							
11.00		0		0		0		11.00
12.00		0		0		0		12.00
13.00		0		0		0		13.00
14.00		0		0		0		14.00
15.00		0		0		0		15.00
16.00	Total Deductions (sum of lines 11-15)		0		0		0	16.00
17.00	Fund balance at end of period per balance sheet (line 10 minus line 16)		-20,338,618		0		0	17.00

		Plant Fund		
		7.00	8.00	
1.00	Fund balances at beginning of period		0	1.00
2.00	Net income (loss) (from Wkst. F-1, line 33)			2.00
3.00	Total (sum of line 1 and line 2)		0	3.00
	Additions (Credit Adjustments)(Specify)			
4.00		0		4.00
5.00		0		5.00
6.00		0		6.00
7.00		0		7.00
8.00		0		8.00
9.00	Total Additions (sum of line 4-8)		0	9.00
10.00	Subtotal (line 3 plus line 9)		0	10.00
	Deductions (Debit Adjustments)(Specify)			
11.00		0		11.00
12.00		0		12.00
13.00		0		13.00
14.00		0		14.00
15.00		0		15.00
16.00	Total Deductions (sum of lines 11-15)		0	16.00
17.00	Fund balance at end of period per balance sheet (line 10 minus line 16)		0	17.00