____
Hospice Name

____
Medicare Provider#

____
Phone number

____
Fax Number

____
Name of contact person for us to reach in case of question.

Administrative:

1. Please provide us with copies of all Medicare correspondence. Especially any lump sum adjustments, cost limit calculations or other approvals.

2. Please provide your Medicare Certification Date ____________________

3. If Medicare Training & Consulting did **NOT** prepare your cost report last year, please send us a copy.

4. Please forward your PS&R from iacs to plonsey@aol.com. Dates of service are January 1, 2018 through December 31, 2018.

5. Have you moved your office since we filed last year's cost report? Did you file the 855a with CMS? Have they acknowledged the move? If so, please give us your current address:

Financial Statements:

6. Year to Date Financial Statement and working Trial Balance

7. A copy of your Balance Sheet

Hospice Name_____________________________________ For the year ended_________________

8. Number of days for the year.

	Title XVIII Medicare Days	Title XIX Medicaid Days	Other Unduplicated Days	Total Days
Continuous Home Care*	________	_________	________	_______
Routine Home Care **	________	_________	_________	_______
Inpatient Respite Care	________	_________	_________	_______
General Inpatient Care ***	________	_________	_________	_______
Total Hospice Days	________	_________	_________	_______

* If Continuous are days are billed, fill out section 8A and 10B.

** If Routine Home Care days are billed, fill out section 8A and 10A.

*** If General Inpatient Care days are billed, fill out section 8A and 10C.

Hospice Name ______________________________ For the year ended ______________

8A. REVENUE

	Medicare	Medicaid	Other	Total
Continuous Home Care	________	________	________	________
Routine Home Care	________	________	________	________
IP Respite Care	________	________	________	________
GIP	________	________	________	________
Room and Board	________	________	________	________

Hospice Name ______________________________________For the year ended_________________

9. General Services

	Salary	Other
Capital related – building *	_XXXXXX_	__________
Capital related – equipment *	_XXXXXX_	__________
Employee Benefits *	__________	__________
Administrative – general *	__________	__________
Plant operations & Maintenance, utilities *	__________	__________
Laundry and Linen Services	__________	__________
Housekeeping	__________	__________
Dietary	__________	__________
Nursing Administration	__________	__________
Routine Medical Supplies	__________	__________
Medical Records	__________	__________
Staff Transportation	__________	__________
Volunteer Services Coordination *	__________	__________
Pharmacy *	__________	__________
Physician – Administrative	__________	__________
Patient/Residential Care	__________	__________

* Mandatory effective December 31, 2018 FYE

Hospice Name ______________________________________For the year ended_________________

10. Patient Care **R E S P I T E C A R E**

	Salary	Other
Inpatient Care	_XXXXXXXXXXX__	______________
Physician Services	______________	______________
Nurse Practitioner	______________	______________
Registered Nurse *	______________	______________
LPN/LVN (New)	______________	______________
Physical Therapy	______________	______________
Occupational Therapy	______________	______________
Speech Therapy	______________	______________
Medical Social Services *	______________	______________
Spiritual Counseling	______________	______________
Dietary Counseling	______________	______________
Other Counseling	______________	______________
Aide and Homemaker *	______________	______________
DME/Oxygen *	_XXXXXXXXXXX__	______________
Patient Transportation	______________	______________
Imaging Services	_XXXXXXXXXXX__	______________
Labs and Diagnostics	_XXXXXXXXXXX__	______________
Medical Supplies (non-routine)	_XXXXXXXXXXX__	______________
Outpatient Services	______________	______________
Palliative Radiation Therapy (New)	______________	______________
Palliative Chemotherapy (New)	______________	______________

* Required December 31, 2018 and after.

Hospice Name ______________________________________For the year ended_________________

10A. Patient Care **R O U T I N E C A R E**

	Salary	Other
Inpatient Care	_XXXXXXXXXXX__	____________
Physician Services	____________	____________
Nurse Practitioner	____________	____________
Registered Nurse	____________	____________
LPN/LVN	____________	____________
Physical Therapy	____________	____________
Occupational Therapy	____________	____________
Speech Therapy	____________	____________
Medical Social Services	____________	____________
Spiritual Counseling	____________	____________
Dietary Counseling	____________	____________
Other Counseling	____________	____________
Aide and Homemaker	____________	____________
DME/Oxygen	_XXXXXXXXXXX__	____________
Patient Transportation Imaging	____________	____________
Services	____________	____________
Labs and Diagnostics	_XXXXXXXXXXX__	____________
Medical Supplies (non-routine)	_XXXXXXXXXXX__	____________
Outpatient Services	____________	____________
Palliative Radiation Therapy	____________	____________
Palliative Chemotherapy (New)	____________	____________

Hospice Name ______________________________________For the year ended_________________

10B. Patient Care **C O N T I N O U S C A R E**

	Salary	Other
Inpatient Care	_XXXXXXXXXXX__	___________
Physician Services	___________	___________
Nurse Practitioner	___________	___________
Registered Nurse	___________	___________
LPN/LVN	___________	___________
Physical Therapy	___________	___________
Occupational Therapy	___________	___________
Speech Therapy	___________	___________
Medical Social Services	___________	___________
Spiritual Counseling	___________	___________
Dietary Counseling	___________	___________
Other Counseling	___________	___________
Aide and Homemaker	___________	___________
DME/Oxygen	_XXXXXXXXXXX__	___________
Patient Transportation	___________	___________
Imaging Services	___________	___________
Labs and Diagnostics	_XXXXXXXXXXX__	___________
Medical Supplies (non-routine)	_XXXXXXXXXXX__	___________
Outpatient Services	___________	___________
Palliative Radiation Therapy (New)	___________	___________
Palliative Chemotherapy (New)	___________	___________

Hospice Name ____For the year ended__________________

10C. Patient Care **G E N E R A L I N P A T I E N T**

	Salary	Other
Inpatient Care	_XXXXXXXXXXX__	________________
Physician Services	__________________	________________
Nurse Practitioner Registered	__________________	________________
Nurse	__________________	________________
LPN/LVN	__________________	________________
Physical Therapy	__________________	________________
Occupational Therapy	__________________	________________
Speech Therapy	__________________	________________
Medical Social Services Spiritual	__________________	________________
Counseling	__________________	________________
Dietary Counseling	__________________	________________
Other Counseling	__________________	________________
Aide and Homemaker	__________________	________________
DME/Oxygen	_XXXXXXXXXXX__	________________
Patient Transportation	__________________	________________
Imaging Services	__________________	________________
Labs and Diagnostics	_XXXXXXXXXXX__	________________
Medical Supplies (non-routine)	_XXXXXXXXXXX__	________________
Outpatient Services	__________________	________________
Palliative Radiation Therapy (New)	__________________	________________
Palliative Chemotherapy (New)	__________________	________________

Hospice Name ___________________________________For the year ended________________

11. General Service Costs

Square footage (by facility) identifying room (space), dimensions of the room, computed square feet, and use of the room. Please use separate paper for this.

Example:

Room	Dimensions	Sq Feet	Use	Cost Center	Cost Report
1	15x28	420	Conference Room	Administration	Administration
2	8x10	80	Physical Therapy	Physical Therapy	Nursing Admin
3	8x10	80	Clergy	Spiritual Counseling	Nursing Admin
4	12x12	144	Volunteers	Volunteer Coord	Volunteer Coord
5	12x10	120	Nursing Admin	Nursing Admin	Nursing Admin
6	12x15	180	Administrator	Admin. Gen	Admin. Gen
7	12x12	144	Dir of Fundraising	Fundraising	Fundraising

Dollar value (segregate property and equipment and lease payments):

	Property	**Lease Payments**
Respite	__________________	_______________
Routine	__________________	_______________
Continuous	__________________	_______________
General In-patient	__________________	_______________

Pharmacy Charges -standard charges of the hospice:

Respite __________________

Routine __________________

Continuous __________________

General In-patient __________________

Miles traveled in owned/leased vehicles, miles paid to staff

Hospice Name ______________________________________For the year ended_________________

12. Tracked Volunteer hours. This is new, and should be done daily. You may use this page, or create a similar page to better suit your needs.

Activity	**Date**	**Hours**
Admin and General		
Laundry and Linen		
Housekeeping		
Dietary		
Nursing Admin		
Medical Records		
Inpatient Facility		

Contracted Inpatient Facility		
Patient Residence/Pt Support		
Bereavement		
Fundraising		
Palliative Care Program		
Marketing and Advertising		
Thrift Store		
Total Hours		

Hospice Name ______________________________________ For the year ended_________________

13. Non-Reimbursable Costs

	SALARY	OTHER
Bereavement Program*	___________	__________
Volunteer program *	___________	__________
Fundraising	___________	__________
Hospice/palliative fellows	___________	__________
Palliative Care program	___________	__________
Other Physician Services	___________	__________
Residential Care	___________	__________
Advertising	___________	__________
Telehealth/telemonitoring	___________	__________
Thrift Store	___________	__________
Nursing facility room and board	___________	__________
Other	___________	__________

* Required FYE 12/31/2018