

HOSPICE COMPENSATION ANALYSIS CONTRATED SERVICES / PURCHASED SERVICES					PROVIDER CCN:	PERIOD : FROM _____ TO _____			WORKSHEET K-3
					HOSPICE CCN:				
COST CENTER DESCRIPTIONS	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
	1	2	3	4	5	6	7	8	9
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Bldg. and Fixt.									1
2 Capital Related Costs-Movable Equip.									2
3 Plant Operation and Maintenance									3
4 Transportation - Staff									4
5 Volunteer Service Coordination									5
6 Administrative and General									6
INPATIENT CARE SERVICE									
7 Inpatient - General Care									7
8 Inpatient - Respite Care									8
VISITING SERVICES									
9 Physician Services									9
10 Nursing Care									10
11 Nursing Care-Continuous Home Care									11
12 Physical Therapy									12
13 Occupational Therapy									13
14 Speech/ Language Pathology									14
15 Medical Social Services									15
16 Spiritual Counseling									16
17 Dietary Counseling									17
18 Counseling - Other									18
19 Home Health Aide and Homemaker									19
20 HH Aide & Homemaker-Cont. Home Care									20
21 Other									21
OTHER HOSPICE SERVICE COSTS									
22 Drugs, Biological and Infusion Therapy									22
23 Analgesics									23
24 Sedatives / Hypnotics									24
25 Other - Specify									25
26 Durable Medical Equipment/Oxygen									26
27 Patient Transportation									27
28 Imaging Services									28
29 Labs and Diagnostics									29
30 Medical Supplies									30
31 Outpatient Services (including E/R Dept.)									31
32 Radiation Therapy									32
33 Chemotherapy									33
34 Other									34
HOSPICE NONREIMBURSABLE SERVICE									
35 Bereavement Program Costs									35
36 Volunteer Program Costs									36
37 Fundraising									37
38 Other Program Costs									38
39 Total (sum of lines 1 through 38)									39

(1) Transfer the amounts in column 9 to Wkst. K, col. 4