ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET O

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS									
1	Cap Rel Costs-Bldg & Fixt*								1
2	Cap Rel Costs-Mvble Equip*								2
3	Employee Benefits Department*								3
4	Administrative & General *								4
5	Plant Operation and Maintenance*								5
6	Laundry & Linen Service*								6
7	Housekeeping*								7
8	Dietary*								8
9	Nursing Administration*								9
10	Routine Medical Supplies*								10
11	Medical Records*								11
12	Staff Transportation*								12
13	Volunteer Service Coordination*								13
14	Pharmacy*								14
15	Physician Administrative Services*								15
16	Other General Service*								16
17	Patient/Residential Care Services								17
DIRECT PATIENT CARE SERVICE COST CENTERS									
25	Inpatient Care-Contracted**								25
26	Physician Services**								26
27	Nurse Practitioner**								27
28	Registered Nurse**								28
29	LPN/LVN**								29
30	Physical Therapy**								30
31	Occupational Therapy**								31
32	Speech/ Language Pathology**								32
33	Medical Social Services**								33
34	Spiritual Counseling**								34
35	Dietary Counseling**								35
36	Counseling - Other**								36
37	Hospice Aide and Homemaker Services**								37
38	Durable Medical Equipment/Oxygen**								38
39	Patient Transportation**								39

* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

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PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET O

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)									
40	Imaging Services**								40
41	Labs and Diagnostics**								41
42	Medical Supplies-Non-routine**								42
42.50	Drugs Charged to Patients**								42.50
43	Outpatient Services**								43
44	Palliative Radiation Therapy**								44
45	Palliative Chemotherapy**								45
46	Other Patient Care Services**								46
NONREIMBURSABLE COST CENTERS									
60	Bereavement Program *								60
61	Volunteer Program *								61
62	Fundraising*								62
63	Hospice/Palliative Medicine Fellows*								63
64	Palliative Care Program*								64
65	Other Physician Services*								65
66	Residential Care *								66
67	Advertising*								67
68	Telehealth/Telemonitoring*								68
69	Thrift Store*								69
70	Nursing Facility Room & Board*								70
71	Other Nonreimbursable*								71
100	Total								100

* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.