Progressive Provider Services

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Home Health Agency Low Utilization 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: _____

E-mail Address: _____

Name of Intermediary: _____

Medicare Provider Number: _____

Date Certified for Medicare: _____

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

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. PS&R Report from Cost Report period being prepared.
(pdf and csv version required**)**

□ 5. Copy of Last Year's Complete Medicare Cost Report*

□ 6. Any Intermediary Correspondences received

Part I - STATISTICAL DATA County:

	Description	Title XVIII		Other		Total	
		Visits	Patients	Visits	Patients	Visits	Patients
		1	2	3	4	5	6
1	Skilled Nursing					0	
2	Physical Therapy					0	
3	Occupational Therapy					0	
4	Speech Pathology					0	
5	Medical Social Services					0	
6	Home Health Aide					0	
7	All Other Services					0	
8	Total Visits (Sum of lines 1-7)	0		0		0	
9	Home Health Aide Hours					0	
10	Unduplicated Census Count - Full Period						

Part II - EMPLOYMENT DATA (FULL TIME EQUIVALENT)

	Number of Hours in Your Normal Work Week Hours =	Staff	Contract	Total
		1	2	3
11	Administrator and Assistant Administrator(s)			0.00
12	Director(s) and Assistant Director(s)			0.00
13	Other Administrative Personnel			0.00
14	Direct Nursing Service			0.00
15	Nursing Supervisor			0.00
16	Physical Therapy Service			0.00
17	Physical Therapy Supervisor			0.00
18	Occupational Therapy Service			0.00
19	Occupational Therapy Supervisor			0.00
20	Speech Pathology Services			0.00
21	Speech Pathology Supervisor			0.00
22	Medical Social Service			0.00
23	Medical Social Service Supervisor			0.00
24	Home Health Aide			0.00
25	Home Health Aide Supervisor			0.00
26				0.00
27				0.00