

# Progressive Provider Services

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## RHC 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 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. Census information for Cost Report period being prepared based on internal records (Chart 1 of worksheet provided)
- 3. PS&R Report from Cost Report period being prepared.
- 4. Copy of Last Year's Complete Medicare Cost Report. \*
- 5. Hours of operation (e.g. Sun 9AM – 5 PM, Mon – Sat 8 AM – 4 PM) \*
- 6. 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. \*
- 7. Amount of malpractice premiums, paid losses, or self insurance and was malpractice is claims-made or occurrence:
- 8. Were there any transactions with related parties? \_\_\_\_\_
- 9. Were your financials [circle one or none] audited/ compiled/ reviewed by a CPA?
- 10. Any GME or Intern-Resident program costs?
- 11. Are you seeking reimbursement for bad debt? If yes, please send a Medicare bad debt log.

Please note: If you are seeking reimbursement for bad debt you are not eligible to file a Low Utilization cost report. Contact PPS for a full cost report checklist.

\*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*