ANALYSIS OF SNF-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	0100	Cap Rel Costs-Bldg & Fixt*								1
2	0200	Cap Rel Costs-Mvble Equip*								2
3	0300	Employee Benefits Department*								3
4	0400	Administrative & General *								4
5	0500	Plant Operation & Maintenance*								5
6	0600	Laundry & Linen Service*								6
7	0700	Housekeeping*								7
8	0800	Dietary*								8
9	0900	Nursing Administration*								9
10	1000	Routine Medical Supplies*								10
11	1100	Medical Records*								11
12	1200	Staff Transportation*								12
13	1300	Volunteer Service Coordination*								13
14	1400	Pharmacy*								14
15	1500	Physician Administrative Services*								15
16	1600	Other General Service*								16
17	1700	Patient/Residential Care Services								17
		DIRECT PATIENT CARE SERVICE COST CENTERS								
25	2500	Inpatient Care-Contracted**								25
26	2600	Physician Services**								26
27	2700	Nurse Practitioner**								27
28	2800	Registered Nurse**								28
29	2900	LPN/LVN**								29
30	3000	Physical Therapy**								30
31	3100	Occupational Therapy**								31
32	3200	Speech/ Language Pathology**								32
33	3300	Medical Social Services**								33
34	3400	Spiritual Counseling**								34
35	3500	Dietary Counseling**								35
36	3600	Counseling - Other**								36
37	3700	Hospice Aide and Homemaker Services**								37
38	3800	Durable Medical Equipment/Oxygen**								38
39	3900	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.

ANALYSIS OF SNF-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	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)										
40	4000	Imaging Services**								40
41	4100	Labs and Diagnostics**								41
42	4200	Medical Supplies-Non-routine**								42
43	4300	Outpatient Services**								43
44	4400	Palliative Radiation Therapy**								44
45	4500	Palliative Chemotherapy**								45
46		Other Patient Care Services **								46
NONREIMBURSABLE COST CENTERS										
60	6000	Bereavement Program *								60
61	6100	Volunteer Program *								61
62	6200	Fundraising*								62
63	6300	Hospice/Palliative Medicine Fellows*								63
64	6400	Palliative Care Program*								64
65	6500	Other Physician Services*								65
66	6600	Residential Care *								66
67	6700	Advertising*								67
68	6800	Telehealth/Telemonitoring*								68
69	6900	Thrift Store*								69
70	7000	Nursing Facility Room & Board*								70
71	7100	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.