HOME HEALTH AGENCY

Medicare Cost Report Questionnaire

Fiscal Year End: _____

Provider Number: _____

Provider Name: _____

Address: _____

_____

City County State Zip

Telephone: _____ Fax: _____

Email: _____

Contact Person _____

Thanks you for choosing us to compile your Medicare cost report (CMS 1728-94) for the current period. With your help this will, for you, be a relatively easy process. Our goal is to provide you with exceptional service. Please contact Larry Shrewsbury if you feel that your service has not been exceptional.

Please provide us with the following documents and/or information to allow us to compile your cost report quickly and efficiently. If you have any questions PLEASE CALL US immediately. We are here to help solve your Medicare cost report problems – not to cause them!

To the extent that the following documents are available in an electronic format, we would like both a hard copy and a copy of the electronic file – which may be emailed.

1. Year to Date Trial Balance (in excel format if available, electronically)
2. Year end Balance Sheet
3. Year to Date Income Statement (sometimes called a Profit & Loss Statement)
4. The Provider Statistical and Reimbursement Summary (PS&R) obtained from Medicare (both the PDF and CSV files in summary format for the year)
5. Copies of any Medicare reimbursement related correspondence
6. Please complete the following tables:

21525 Trumpeter Drive
Land O' Lakes, Florida 34639-4449
www.ShrewsburyCPA.com
Office (813) 929-8800
Facsimile (813) 929-8801
Cellular (813) 245-9588

HOME HEALTH AGENCY

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Provider Number: _____

Provider Name: _____

Fiscal Year Ended: _____

A. Full Time Equivalents

	Staff	Agency/Contract (People NOT on Payroll)
Director		
Other Admin Personnel		
Direct Nursing Service		
Nursing Supervisor		
PT Service		
PT Supervisor		
OT Service		
OT Supervisor		
ST Service		
ST Supervisor		
Medical Social Services		
Med Soc Serv Supervisor		
Home Health Aide		
Home Health Aide Supervisor		

B. Statistical Data

	Medicare		**Other**		**TOTAL**	
Category	Visits	Patients	Visits	Patients	Visits	Patients
Skilled Nursing Care						
Physical Therapy						
Occupational Therapy						
Speech Therapy						
Medical Social Services						
Home Health Aide						
All Other Services						
TOTAL VISITS						
Home Health Aide Hours						
Unduplicated Census Count						

Certified Public Accountant

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7. Please provide a schedule of all asset (defined as any single item with a purchase price of $5,000 or more and a useful life of two years or longer) purchases and dispositions. Please format your work paper as follows:

   Asset Description **Purchase/Disposal Date** **Cost/Price**

8. Please provide a floor plan of your office(s) complete with square footage for the following areas:
   a. Plant Operations/Maintenance
   b. Administration
   c. Nursing
   d. PT
   e. OT
   f. ST
   g. Medical Social Services
   h. Home Health Aides
   i. Supplies
   j. Drugs
   k. DME
9. If you provided flu vaccines please call us for further instructions
10. If you have a home office please call us for further instructions

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