MY ACCOUNTING CENTER, INC.
(CPA FIRM)

Home Health Agency 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: ____

Email Address: ____

Name of Intermediary: ____

Medicare Provider Number: ____

Date Certified for Medicare: ____

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

Current Cost Report Year Depreciation: $____

Current Cost Report Malpractice premiums: $______________________________________

Total Cost of Medical Supplies for both Medicare / non-Medicare: $_____________________

460 South Central Avenue • Glendale, CA 91204
Phone: (818) 500-0714 • Fax: (866) 817-8910
lusine@myaccountingcenter.com
www.myaccountingcenter.com

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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. Square footage of office and copy of floor plan*

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

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

7. Any Intermediary Correspondences received

8. Departmental Payroll Breakdown (if the Trial Balance (TB) does not break down payroll by disciplines)

9. Breakdown of Contract Labor Account (if not done on the TB)

If your prior year cost report was prepared by My Accounting Center Inc, we have your information on file. Please indicate if there has been any square footage changes.

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Please review your Trial Balance for any of the accounts listed below. If any exist, please explain their nature on the line provided:

Other/Misc Revenues Account Amount: _____________
Description: ____

Other/Misc Expenses Account Amount: _____________
Description: ____

Promotional Advertising Account Amount: _____________
Description: ____

Travel Account Amount: _____________
Description: (who was reimbursed and how) ____________________________________

Meals and/or Entertainment Account Amount: _____________
Description: ____

Any other account that might require an explanation:

Account Name: _______________________ Account Amount: _____________
Description: ____

Account Name:________________________ Account Amount: _____________
Description: ____

Account Name: ________________________ Account Amount: _____________
Description: ____

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