

Progressive Provider Services

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www.ppsassistant.com

FQHC Agency Cost Report Preparation Checklist and Questionnaire

Please note: Client specific information is not requested here. If supplied, we will ask you to sign a Business Associate Agreement, as required by HIPAA.

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

Clinic Name: _____ *

Does this facility have other consolidated sites? _____

If yes, please complete the additional consolidated checklist.

County: _____ *

Address: _____ *

Person Compiling this Form: _____

Position Title: _____

Telephone Numbers: _____

E-mail Address: _____

Name of Intermediary / MAC: _____

Medicare Provider Number: _____ *

Date Certified for Medicare: _____ *

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

Section 330 Grant #: _____ Date: _____

COVID-19 PRF & Small business loan forgiveness revenues or TB accounts: _____

Telehealth expenses & TB account containing those expenses: _____

Summary Checklist of Required Cost Report Preparation Items

- ☐ 1. Complete Financial Statements
- ☐ 2. Year End Working Trial Balance in Excel format
- ☐ 3. Detailed visit and FTE information for Cost Report period being prepared based on internal records (according to worksheet provided)
- ☐ 4. PS&R Report from Cost Report period being prepared in both PDF and CSV formats
- ☐ 5. Copy of Last Year's Complete Medicare Cost Report*
- ☐ 6. Departmental Payroll Breakdown (if the TB does not break down payroll by disciplines)
- ☐ 7. Breakdown of Contract Labor Account by department (if not done on the TB)
- ☐ 8. Were there any transactions with related parties? If yes, please provide detail.
- ☐ 9. Are you claiming Medicare Bad Debt? If so, please send a Medicare bad debt log.
- ☐ 10. Is this FQHC part of an entity which owns or operates several FQHCs? *
- ☐ 11. Is this FQHC part of a chain organization which files a Home Office Cost Statement? *
- ☐ 12. Did you submit an application for medical malpractice under FTCA with HRSA? If so, what is the effective date of coverage?
- ☐ 13. Do you also carry commercial malpractice? If so, how much was malpractice and is it claims-made or occurrence?
- ☐ 14. Vaccine info –
 - Vaccine staff time (or average time it takes to administer pneumococcal, influenza, and COVID vaccines)
 - Number of pneumococcal, influenza, and COVID vaccines (each) administered (total)
 - Number of pneumococcal, influenza, and COVID vaccines (each) administered to Medicare beneficiaries
 - Cost of pneumococcal, influenza, and COVID vaccine drugs and supplies.*Accuracy of vaccine information will affect reimbursement.*
- ☐ 15. Do/ Did you
 - Have an approved or unapproved GME program? (circle one)
 - Receive a Primary Care Residency Expansion (PCRE) grant?
 - Receive a Teaching Health Center Development grant?
- ☐ If your prior year cost report was prepared by Progressive Provider Services, we have your information on file.

****Please note per cost report instructions,
expenses must be shown on an accrual basis****

Please note that there may be additional information that we will request from you. Page 2 of 2

FQHC Visit and FTE Information for Medicare Cost Report

CHART 1 (for this site only)

	Title V 1	Medicare Title XVIII 2	Medicaid Title XIX 3	Other 4
Medical Visits				
Mental Health Visits				
Number of Visits Performed by Interns and Residents				

CHART 2 (for all sites combined) TOTAL VISITS BY:	Total Medical Visits	Medicare Medical Visits	Mental Health Visits	Medicare Mental Health Visits
Physician				
Physician Services Under Agreement				
Physician Assistant				
Nurse Practitioner				
Visiting Registered Nurse				
Visiting Licensed Practical Nurse				
Certified Nurse Midwife				
Clinical Psychologist				
Clinical Social Worker				
Reg Dietician/Cert DSMT/MNT Educator				

FTEs	Staff	Contract
Physician		
Physician Assistant		
Nurse Practitioner		
Registered Nurse		
Licensed Practical Nurse		
Certified Nurse Midwife		
Clinical Psychologist		
Clinical Social Worker		
Laboratory Technician		
Reg Dietician/Cert DSMT/MNT Educator		
Physical Therapist		
Occupational Therapist		
Other Allied Health Personnel		
Interns & Residents		