

Maryland Health Care Commission
HOSPICE SURVEY PART 2
2015
 (Print version)

User Name
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SECTION F - PRODUCTIVITY AND COST OF CARE

F5.COSTS (PART II)

Please provide a summary of cost data you submitted in your FY2015 Medicare Cost Report. Enter the data for each line number (at left) from your Medicare Cost Report Worksheet and Column noted at the top of each column below. Freestanding, hospital-based and home health-based hospice cost reports request the same information, but have different worksheet, column and line references. This survey contains references for the Free-standing Hospice Cost Report. If your costs are submitted to CMS on a hospital or home health cost report and you are having difficulty identifying the appropriate spaces for your responses, please call Linda Cole at 410-764-3337 with any questions concerning the Maryland Hospice survey. If she is unavailable, you may leave a message for her or email lcole@mhcc.state.md.us.

	Total Costs by Item Worksheet A, Column 10	Total Fully Loaded Costs Worksheet B, Column 7
General Service Cost Centers		
1. Capital Related Costs-Bldg and Fixtures	<input type="text"/>	In this column, general service costs have been allocated, according to the method you selected, to the direct cost service centers below.) Do not include the values entered in rows 6.01, 6.02, and 6.03 when computing the sum of Totals
2. Capital Related Costs – Movable Equipment	<input type="text"/>	
3. Plan Operation and Maintenance	<input type="text"/>	
4. Transportation – Staff	<input type="text"/>	
5. Volunteer Service Coordination	<input type="text"/>	
6. Administrative and General	<input type="text"/>	
----6.01 A and G Shared Costs	<input type="text"/>	
----6.02 A and G Reimbursable Costs	<input type="text"/>	
----6.03 A and G Non-reimbursable Costs	<input type="text"/>	
Inpatient Care Service Costs Centers		
10. Inpatient – General Care	<input type="text"/>	Costs by Item
11. Inpatient – Respite Care	<input type="text"/>	<input type="text"/>
Visiting Services		
15. Physician Services	<input type="text"/>	<input type="text"/>
16. Nursing Care	<input type="text"/>	<input type="text"/>
17. Physical Therapy	<input type="text"/>	<input type="text"/>
18. Occupational Therapy	<input type="text"/>	<input type="text"/>
19. Speech/Language Pathology	<input type="text"/>	<input type="text"/>
20. Medical Social Services – Direct	<input type="text"/>	<input type="text"/>
21. Spiritual Counseling	<input type="text"/>	<input type="text"/>
22. Dietary Counseling	<input type="text"/>	<input type="text"/>
23. Counseling – Other	<input type="text"/>	<input type="text"/>
24. Home Health Aides and Homemakers	<input type="text"/>	<input type="text"/>

25. Other		
Other Hospice Service Cost Centers		
30. Drugs, Biologicals and Infusion		
31. Durable Medical Equipment/Oxygen		
32. Patient Transportation		
33. Imaging Services		
34. Labs and Diagnostics		
35. Medical Supplies		
36. Outpatient Services (incl. ER Dept)		
37. Radiation Therapy		
38. Chemotherapy		
39. Other		
Hospice Non-reimbursable Service		
50. Bereavement Program Costs		
51. Volunteer Program Costs		
52. Fundraising		
53. Other Program Costs		
100. Total Costs		

APPORTIONMENT STATISTICS

Worksheet S-1 Column 6

Please enter the numbers as submitted on your Medicare Cost Report Worksheet S-1, Column 6 on the lines noted

Line 11 – General Inpatient Days

Line 10 – Inpatient Respite Days

Line 12 – Total Patient Days

Cost Report Worksheet S-1 Column 1, on the lines noted.

Line 14 – Continuous Care Hours

SECTION G - REVENUE AND PAYER MIX

Please complete the following for FY2015.

G1. LEVEL OF CARE AND PAY SOURCE (PART II)

Number of Patients Served: Do not count re-admissions within the same payment source.

Please provide patient days for all patients served, including those in nursing facilities, during FY2014. Patients who changed primary pay source during FY2015 should be reported with the number of days of care recorded for each pay source (count each day only once even if there is more than one pay source on any given day).

Hospice Payment Source	(1) Number of Patients Served	(2) Days of Routine Home Care	(3) Days of Inpatient Care	(4) Days of Respite Care	(5) Days of	(6) Total Patient Care Days

					Continuous Care	
a. Hospice Medicare						
b. Hospice General Medicaid						
c. Hospice Medicaid MCO						
d. Total Managed Care or Private Insurance (do not include Blue Cross)						
d1. Commercial Non-Managed Care Organization						
d2. Commercial Managed Care Organization						
e. Total Blue Cross						
e1. Blue Cross Non-Managed Care Organization						
e2. Blue Cross Managed Care Organization						
f. Self Pay						
g1. Uncompensated Care						
g2. Charity Care						
h. Other*						
i. TOTALS						

*Other Payer Source may include but is not limited to Workers Comp, donations, etc.

G2 REVENUE (PART II)

This question does not correspond to cost centers in the Cost Report, therefore base responses on your accounting records, not your Cost Report submission. Responses should reflect gross revenue for FY2015.

Hospice Service

Revenue: Payment for services. Include all Medicare per diem payments for all levels of care, Medicaid, private insurance and private pay.

Expenses: Related to service delivery. Include reimbursable and non-reimbursable (bereavement and volunteer) program services.

Total Agency Fundraising

Revenue: Include grants, fundraising including capital campaign funds, bequests, memorial donations, United Way and other community support, as well as transfers from your hospice foundation, if any.

Expenses: Include any expenses related to fundraising.

Other

Revenue: Include revenue from palliative care, non-hospice patient care and other community services, nursing home room and board and pass-through costs, as well as interest or investment income.

Expenses: Related to palliative care, non-hospice patient care, and other community services.

Revenue Source	Revenue	Expenses
Hospice Service	<input type="text"/>	<input type="text"/>
Total Agency Fundraising	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>
Overhead Expenses (administrative and general)	NA	<input type="text"/>
Total Revenue (include earned revenues, fundraising allocation from endowment, and other fundraising)		
<input type="text"/>		<input type="text"/>
Total Expenses		
<input type="text"/>		<input type="text"/>

G3 RECEIVABLES MANAGEMENT

Please provide the number of days your revenue is outstanding in accounts receivable. Multiply the total accounts receivable on the last day of your fiscal year by 365 and divide by your total Hospice Service Revenue.

Average Days Revenue Outstanding (A/R Days):

CERTIFICATION HOSPICE SURVEY PART 2

To complete the online survey, you must Certify the information you provided by reading the following and clicking on the Certify Button

I hereby certify the following:

- I have authorization to complete the Maryland Health Care Commission Hospice Survey;
- All information contained in this **Hospice Survey Part 2** is true, correct and complete to the best of my knowledge and belief;
- No information, data, report, statement, schedule or other filing required to be filed or filed hereunder contains any medical, individual or confidential information personally identifiable to a patient or consumer of health services, whether directly or indirectly;
- I understand that the Hospice Survey is required to be filed with the Maryland Health Care Commission and is considered a public record which is available for public inspection, unless such disclosure conflicts with the Maryland Health Care Commission's then existing data disclosure policy.

Part 2 Date Certified and Submitted: