Progressive Provider Services

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RHC 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: Patient 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: _____*

Medicare Provider Number: _____* County: _____*

Full Address: _____*

Person Compiling this Form: _____

Position Title: _____ Confirm Price Agreed: _____

Telephone Numbers: _____ E-mail Address: _____

Date Certified for Medicare: _____* Name of Intermediary / MAC: _____

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

Is RHC part of an entity that owns/ leases/ controls multiple RHCs? _____*

If yes, provide name and full address of entity: _____*

Is this RHC part of chain organization? _____ If yes, Home Office CCN: _____*

If yes, provide name and full address of home office: _____*

HRSA Award Number: _____ Date of Grant: _____

Is the RHC filing a consolidated cost report? If yes, contact PPS for more instructions. _____

Did you participate in any payment demonstration this year? _____

Summary Checklist of Required Cost Report Preparation Items

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

□ 1. Complete Financial Statements**

□ 2. Year End Working Trial Balance** *in **Excel** format*
Identify separately: COVID-19 PRF & loan forgiveness revenues & Telehealth expenses

□ 3. Detailed census and FTE information for Cost Report period being prepared based on internal records (Charts 1 and 2 of worksheet provided)

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

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

□ 7. Hours of operation (e.g. Sun 9AM – 5 PM, Mon – Sat 8 AM – 4 PM) *

□ 8. Does facility operate as other than an RHC? If so, provide services (e.g., Dental Clinic) and hours of operation that operates as other than RHC. *

□ 9. Amount of malpractice premiums, paid losses, or self insurance and was malpractice is claims-made or occurrence:

□ 10. Departmental Payroll Breakdown (if the TB does not break down payroll by disciplines)

□ 11. Breakdown of Contract Labor Account by department (if not done on the TB)

□ 12. Were there any transactions with related parties? If yes, please provide detail.

□ 13. Vaccine information (Chart 3 of worksheet provided)

□ 14. Were your financials [circle one or none] audited/ compiled/ reviewed by a CPA?

□ 15. Any GME or Intern-Resident program costs?

□ 16. Are you seeking reimbursement for bad debt? If yes, please send a Medicare bad debt log.

*****If your prior year cost report was prepared by Progressive Provider Services, we have your information on file. If there were no changes, you need not submit these items again.

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

RHC Visit, FTE, and Vaccine Information for Medicare Cost Report

CHART 1

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

**As part of an Intern-Residents program*

CHART 2 - VISITS & FTES	**FTEs**	**Total Visits**
Physician		
Physician Services Under Agreement (Contract MDs)		
Physician Assistant		
Nurse Practitioner		
Certified Nurse Midwife		
Registered Nurse		
Licensed Practical Nurse		
Clinical Psychologist		
Clinical Social Worker		

CHART 3 - VACCINES	**Influenza**	**Pneumo-coccal**
Total Number Administered		
Medicare Vaccines Administered		
Total Cost of Supplies or Cost Per Vaccine		
Average Vaccine Administration Time (e.g., 15 min.)		