Progressive Provider Services

(248) 968-4100 ~ (888) 405-4162 fax
www.ppsassistant.com

Hospice Cost Report Preparation Checklist and Questionnaire

Please fill out the entire form. E-mail files to blimi@ppsassistant.com
If there are any questions, please contact us for clarification.

Hospice name: _____

Medicare provider number (6 digit -PTAN/CCN): _____

Hospice address, city, state, zip*: _____

County where hospice is located*: _____

Person compiling this form, title: _____

Telephone numbers: _____

E-mail address: _____

Name of contractor/MAC: Choose... _____

Date certified for Medicare*: _____

Type of organization (Corp, Partnership, etc.)*: _____

Current cost report year malpractice premiums: $_____

Counties ***serviced*** this year: _____

If your facility had more than one level of care, please fill out the following:

Department	Continuous Care Avg Daily/Wkly Hrs/Visits or Total Compensation	Routine Care Avg Daily/Wkly Hrs/Visits or Total Compensation	Respite Care Avg Daily/Wkly Hrs/Visits or Total Compensation	General Inpatient Avg Daily/Wkly Hrs/Visits or Total Compensation
RN				
LPN				
Social Workers				
Chaplains				
Aides				

* If your prior year cost report was prepared by PPS, we have your information on file.

Summary Checklist of Required Cost Report Preparation Items

☐ 1. Trial Balance *in **Excel** format* (****Expenses must be shown on an accrual basis****)
***COVID-19 PRF & small business loan forgiveness revenues and telecommunications technology expenses should be separately identified.*

☐ 2. **Profit and Loss and Balance Sheet**

☐ 3a. **Patient days by payor and Level of Care**

	Unduplicated Days		
Levels of Care	**Medicare**	**Medicaid**	**Other**
Continuous Home Care			
Routine Home Care			
Inpatient Respite Care			
General Inpatient Care			

☐ 3b. **Contracted inpatient days** (number of days for inpatients who did not reside in your facility) by payor and Level of Care.

	Unduplicated Days		
Levels of Care	**Medicare**	**Medicaid**	**Other**
Inpatient Respite Care			
General Inpatient Care			

☐ 4. **Square footage of office by department** * (Were there any square footage changes from PY?)

☐ 5. **Information regarding related party vendors**.

a. Do any of the owners receive compensation for work done at the facility? choose... If so, who, what percentage of the facility does he/ she own, what is his/ her position, and how much compensation?

_____

b. Does anyone immediately related to an owner receive compensation for work done at the facility? choose...
If so, who, what is his/ her position, and how much compensation? _____

c. Does any vendor owned by a facility owner or an immediate relative of a facility owner provide services to the facility? choose... If so, please let us know, and we will request further information.

☐ 6. **Prior Year Complete Medicare Cost Report and supporting documents**. *

☐ 7. **Any MAC Correspondences received regarding the cost report.**

☐ 8. **Departmental Payroll Breakdown** (if the TB does not break down payroll by department.)

☐ 9. **Breakdown of Contract Labor Account by Department** (if not done on the TB)

☐ 10. **Revenue Breakdown**- Enter revenue amount by payor

Medicare: $_____

Medicaid: $_____

Other: $_____

☐ 11. **PS&R** – this form is used to determine the Net Medicare Reimbursement. *Only required if it is unclear if the Net Reimbursement is under or over $200,000*.

* If your prior year cost report was prepared by PPS, we have your information on file.