Progressive Provider Services

248) 968-4100 ~ (800) 447-2540

www.ppsassistant.com

Hospice Cost Report Preparation Checklist

To submit information, upload to secure Dropbox link.
To obtain link contact blimi@ppsassistant.com or call (248)968-4100.
Feel free to contact us for clarification or questions.

Hospice name: _____

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

Hospice address, city, state, zip*: _____

County where hospice is located*: _____

Date certified for Medicare*: _____

Date Hospice Began Operations: _____

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.

Checklist of Required Cost Report Preparation Items

1. **Trial Balance** *in **Excel** format* (**Expenses must be shown on an accrual basis**)
   ***COVID-19 ERC, 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? _____ 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? _____
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? _____ 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.