SELF DETERMINED HOSPICE CAP REPORT (SDHC report)

PROVIDER SELF-REPORTING OF AGGREGATE CAP LIMITATION

PROVIDER NAME: Hospice Agency
PROVIDER NUMBER: XX-1234
NPI NUMBER: **556666666**
CAP YEAR ENDING: **9/30/2023**

CAP ON OVERALL MEDICARE REIMBURSEMENT

1. MEDICARE BENEFICIARIES UNDER HOSPICE CARE PER THE PS&R	54.0000
a. Run Date of Report: 1/1/2024	
b. Check Methodology for counting beneficiaries (if not checked, will be assumed to be Fully Prorated (PP))	
[X] Fully Prorated (PP)	
[ ] Streamlined Method (use only if grandfathered back in 2012)	
2. STATUTORY CAP AMOUNT FOR THE CAP YEAR	**$32,486.92**
3. ALLOWABLE MEDICARE PAYMENTS (line 1 X line 2)	$1,754,293.68
4. NET PAYMENTS PER THE PS&R	$1,800,000.00
5. PAYMENTS IN EXCESS OF THE AGGREGATE CAP AMOUNT (line 3 - line 4)	($45,706)

(If line 4 is less than line 3, enter a zero on line 5, if line 4 is greater than line 3 enter amount whole number, **no cents**)

THE CONTRACTOR WILL MAKE THE ADJUSTMENT FOR SEQUESTRATION AT THE FINAL CAP DETERMINATION

CERTIFICATION

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED ON THIS REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

Certification of Officer or Authorized Representative of the Hospice:

I hereby certify that I have read the above statement and that I have examined this report for the above name hospice and to the best of my knowledge and belief, it is a true, correct and complete report.

Signature of Officer or Authorized Representative of Hospice

Typed or printed name and title of above signature

Name and number of person to contact for additional information:

Printed Name: Telephone Number:

Send completed form by email to: **HospiceCap@palmettogba.com**

(reference only the Provider Number in the subject line)

Main Report