

Progressive Provider Services

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www.ppsassistant.com

Home Health 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.

Agency Name: _____

County: _____

Agency Address: _____

Person Compiling this Form: _____

Position Title: _____

Telephone Numbers: _____

E-mail Address: _____

Name of Intermediary: _____

Medicare Provider Number: _____

Date Certified for Medicare: _____

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

Current Cost Report Year Depreciation: \$_____

Current Cost Report Year Malpractice premiums: \$_____

Total Cost of Medical Supplies for both Medicare / non-Medicare: \$_____

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 census and FTE information for Cost Report period being prepared based on internal records (according to worksheet provided)
- 4. Square footage of office and copy of floor plan*
- 5. PS&R Report from Cost Report period being prepared.
(pdf and csv version required**)**
- 6. Copy of Last Year's Complete Medicare Cost Report
- 7. Any Intermediary Correspondences received
- 8. Departmental Payroll Breakdown (if the TB does not break down payroll by disciplines)
- 9. Did the HHA contract with outside suppliers for therapy services?
Circle: (Physical Therapy, Occupational Therapy, Speech Therapy, NONE)
- 10. Breakdown of Contract Labor Account (if not done on the TB)
- 11. Were there any transactions with related parties? If yes, please provide detail.

*If your prior year cost report was prepared by Progressive Provider Services, we have your information on file.
Please indicate if there has been any square footage changes.*

****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: _____

Travel Account Amount: _____
Description: (who was reimbursed and how) _____

Meals and/or Entertainment 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: _____