

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

					PROVIDER CCN:	PERIOD:	WORKSHEET O		
					HOSPICE CCN:	FROM _____			
						TO _____			
		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	
<b>GENERAL SERVICE COST CENTERS</b>									
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
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>									
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 0

	SALARIES 1	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 ) 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL ( col. 5 ± col. 6 ) 7	
<b>DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)</b>								
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
<b>NONREIMBURSABLE COST CENTERS</b>								
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/Telemetry*							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.