Maryland Health Care Commission

HOSPICE SURVEY PART 2

20YY

(Print version)

SECTION F - PRODUCTIVITY AND COST OF CARE

F5.COSTS (PART II)

Please provide a summary of cost data you submitted in your FY 20YY 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 Catherine Victorine at 410-764-3254 with any questions concerning the Maryland Hospice survey. If she is unavailable, you may leave a message for her or email catherine.victorine@maryland.gov

	Total Costs by Item Worksheet A, Column 7	**Total Fully Loaded Costs** Worksheet B, Column 18
General Service Cost Centers		
1. Capital Related Costs-Bldg and Fixtures		
2. Capital Related Costs – Movable Equipment		
3. Employee Benefits Department		
4. Administrative and General		
5. Plant Operation and Maintenance		
6. Laundry & Linen Service		
7. Housekeeping		
8. Dietary		
9. Nursing Administration		
10. Routine Medical Supplies		
11. Medical Records		
12. Staff Transportation		
13.Volunteer Services Coordination		
14. Pharmarcy		
15. Physician Administrative Servies		
16. Other General Services (specify)		
17. Patient/Residential Care Services		
Direct Patient Care Service Cost Centers		
25. Inpatient Care - Contracted		
26. Physician Services		
27. Nurse Practitioner		
28. Registered Nurse		
29. LPN/LVN		
30. Physical Therapy		
31. Occupational Therapy		
32. Speech/Language Pathology		
33. Medical Social Services		
34. Spiritual Counseling		
35. Dietary Counseling		
36. Counseling - Other		
37. Hospice Aide and Homemaker Services		
38. Durable Medical Equipment/Oxygen		
39. Patient Transportation		
40. Imaging Services		
41. Labs and Diagnostics		

42. Medical Supplies - Non-routine		
43. Outpatient Services		
44. Palliative Radiation Therapy		
45. Palliative Chemotherapy		
46. Other Patient Care Services (specify)		
50. Continous Home Care		
51. Routine Home Care		
52. Inpatient Respite		
53. General Inpatient		
Non-Reimbursable Cost Centers		
60. Bereavement Program		
61. Volunteer Program		
62. Fundraising		
63. Hospice/Palliative Medicine Fellows		
64. Palliative Care Program		
65. Other Physician Services		
66. Residential Care		
67. Advertising		
68. Telehealth/Telemonitoring		
69. Thrift Store		
70. Nursing Facility Room & Board		
71. Other Nonreimbursable (specify)		
101. Total Costs		

APPORTIONMENT STATISTICS
Worksheet S-1 Part 2 Statistical Data
Please enter the numbers as submitted on your Medicare Cost Report Worksheet S-1, Column 6 on the lines noted

Level of Care	Total Days
Line 30 - Continuous Home Care	
Line 31 - Routine Home Care	
Line 32 – Inpatient Respite Days	
Line 33 – General Inpatient Days	
Line 34 – Total Hospice Days	

F6. PALLIATIVE CARE

Total Palliative Care Visits	
Total Palliative Care Revenue:	

SECTION G - REVENUE AND PAYER MIX

Please complete the following for FY 20YY.

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 FY 20YY. Patients who changed primary pay source during FY 20YY 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 Continuous Care	(6) Total Patient Care Days
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 FY 20YY.

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		
Total Agency Fundraising		
Other		
Overhead Expenses (administrative and general)	NA	

Total Revenue (include earned revenues, fundraising allocation from endowment, and other fundraising)	
Total Expenses	

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):

PART 2 - COMMENTS
Please enter any additional information you would like us to have regarding your data.
No Comments

If you have any comments or suggestions for future state surveys, please call us or note them here.
No Suggestions

CERTIFICATION HOSPICE SURVEY

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 1 and 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.

Date Certified and Submitted: