WALTERS & ASSOCIATES
CPAs
CERTIFIED PUBLIC ACCOUNTANTS

Today's Date:_____

HOME HEALTH AGENCY MEDICARE COST REPORT INFORMATION REQUEST

1. Please complete the following general information on the Agency:

Agency Name	
Contact Name (person completing this form)	
Name of Authorized Signer (Officer of the company)	
Agency Address	**Street:**
Address	**City:** **ST:** **Zip:** Has the Agency address changed since the previous cost reporting period? ☐Yes ☐No
County	
Agency Phone	
Agency Fax	
Email Address	
Provider Number	
Cost Reporting Period:	
Date Certified	

2. Please complete the following table with visits and patients by discipline and payer source. Please note that you do not need to provide detail on each Managed care payer. Total all non Medicare payers and put them in the "other" column.

	Medicare		Other		Total	
	Visits	Patients	Visits	Patients	Visits	Patients
SN						
PT						
OT						
ST						
MSW						
HHA						
Attendant / Private Duty						

Each patient should be counted once for each discipline. If a patient received nursing services and physical therapy services he/she should be counted once for each service.

3. Unduplicated Census Count:

Medicare	
Other	
Total	

4. Average Rates per Visit

Please list your average rates paid for the following disciplines:

Discipline	Average Rate
SN	$
PT	$
OT	$
ST	$
MSW	$
HHA	$

5. List Employment Data:

Department	Staff FTEs	Contract FTEs	Total FTEs
Administrator and Assistant Administrator (s)			
Director(s) and Assistant Director(s)			
Other Administrative Personnel			
Direct Nursing Service			
Nursing Supervisor			
PT Service			
PT Supervisor			
OT Service			
OT Supervisor			
ST Service			
ST Supervisor			
MSW Service			
Home Health Aide			
Home Health Aide Supervisor			
Other -			
Other -			

6. Please provide a copy of the Provider Statistical and Reimbursement Report (PS&R) for the cost reporting period. If possible, please send both the pdf and cvs formats. For detailed instructions, please visit our website www.walters-financial.com. Click on "Medicare Cost Reports" then follow instructions under "How to obtain your PS&R."

7. Provide a Working Trial Balance for the cost reporting period. If an outside accountant prepares your financials, please provide the accountant's contact information. The Working Trial Balance must be prepared on an accrual basis.

8. If the Working Trial Balance does not separately identify the direct salary and contract labor amounts by discipline, please complete the following: (If Filing a Less-Than-Full or No-Utilization report, this item is not applicable).

Discipline	Salary Cost	Contract Labor Cost
Skilled Nursing*		
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Medical Social Services		
Home Health Aide		
Private Duty, If Applicable		
Marketing Personnel		

*Please note that skilled nursing costs should only include the cost associated with providing visits. Exclude office nurses (ie. Director of Nursing, Supervisors).

9. Does the agency contract with outside suppliers for the following therapy?
   a. Physical Therapy ☐Yes ☐No
   b. Occupational Therapy ☐Yes ☐No
   c. Speech Therapy ☐Yes ☐No

10. Has the Agency had a Change of Ownership during the cost reporting period?
    ☐Yes ☐No
    If 'Yes' submit name and address of new owner, date of change, and a copy of the sales agreement or similar agreement affecting the change of ownership

11. Please indicate the expected Medicare reimbursement during the cost reporting period for your agency:
    - ☐ $0
    - ☐ Less than $200,000
    - ☐ Greater than $200,000

12. For new clients, please provide a copy of the prior year Medicare cost report, if applicable.

13. Please list the name of your Fiscal Intermediary and provide any correspondence received related to the Medicare cost report.

14. List the amount of Malpractice Premiums and Paid Losses.

    a. Malpractice Premiums _____
    b. Paid Losses _____

15. If financial statements are prepared on a cash basis:
    a. List of Accrued Expenses (2016 expenses paid in 2015)
    b. Accounts Receivable for Medicare, Medicaid and Private/Commercial Insurance (2017 payments received for 2016 claims)

Once complete, please email this form to doug@waltersaccounting.com or fax it to 727-279-2851. Feel free to call Doug at 941-756-0700 with any questions. Thank you.