

Progressive Provider Services

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FQHC Agency 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 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: _____

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: _____

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. Detailed visit and FTE information for Cost Report period being prepared based on internal records (according to worksheet provided)
- 5. PS&R Report from Cost Report period being prepared in both PDF and CSV formats
- 6. Copy of Last Year's Complete Medicare Cost Report*
- 7. Departmental Payroll Breakdown (if the TB does not break down payroll by disciplines)
- 8. Breakdown of Contract Labor Account by department (if not done on the TB)
- 9. Were there any transactions with related parties? If yes, please provide detail.
- 10. Are you claiming Medicare Bad Debt? If so, please send a Medicare bad debt log.
- 11. Is this FQHC part of an entity which owns or operates several FQHCs?
- 12. Is this FQHC part of a chain organization which files a Home Office Cost Statement?
- 13. Did you submit an application for medical malpractice under FTCA with HRSA? If so, what is the effective date of coverage?
- 14. Do you also carry commercial malpractice? If so, how much was malpractice and is it claims-made or occurrence?
- 15. Vaccine info – vaccine staff time (or average time it takes to administer pneumococcal and influenza vaccines), number of pneumococcal and influenza vaccines (each), number of pneumococcal and influenza vaccines to Medicare beneficiaries.
- 16. 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 review your Trial Balance for any of the accounts listed below. If any exist, please explain their nature on the line provided:

Other/Misc Revenues Account Amount: _____
Description: _____

Other/ Misc Expenses Account Amount: _____
Description: _____

Promotional Advertising Account Amount: _____
Description: _____

Any other account that might require an explanation:

Account Name: _____ Account Amount: _____
Description: _____

Account Name: _____ Account Amount: _____
Description: _____

Account Name: _____ Account Amount: _____
Description: _____

Please note that, due to the new cost report forms, there may be extra information which we will request from you during the cost reporting process.

FQHC Visit and FTE Information for Medicare Cost Report

CHART 1

	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 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		