

# Progressive Provider Services Hospice Cost Report Preparation Checklist

To submit information, upload to secure Dropbox link.  
To obtain link contact [blimi@ppsassistant.com](mailto:blimi@ppsassistant.com) or call (248)968-4100.

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. Financial Documents:**

- **Trial Balance** *in Excel format* (\*\*Expenses must be shown on an accrual basis\*\*)
- **Profit and Loss**
- **Balance Sheet**

Trial Balance must match the Profit & Loss and Balance Sheet

COVID-19 ERC, PRF & small business loan forgiveness revenues and telecommunications technology expenses should be separately identified.

**2. 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.*

**3. Prior Year Complete Medicare Cost Report and supporting documents. \***

**4a. Patient days by payor and Level of Care**

<u>Levels of Care</u>	Unduplicated Days		
	Medicare	Medicaid	Other
Continuous Home Care			
Routine Home Care			
Inpatient Respite Care			
General Inpatient Care			

**4b. Contracted inpatient days** (number of days for inpatients who did not reside in your facility) by payor and Level of Care.

<u>Levels of Care</u>	Unduplicated Days		
	Medicare	Medicaid	Other
Inpatient Respite Care			
General Inpatient Care			

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

**6. Information regarding related party vendors.**

a. If any owners or relatives of owners work for the Hospice, please provide name, position, salary, and % of ownership: \_\_\_\_\_

b. If any owners or relatives of owners also own a company which provides services to the HHA, please provide name, position, salary, and % of ownership: \_\_\_\_\_

**7. Departmental Payroll and Contract Labor Breakdown by Department** (if not done on the TB)

**8. Revenue Breakdown-** Enter revenue amount by payor

Medicare: \$ \_\_\_\_\_ Medicaid: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

**9. Expense Breakdown:** DME: \_\_\_\_\_ Drugs: \_\_\_\_\_ Lab: \_\_\_\_\_

Inpatient Contract: \_\_\_\_\_ Volunteer Coordinator Salary: \_\_\_\_\_ - \_\_\_\_\_

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