MY ACCOUNTING CENTER, INC.
(CPA FIRM)

Hospice Cost Report
Preparation Checklist and Questionnaire

This form is to assist the provider with compiling information in connection with the preparation of their year-end Medicare cost report. The information obtained from this form will be used to complete the appropriate Medicare cost report and supplemental information. This form may be submitted to the intermediary as additional supporting documentation and provider representation regarding certain information included within this form.

In addition, we will likely be contacting you during the preparation process to inquire about certain issues or request additional required information. If you have any questions regarding this form or individual items requested, please do not hesitate to contact us.

PLEASE FILL OUT THE ENTIRE FORM.
IF THERE ARE ANY QUESTIONS, PLEASE CONTACT US FOR CLARIFICATION.

Agency Name: _____

County: _____

Agency Address: _____

Person Compiling this Form: _____

Position Title: _____

Telephone Numbers: _____

Email Address: _____

Medicare Provider Number: _____

Date Certified for Medicare: _____

460 South Central Avenue • Glendale, CA 91204
Phone: (818) 500-0714 • Fax: (866) 817-8910
lusine@myaccountingcenter.com
www.myaccountingcenter.com

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Summary Checklist of Required Cost Report Preparation Items

Please prepare a copy of all of the following items and submit to us the following:

1. Complete Financial Statements

2. Year End Working Trial Balance **in Excel format**

3. Square footage of office and copy of floor plan*****

4. Any Intermediary Correspondences received, including interim rate and lump-sum payment notices

5. PS&R Report from Cost Report period being prepared.

6. Copy of Last Year's Complete Medicare Cost Report

7. Account Analysis: Please provide detail of the items included in the following accounts: (account names may vary) Other/Misc. Revenues, Promotional Advertising, Other/Misc. Expenses.

8. Related Party Information: Please include description and dollar amounts of expenses for services or goods provided by related party vendors.

9. Worksheet S-1: Please see the attached sheet and complete Lines 8-16. (shaded areas)

*****If your prior year cost report was prepared by My Accounting Center Inc, we have your information on file. Please indicate if there has been any square footage changes.*****

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	Enrollment Days	Title XVIII Unduplicated Medicare Days	Title XIX Unduplicated Medicaid Days	Title XVIII Unduplicated Skilled Nursing Facility Days	Title XIX Unduplicated Nursing Facility Days	Other Unduplicated	Total Unduplicated Days	
		1	2	3	4	5	6	
8	Continuous Home Care							8.
9	Routine Home Care							9.
10	Inpatient Respite Care							10.
11	General Inpatient Care							11.
12	Total Hospice Days							12.

PART III

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	Other	Total	
		1	2	3	4	5	6	
13	Number of Patients Receiving Hospice Care							13.
14	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							14.
15	Average Length of Stay							15.
16	Unduplicated Census Count							16.

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