

PROGRESSIVE PROVIDER SERVICES OF COLORADO LLC
245 S. Benton St., Suite 300 – Lakewood, CO 80226
(303) 233-5143 (303) 233-5147 FAX

SKILLED NURSING FACILITY
MEDICARE COST REPORT PREPARATION CHECKLIST

FACILITY NAME: _____

COUNTY: _____

FACILITY ADDRESS: _____

PERSON COMPILING THIS FORM: _____

POSITION TITLE: _____

TELEPHONE NO.: _____

EMAIL ADRESS: _____

MEDICARE PROVIDER NO.: _____

DATE CERTIFIED: _____

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.

*******If you send any patient-specific information, please send in Excel format with password protection, and we will send you a Business Associate HIPAA Agreement to sign.**

SUMMARY CHECKLIST OF REQUIRED COST REPORT PREPARATION ITEMS

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 1. FINANCIAL STATEMENTS: Have you attached a copy of your year-end financial statements? (Excel format preferable) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. WORKING TRIAL BALANCE: Have you attached a copy of your year-end working trial balance? (Excel format preferable) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DEPRECIATION SCHEDULE: Have you attached a copy of your updated depreciation schedule? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. CENSUS: Have you included your detailed census information? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. SQUARE FOOTAGE: : Have you included your square footage detail? (You only need to show changes since last year's cost report.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. MEDICARE BAD DEBT and INTERIM PAYMENTS FOR BAD DEBT
Have you included a schedule of all your Medicare bad debts? <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you included all interim payments received from MCR for Bad Debt? <input type="checkbox"/> | | <input type="checkbox"/> |
| (See above regarding patient-specific information) | | |
| 7. INTERMEDIARY CORRESPONDENCE: Have you included copies of your intermediary correspondence, including payments for estimated bad debt? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. PS&R REPORT: Have you included a copy of your latest PS&R Report from your intermediary? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. LAST YEAR'S MEDICARE COST REPORT: Have you included a copy of last year's Medicare cost report? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. ADMISSIONS AND DISCHARGES: Have you included a summary of your admission and discharge information? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. WAGE INDEX: Have you included detailed wage related hours and contract labor hours? The wage related hours detail should include the trial balance account number or the department name, and the related hours worked. The contract labor detail should only include direct patient care personnel (e.g. nurse pool & contract therapies) . | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. MALPRACTICE: Are you legally required to carry malpractice? YES / NO (Please circle)
Is it claims-made or occurrence ? (Please circle)
What is the cost of the malpractice insurance (if not a separate GL account)? _____ | | |
| 13. REVIEW: Were financials audited, reviewed, or compiled by an outside independent accountant? (Please circle if applicable) | | |

14. **ACCOUNT ANALYSIS:** Please provide a detailed explanation of the nature of the following revenue or expense account items:

OTHER/MISC REVENUES: Account Amount _____

Description: _____

OTHER/MISC. EXPENSES: Account Amount _____

Description: _____

PROMOTIONAL ADVERTISING: Account Amount _____

Description: _____

****Please note per cost report instructions, expenses must be shown on an accrual basis****