This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S, PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only

[ ] Electronically filed cost report
[ ] Manually submitted cost report
[ ] If this is an amended report enter the number of times the provider resubmitted this cost report

Date: Time:

Contractor use only	[ ] Cost Report Status	If 3 or 4:	Date Received: _____
	(1) As Submitted (3) Settled	[ ] Desk Reviewed	Contractor No._____
	(2) Amended (4) Reopened	[ ] Audited	[ ] First Report Processed by Contractor
		If 4, number of times reopened [ ]	[ ] Last Report to be Processed by Contractor

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN T REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____{Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL						1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL						200

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET S-2 Part I

Hospital and Hospital Health Care Complex Address:

1	Street:	P.O. Box:	1
2	City: State:	Zip Code: County:	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital									3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF									7
8	Swing Beds-NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC									15
16	Hospital-Based Health Clinic-FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From:_____ To: _____	20
		1 2	
21	Type of Control (see instructions)		21

Inpatient PPS Information

22	Does your facility qualify and is currently receiving disproportionate share hospital payment in accordance with 42 CFR §412.106, or low income payment in accordance with 42 CFR §412.624 (e)(2)? Enter in column 1, "Y" for yes and "N" for no. Is this facility subject to 42 CFR §412.06 (c)(2) (Pickle amendment hospital?) Enter in column 2 Y"Y for yes or "N" for no.		22
23	Which method is used to determine Medicaid days on Worksheet S-3, Part I column 7? Enter in column 1, 1 if it is based on date of admission, 2 if it is based on census days, or 3 if it is based on date of discharge. Enter in column 2 "Y" for yes or "N" for no.		23

		In-State Medicaid paid days 1	In-State Medicaid eligible days 2	Out-of State Medicaid paid days 3	Out-of State Medicaid eligible days 4	Medicaid HMO days 5	Other Medicaid days 6	
24	If line 22 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2 out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.							24
25	If line 22 is "yes", and this provider is an IRF then, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of state Medicaid eligible days in col. 4 Medicaid HMO days in col. 5 and other Medicaid days in col. 6.							25

26	For standard Geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter (1) for urban and (2) for rural.		26
27	For standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban and (2) for rural.		27

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET S-2 Part I (CONT.)

	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the C/R period.		
35	Enter beginning and ending dates of SCH status on line 36. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		35
36	Enter the applicable SCH dates: Beginning:_____ Ending: _____		36
	If you are a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in this C/R period.		
37	Enter beginning and ending dates of MDH status on line 38. Subscript line 38 for number of periods in excess of one and enter subsequent dates.		37
38	MDH period Beginning:_____ Ending: _____		38

	Prospective Payment System (PPS)-Capital	V 1	XVIII 2	XIX 3	
45	Does your facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions)				45
46	If you are eligible for the special exceptions payment pursuant to 42 CFR §412.348(g)? If yes, Worksheet L, Part III and L-1, Parts I-III				46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes and "N" for no in column 1. Are you electing full federal payment? Enter "Y" for yes and "N" for no in col. 2				47

	Teaching Hospitals	V 1	XVIII 2	XIX 3	
55	Is this a teaching hospital? Enter "Y" for yes or "N" for no.				55
56	Is this teaching program approved in accordance with CMS Pub. 15-1, chapter 4?				5
57	If line 56 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? If yes, complete Worksheet E-4 . If no, complete Worksheet D, Part III & IV D-2, Parts II if applicable.				57
58	As a teaching hospital, did you elect cost reimbursement for physicians' services as defined in CMS Pub. 15-I, section 2148? If yes, complete Worksheet D-4.				58
59	Are you claiming costs on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.				59
60	Has your facility direct GME FTE cap (column 1) or IME FTE cap (column 2) been reduced under 42 CFR §413.79(c)(3) or42 CFR §412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable columns (see instructions)				60
61	Has your facility received additional direct GME FTE resident cap slots or IME FTE residents cap slots under 42 CFR §413.79(c)(4)or 42 CFR §412.105(f)(1)(iv)(C)? Enter "Y" for yes and "N" for no in the applicable columns (see instructions)				61
62	Are you claiming nursing and allied health costs? (see instructions)				62

	Inpatient Psychiatric Facility PPS				
70	Are you an Inpatient Psychiatric Facility (IPF), or are you an IPF Subprovider? Enter in column 1 "Y" for yes and "N" for no.				70
71	If line 70 column 1 is Y, does the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter in column 1 "Y" for yes or "N" for no. Is this facility training residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter in column 2 "Y" for yes and "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth year enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)				71

	Inpatient Rehabilitation Facility PPS				
75	Are you an Inpatient Rehabilitation Facility (IRF), or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no.				75
76	If line 70 column 1 is Y, does the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in a new teaching programs in accordance with 42 CFR § 412.424 (d)(1)(iii)(2)? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the teaching program in existence, enter 5. (see instructions)				76

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.: _____		PERIOD: FROM_____ TO_____	WORKSHEET S-2 Part I (CONT.)	

Long Term Care Hospital PPS						
80	Are you a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.					80
TEFRA Providers						
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes, and "N" for no.					85
86	Have you established a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes, and "N" for no.					86
			V	XIX		
Title V *or* XIX Inpatient Services			1	2		
90	Do you have title V and XIX inpatient hospital services?					90
91	Is this hospital reimbursed for title V and XIX through the cost report either in full or in part?					91
92	Does the title V and XIX program reduce capital following the Medicare methodology?					92
93	Do you operate an ICF\MR facility for purposes of title V and XIX?					94
94	Does Title XIX reduces Capital Cost? Enter "Y" for yes or "N" for no.					94
95	If line 95 is "Y", by what percentage?					95
96	Does Title XIX reduces Operating Cost? Enter "Y" for yes or "N" for no.					96
97	If line 97 is "Y", by what percentage?					97
Rural Providers						
105	Does this hospital qualify as a Critical Access Hospital (CAH)?					105
106	If this facility qualifies as an CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes and "N" for no. If yes, the GME elimination would not be on Worksheet B, Part I, column 26 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see inst.)					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c).					108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes, or "N" for no for the type of therapy as follow: physical therapy in column 1, occupational therapy in column 2, speech therapy in column 3 and respiratory therapy in column 4.					109
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.					115
116	Are you classified as a referral center?					116
117	Are you legally-required to carry malpractice insurance?					117
118	Is the malpractice a claims-made or occurrence policy? If the policy is claims made enter 1. If the policy is occurrence, enter 2.					118
119	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.					119
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in PPACA §3121?Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with ≤100 beds which qualifies for the Outpatient Hold Harmless provision in PPACA §3221?. Enter in column 2 "Y" for yes or "N" for no.					120
Transplant Center Information						
125	Does this facility operate a transplant center? If yes, enter certification date(s) (mm/dd/yyyy) below.					125
126	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date if applicable in column 2.					129
130	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination if applicable in column 2.					131
132	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date if applicable in column 2.					132
133	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date if applicable in column 2.					134

All Providers

140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? If yes, and there are home office cost, enter in column 2 the home office chain number. (See instructions.) If this is facility is part of a chain organization enter the name and address of the home office on lines 111-113.			140
141	Name: Contractor's Name: _____	Contractor's Number: _____		141
142	Street:	P. O. Box		142
143	City:	State:	Zip Code:	143
144	Are provider based physicians' costs included in Worksheet A?			144
145	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?			145
146	Have you changed your cost allocation methodology from the previously filed cost report? See CMS Pub. 15-2, section 4020. If yes, enter the approval date (mm/dd/yyyy) in column 2.			146
147	Was there a change in the statistical basis?			147
148	Was there a change in the order of allocation?			148
149	Was the change to the simplified cost finding method?			149

If this facility contains a provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for exemption. Enter "N" if not exempt in the applicable columns below. (See 42 CFR §413.13.)

		Part A	Part B	
		1	2	
155	Hospital			155
156	Subprovider - IPF			156
157	Subprovider - IRF			157
158	Subprovider - Other			158
159	SNF			159
160	HHA			160
161	CMHC			161

Multicampus

165	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSA? Enter "Y" for yes and "N" for no.						165
	If line 165 is yes, enter the name in col. 0, county in column 1, state in column 2, zip in column 3, CBSA in column 4, FTE/Campus in col. 5.	County	State	Zip Code	CBSA	FTE/Campus	
		1	2	3	4	5	
166	Name:						166

Health Information Technology incentive in the American Recovery and Reinvestment Act (HIT)

167	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.		167
168	If this provider is a CAH, line 105 is "Y" and is a meaningful user, line 167 is "Y" enter the reasonable cost incurred for the HIT assets (see instructions)		168

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	PROVIDER NO.:	PERIOD: FROM TO	WORKSHEET S-2 Part II

General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No
For all the dates responses the format will be (mm/dd/yyyy)

Completed by All Hospitals, Provider Organization and Operation

		1 Y/N	2 Date		
1	Has the Provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)				1

		1 Y/N	2 Date	3 V/I	
2	Has the provider terminated participation in the Medicare Program? If column 1 is yes enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

Financial Data and Reports

		1 Y/N	2 Type	3 Date	
4	Were the financial statements prepared by a Certified Public Accountant? If column 1 is "Y" enter "A" for Audited, "C" for Compiled, or "R" for Reviewed in column 2. Submit complete copy or enter date available in column 3. (see instructions)If column 1 is "N" see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.				5

Approved Educational Activities		1 Y/N	2 Legal Oper.	
6	Were costs claimed for Nursing School? If column 1 is "Y", enter "Y" or "N" in column 2 to indicate whether the provider is the legal operator of the program			6
7	Were costs claimed for Allied Health Programs? If "Y" see instructions.			7
8	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Programs? If "Y", see instructions.			8
9	Are Intern-Resident costs claimed on the current cost report? If "Y" see instructions.			9
10	Has an Intern-Resident program been initiated or renewed in the current cost reporting period? If "Y" see instructions.			10

Bad Debts

		1 Y/N	
11	Is the provider seeking reimbursement for bad debts? If "Y", see instructions.		11
12	If line 11 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		12
13	If line 11 is "Y", are patient deductibles and/or co-payments waived? If "Y", see instructions.		13

Bed Complement

14	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		14

PS&R Data		1 Y/N Part A	2 Date Part A	3 Y/N Part B	4 Date Part B	
15	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4 .(see Instructions.)					15
16	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date in cols. 2 and 4. (see Instructions)					16
17	If line 15 or 16 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					17
18	If line 15 or 16 is "Y", then were adjustments made to PS&R data for corrections of other PS&R information? If "Y", see Instructions.					18
19	If line 15 or 16 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: _____					19
20	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					20

HOSPITAL AND HOSPITAL HEALTH CARE	PROVIDER NO.:	PERIOD:	WORKSHEET S-2

REIMBURSEMENT QUESTIONNAIRE		FROM TO	Part II

General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No
For all the dates responses the format will be (mm/dd/yyyy)

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY

Capital Related Cost

21	Have assets been relifed for Medicare purposes? If "Y" see instructions		21
22	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If "Y", see instructions.		22
23	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If "Y", see instructions		23
24	Have there been new capitalized leases entered into during the cost reporting period? If "Y" see instructions.		24
25	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If "Y", see instructions.		25
26	Has the provider's capitalization policy changed during the cost reporting period? If "Y", submit copy.		26

Interest Expense

27	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If "Y", see instructions.		27
28	Does the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If "Y" see instructions		28
29	Has existing debt been replaced prior to its scheduled maturity with new debt? If "Y" see instructions.		29
30	Has debt been recalled before scheduled maturity without issuance of new debt? If "Y" see instructions.		30

Purchased Services

31	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If "Y" see instructions.		31
32	If line **31** is "Y", were the requirements of Sec. 2135.2 applied pertaining to competitive bidding?. If "N" see instructions.		32
33	Are GME costs directly assigned to cost centers other than I/R Services in an Approved Teaching Program on Worksheet A? If "Y", see instructions.		33

Provider-Based Physicians

34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.		34
35	If line 34 is "Y", are there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If "Y" (see instructions)		35

Home Office Costs		1 Y/N	2 Date	
36	Are Home Office Cost claimed on the cost report?			36
37	If line 36 is "Y", has a home office cost statement been prepared by the home office? If "Y" see instructions.			37
38	If line 36 "Y", is the fiscal year end of the home office different from that of the provider? If column 1 is "Y", enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is "Y", does the provider render services to other chain components? If "Y" see instructions.			39
40	If line 36 is "Y", does the provider render services to the home office? If "Y" see instructions.			40

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
STATISTICAL DATA

PROVIDER NO.: _____

PERIOD
FROM _____
TO _____

WORKSHEET S-3,
PART I

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips				Full Time Equivalents			Discharges			
						Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)															
2	HMO															
3	HMO IPF															
4	HMO IRF															
5	Hospital Adults & Peds. Swing Bed SNF															
6	Hospital Adults & Peds.Swing Bed NF															
7	Total Adults and Peds. (exclude observation beds) (see instructions)															
8	Intensive Care Unit															
9	Coronary Care Unit															
10	Burn Intensive Care Unit															
11	Surgical Intensive Care Unit															
12	Other Special Care															
13	Nursery															
14	Total (see instructions)															
15	CAH visits															
16	Subprovider - IPF															
17	Subprovider - IRF															
18	Subprovider - Other															
19	Skilled Nursing Facility															
20	Nursing Facility															
21	Other Long Term Care															
22	Home Health Agency															
23	ASC (Distinct Part)															
24	Hospice (Distinct Part)															
25	CMHC															
26	RHC/FQHC (specify)															
27	Total (sum of lines 14-26)															
28	Observation Bed Days															
29	Ambulance Trips															
30	Employee discount days (see instruction)															
31	Employee discount days -IRF															
32	Labor & delivery days (see instructions)															
33	LTCH non-covered days															

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HOSPITAL WAGE INDEX INFORMATION	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-3, PART II

PART II - WAGE DATA

		Worksheet A Line Number	Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)							1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A							4
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)							7
8	Home office personnel							8
9	SNF							9
10	Excluded area salaries (see instructions)							10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Management and administrative services							12
13	Contract labor: physician-Part A							13
14	Home office salaries & wage-related costs							14
15	Home office: physician Part A							15
16	Teaching physician salaries (see instructions)							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core) Wkst S-3, Part IV line 24							17
18	Wage-related costs (other)Wkst S-3, Part IV line 25							18
19	Excluded areas							19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A							22
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25

DRAFT FORM CMS-2552-10 4090 (Cont.)

HOSPITAL WAGE INDEX INFORMATION PROVIDER NO.: PERIOD: WORKSHEET S-3,

PART II - WAGE DATA

		Worksheet A Line Number	Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1	2	3	4	5	6	
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits							26
27	Administrative & General							27
28	Administrative & General under contract (see inst.)							28
29	Maintenance & Repairs							29
30	Operation of Plant							30
31	Laundry & Linen Service							31
32	Housekeeping							32
33	Housekeeping under contract (see instructions)							33
34	Dietary							34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration							38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library							41
42	Social Service							42
43	Other General Service							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	Net salaries (see instructions)							1
2	Excluded area salaries (see instructions)							2
3	Subtotal salaries (line 1 minus line 2)							3
4	Subtotal other wages & related costs (see inst.)							4
5	Subtotal wage-related costs (see inst.)							5
6	Total (sum of lines 3 thru 5)							6
7	Total overhead cost (see instructions							7

HOSPITAL WAGE RELATED COSTS	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-3, PART IV

PART IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401K/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accidental Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 -23)		24

Part B Other than Core Related Cost

25	Other Wage Related Costs (specify)_____		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-3, PART V

PART V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	Contract Labor	Benefit Cost	
	0	1	2	3	4	
1	Total facility's contract labor and benefit cost					1
2	Hospital					2
3	Subprovider- IPF					3
4	Subprovider- IRF					4
5	Subprovider- (Other)					5
6	Swing Beds-SNF					6
7	Swing Beds-NF					7
8	Hospital-Based SNF					8
9	Hospital-Based NF					9
10	Hospital-Based OLTC					10
11	Hospital-Based HHA					11
12	Separately Certified ASC					12
13	Hospital-Based Hospice					13
14	Hospital-Based Health Clinic RHC					14
15	Hospital-Based Health Clinic FQHC					15
16	Hospital-Based-CMHC					16
17	Renal Dialysis					17

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER NO.: _____ HHA NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA County: _____

	DESCRIPTION	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	
1	Home Health Aide Hours						1
2	Unduplicated Census Count (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

	Enter the number of hours in your normal work week _____	Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Directors and Assistant Director(s)				4
5	Other Administrative Personnel				5
6	Direct Nursing Service				6
7	Nursing Supervisor				7
8	Physical Therapy Service				8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service				10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide				16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

	HOME HEALTH AGENCY CBSA CODES		
		1	
19	How many CBSAs in column 1 did you provide services to during this cost reporting period.		19
20	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		20

PPS ACTIVITY DATA

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (cols. 1-4)	
		1	2	3	4	5	
21	Skilled Nursing Visits						21
22	Skilled Nursing Visit Charges						22
23	Physical Therapy Visits						23
24	Physical Therapy Visit Charges						24
25	Occupational Therapy Visits						25
26	Occupational Therapy Visit Charges						26
27	Speech Pathology Visits						27
28	Speech Pathology Visit Charges						28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits						31
32	Home Health Aide Visit Charges						32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)						33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)						35
36	Total Number of Episodes (standard/non outlier)						36
37	Total Number of Outlier Episodes						37
38	Total Non-Routine Medical Supply Charges						38

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.		13
14	Epoetin amount from Worksheet A for Home Dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.		17
18	ARANESP amount from Worksheet A for Home Dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (enter "X" if method(s) is applicable)

21	MCP_____	INITIAL METHOD_____	21

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET S-6

COMMUNITY MENTAL HEALTH & OTHER OUTPATIENT REHABILITATION PROVIDER- NUMBER OF EMPLOYEES (FULL TIME EQUIVALEN

Check Applicable Box	[ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT

Enter the number of hours in your normal workweek _____

		Staff	Contract	Total (col. 1 + col. 2)
		1	2	3
1	Administrator and Assistant Administrator(s)			
2	Director(s) and Assistant Director(s)			
3	Other Administrative Personnel			
4	Direct Nursing Service			
5	Nursing Supervisor			
6	Physical Therapy Service			
7	Physical Therapy Supervisor			
8	Occupational Therapy Service			
9	Occupational Therapy Supervisor			
10	Speech Pathology Service			
11	Speech Pathology Supervisor			
12	Medical Social Service			
13	Medical Social Service Supervisor			
14	Respiratory Therapy Service			
15	Respiratory Therapy Supervisor			
16	Psychiatric/Psychological Service			
17	Psychiatric/Psychological Service Supervisor			
18	Other (specify)			

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-7

1	If this facility contains a hospital-based SNF, are all patients are under managed care or there was no Medicare utilization enter "Y" and do not complete the rest of this worksheet.				1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2

	GROUP	SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUC				3
4	RUB				4
5	RUA				5
6	RUX				6
7	RUL				7
8	RVC				8
9	RVB				9
10	RVA				10
11	RVX				11
12	RVL				12
13	RHC				13
14	RHB				14
15	RHA				15
16	RHX				16
17	RHL				17
18	RMC				18
19	RMB				19
20	RMA				20
21	RMX				21
22	RML				22
23	RLB				23
24	RLA				24
25	RLX				25
26	SE3				26
27	SE2				27
28	SE1				28
29	SSC				29
30	SSB				30
31	SSA				31
32	CC2				32
33	CC1				33
34	CB2				34
35	CB1				35
36	CA2				36
37	CA1				37
38	IB2				38
39	IB1				39
40	IA2				40
41	IA1				41
42	BB2				42
43	BB1				43
44	BA2				44
45	BA1				45
46	PE2				46
47	PE1				47
48	PD2				48

STATISTICAL DATA _____ FROM _____ TO _____

	GROUP	SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
49	PD1				49
50	PC2				50
51	PC1				51
52	PB2				52
53	PB1				53
54	PA2				54
55	PA1				55
56	Default rate				56
57	TOTAL				57

SNF SERVICES

58	Enter in column 1 the SNF CBSA code or 5 character code if Rural based facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1, of the cost reporting period (if applicable).				58

A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (See instructions)

		Expenses	Percentage	Y/N	
59	Staffing				59
60	Recruitment				60
61	Retention of employees				61
62	Training				62
63	Other (Specify)				63
64	Total SNF revenue (Worksheet G-2, Part I, line 6, column 3)				64

PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET S-8

Check Applicable Box:	[ ] RHC [ ] FQHC

Clinic Address and Identification:

1	Street:	1
2	City: State: Zip Code: County:	2
3	Designation (for FQHCs only) - Enter "R" for rural or "U" for urban	3

Source of Federal Funds:		Grant Award 1	Date 2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look-Alikes			8
9	Other (specify)			9

10	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 12 the type of other operation(s) and the operating hours.)			10

Facility hours of operations (1)

	Type Operation	Sunday from	Sunday to	Monday from	Monday to	Tuesday from	Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday to	Friday from	Friday to	Saturday from	Saturday to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic															11

(1) Enter clinic hours of operation on line 13 and other type operations on subscripts of line 13 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

12	Have you received an approval for an exception to the productivity standard?			12
13	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			13
14	Provider name: _____ CCN number: _____			14

		1 Y/N	2 V	3 XVIII	4 XIX	
15	Have you provided all or substantially all GME costs. Enter in column 1 ,"Y" for yes and "N" for no col. 1. If yes, enter in col. 2, 3 and 4 the number of program visits performed by Intern & Residents. (See instructions)					15

HOSPICE IDENTIFICATION DATA	PROVIDER NO.:_____ HOSPICE NO.:_____	PERIOD: FROM _____ TO _____	WORKSHEET S-9, PARTS I & II

PART I - ENROLLMENT DAYS

	Enrollment Days	Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II - CENSUS DATA

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

NOTE: Parts I & II, columns 1 and 2 also include the days reported in columns 3 and 4 .

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	PROVIDER NO. _____	PERIOD: FROM_____ TO_____	WORKSHEET S-10

	Uncompensated and indigent care cost computation	1	
1	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		1
	Medicaid (see instructions for each line)		
2	Net revenue from Medicaid		2
3	Did you receive DSH or supplemental payments from Medicaid?		3
4	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4
5	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges		6
7	Medicaid cost (line 1 times line 6)		7
8	Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)		8
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)		12
	Other state or local government indigent care program (see instructions for each line)		
13	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13
14	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 13 minus line 15)		16
	Uncompensated care (see instructions for each line)		
17	Private grants, donations, or endowment income restricted to funding charity care		17
18	Government grants, appropriations or transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility				20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)				21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)				23

		1	
24	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24
25	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		25
26	Total bad debt expense for the entire facility (see instructions)		26
27	Medicare bad debts for §1886(d) hospitals fromWorksheets E, Part A and E, Part B, or CAHs from Worksheet E-3, Part V.		27
28	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		28
29	Cost of non-Medicare bad debt expense (line 1 times line 28)		29
30	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31