Information Request
Skilled Nursing Facility Medicare Cost Report

Facility Name: ____________________
Street Address: ____________________
City, State, Zip ____________________
County: ____________________
Medicare Provider#: ____________________
Cost Reporting Period: ____________________
Medicare Certification Date: ____________________

NURSING HOME BEDS

	Mcare Certified	Non Certified	Effective Date
1) Beds			
Beginning of Year			
Change			
End of Year			

2) Patient Days	SNF Certified	SNF Non Certified
Medicare		-
Medicaid		-
Other		
Subtotal	-	-
Less holding and leave days if included above		
Medicaid	-	-
Other		
Total	-	-

3) Admissions	Mcare Certified	Non Certified
Medicare		
Medicaid		
Other		
Total	-	-

4) Discharges	Mcare Certified	Non Certified
Medicare		
Medicaid	-	
Other		
Total	-	-

5) Average # of FTE's	Mcare Certified	Non Certified
Total		

6) Private Room Rates	Mcare Certified	Non Certified
Private Room		
Semi - Private Room		

7) Detail of Square Feet (format enclosed). Please inform us of any changes in square feet and the effective dates for each. If no changes from last year, simply indicate that.

8) Labor hours by department (format enclosed).

9) Part A Bad Debt Log (format enclosed).

10) If your facility has an Assisted Living Facility:

ALF Days		
ALF Admissions		
ALF Discharges		
ALF FTEs		

11) Direct Care Expense (format enclosed).

Once complete, please email this form to dwalterscpa@gmail.com or fax it to 727-279-2851.

Feel free to call Doug at 941-756-0700 with any questions. Thank you.