

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

PROVIDER CCN:
HOSPICE CCN:

PERIOD:
FROM _____
TO _____

WORKSHEET O

	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	
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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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.