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
Intermediary use only	[ ] Audited [ ] Desk Reviewed	Date Received: _____ Intermediary No._____	[ ] Initial [ ] Reopening [ ] Final [ ] MCR Code	

PART I - CERTIFICATION

Check applicable box	[ ] Electronically filed cost report [ ] Manually submitted cost report	Date:_____	Time:_____

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 THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE 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 Names(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that 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 and that the 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 II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL					1
2	SUBPROVIDER					2
3	SWING BED - SNF					3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER (specify)					8
9	HEALTH CLINIC (specify)					9
100	TOTAL					100

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB c number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instru search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or su for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-2552-96 (4/2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 3603-3603.2)

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

Hospital and Hospital Health Care Complex Address:

1	Street:	P.O. Box:			1
1.01	City:	State:	Zip Code:	County:	1.01

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	NPI Number	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	2.01	3	4	5	6	
2	Hospital								2
3	Subprovider								3
4	Swing Beds-SNF								4
5	Swing Beds-NF								5
6	Hospital-Based SNF								6
7	Hospital-Based NF								7
8	Hospital-Based OLTC								8
9	Hospital-Based HHA								9
11	Separately Certified ASC								11
12	Hospital-Based Hospice								12
14	Hospital-Based Health Clinic (specify)								14
15	Outpatient Rehab. Clinic (specify)								15
16	Renal Dialysis								16

17	Cost Reporting Period (mm/dd/yyyy)	From: _____ To: _____		17
		1	2	
18	Type of Control (see instructions)			18
Type of hospital/subprovider (see instructions)				
19	Hospital			19
20	Subprovider			20
Other Information				
21	Indicate if your hospital is either (1) urban or (2) rural at the end of the cost reporting period in column 1. If your hospital is geographically classified or located in a rural area, is your bed size in accordance with CFR 42 412.105 less than or equal to 100 beds, enter in column 2 "Y" for yes or "N" for no.			21
21.01	Does your facility qualify and is currently receiving payment for disproportionate share hospital adjustment in accordance with 42 CFR 412.106 *Enter in column 1 "Y" for yes or "N" for no.* *Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle amendment hospitals)? Enter in column 2 "Y" for yes or "N" for no.*			21.01
21.02	Has your facility received a new geographic reclassification status change after the first day of the cost reporting period from rural to urban and vice versa? Enter "Y" for yes and "N" for no. If yes, enter in column 2 the effective date (mm/dd/yyyy) (See instructions)			21.02
21.03	Enter in column 1 your geographic location either (1) urban (2) rural If you answered urban in column 1 indicate if you received either a wage or standard geographic reclassification to a rural location, enter in column 2 "Y" for yes and "N" for no. If column 2 is yes enter in column 3 the effective date (mm/dd/yyyy) (see instruction). Does your facility contain 100 or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 "Y" for yes and "N" for no. Enter in column 5 the providers actual MSA or CBSA			21.03
21.04	For standard Geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter (1) urban and (2) rural.			21.04
21.05	For standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) urban and (2) rural.			21.05
21.06	Does this hospital qualifies for the three -year transition of hold harmless payments for small rural hospital under the prospective payment system for hospital outpatient services under DRA §5105 or MIPPA §147? (See instructions). Enter "Y" for yes, and "N" for no.			21.06
21.07	Does this hospital qualify as a SCH with 100 or fewer beds under MIPPA§147? Enter "Y" for yes and "N" for no.(See instructions)			21.07
21.08	*Which method is used to determine Medicaid days on S-3, Part I, col. 5 Enter in column 1, "1" if it is based on date of admission, "2" if it based on census days, or "3" if it is based on date of discharge. Is this method different than the method used in the preceeding cost reporting period? Enter in column 2,"Y" for yes or "N" for no.*			21.08
22	Are you classified as a referral center?			22

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		PROVIDER NO _____	PERIOD: FROM_____ TO_____		WORKSHEET S-2 (CONT.)		
23	Does this facility operate a transplant center? If yes, enter certification date(s) in column 2 and termination date(s) in column 3 (mm/dd/yyyy) below:						23
23.01	If this is a Medicare certified kidney transplant center, enter the certification date in col. 2 and termination in col. 3						23.01
23.02	If this is a Medicare certified heart transplant center, enter the certification date in col. 2 and termination in col. 3						23.02
23.03	If this is a Medicare certified liver transplant center, enter the certification date in col. 2 and termination in col. 3						23.03
23.04	If this is a Medicare certified lung transplant center, enter the certification date in col. 2 and termination in col. 3						23.04
23.05	If Medicare pancreas transplant are performed see instructions for entering certification and termination date.						23.05
23.06	If this is a Medicare certified intestinal transplant center, enter the certification date in col. 2 and term. in col. 3						23.06
23.07	If this is a Medicare certified islet transplant center, enter the certification date in col. 2 and termination in col. 3.						23.07
24	If this is an organ procurement organization (OPO), enter the OPO number in col.2 and termination date in col 3.						24
24.01	If this is a Medicare Transplant Center, enter CCN in col. 2, the certification or recertification date after (12/26/2007) in column 3 (mm/dd/yyyy).						24.01
25	Is this a teaching hospital or affiliated with a teaching hospital and you are receiving payments for I & R?						25
25.01	Is this teaching program approved in accordance with CMS Pub. 15-I, chapter 4?						25.01
25.02	If line 25.01 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-3, Part IV. If no, complete Worksheet D, Parts III and IV and D-2, Part II if applicable.						25.02
25.03	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-9.						25.03
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Worksheet D-2, Part I.						25.04
25.05	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)						25.05
25.06	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).						25.06
26	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the C/R period. Enter beginning and ending dates of SCH status on line 26.01. Subscript line 26.01 for number of periods in excess of one and enter subsequent dates.						26
26.01	Enter the applicable SCH dates: (see instructions) Beginning:_____ Ending:						26.01
26.02	Enter the applicable SCH dates: (see instructions) Beginning:_____ Ending:						26.02
27	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.						27
28	If this facility contains a hospital-based SNF, are all patients under managed care or there were no Medicare utilization enter "Y" , if "N" complete lines 28.01 and 28.02.						28
28.01	If hospital based SNF, enter appropriate transition period 1, 2, 3, or 100 in column 1. Enter in columns 2 and 3 the wage index adjustment factor before and on or after the October 1st (see instructions)						28.01
28.02	Enter in column 1 the hospital based SNF facility specific rate (from your fiscal intermediary) if you have not transitioned to 100% SNP PPS payment. In column 2 enter the facility classification Urban(1) or Rural(2). In column 3, enter the SNF MSA code or two character state code if a Rural based facility. In column 4, enter the SNF CBSA code or two character state code if a Rural based facility						28.02
	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 percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. Indicate in column 2 "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)						
28.03	Staffing						28.03
28.04	Recruitment						28.04
28.05	Retention of employees						28.05
28.06	Training						28.06
28.07	Other (Specify)						28.07
29	Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional method of reimbursement?						29

COMPLEX IDENTIFICATION DATA			FROM_____ TO_____		(CONT.)	
30	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access Hospital (CAH)? (see 42 CFR 485.606ff)					30
30.01	If so, is this the initial 12 month period for the facility operated as an RPCH/CAH? See 42 CFR 413.70.					30.01
30.02	If this facility qualifies as an RPCH/CAH, has it elected the all-inclusive method of payment for outpatient services?(See instructions)					30.02
30.03	If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulance services? If yes, enter in column 2 the date of eligibility determination (date must be on or after 12/21/2000).					30.03
30.04	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, also complete Worksheet D-2, Part II, if applicable.					30.04
31	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c).					31

Miscellaneous Cost Reporting information						
32	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.					32
33	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes and "N" for no in column 1. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100% Federal capital payment? Enter "Y for yes and "N" for no in column 2.					33
34	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA?					34
35	Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)?					35
		V	XVIII	XIX		
Prospective Payment System (PPS)-Capital		1	2	3		
36	Do you elect fully prospective payment methodology for capital costs? (See instructions)					36
36.01	Does your facility qualify and receive payment for disproportionate share in accordance with 42 CFR 412.320 ? (see instructions)					36.01
37	Do you elect hold harmless payment methodology for capital costs? (See instructions)					37
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal rate?					37.01

Title XIX inpatient services						
38	Do you have title XIX inpatient hospital services?					38
38.01	Is this hospital reimbursed for title XIX through the cost report either in full or in part?					38.01
38.02	Does the title XIX program reduce capital following the Medicare methodology?					38.02
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions)					38.03
38.04	Do you operate an ICF/MR facility for purposes of title XIX?					38.04
40	Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? If yes, *and this facility is part of a chain organization, enter in col. 2 the chain home office chain number. (See inst.)* If this facility is part of a chain organization enter the name and address of the home office on lines 40.01-40.03.					40
40.01	Name: FI/Contractor's Name: _____		FI/Contractor's Number:			40.01
40.02	Street:		P. O. Box			40.02
40.03	City:		State:	Zip Code:		40.03
41	Are provider based physicians' costs included in Worksheet A?					41
42	Are physical therapy services provided by outside suppliers?					42
42.01	Are occupational therapy services provided by outside suppliers?					42.01
42.02	Are speech pathology services provided by outside suppliers?					42.02
43	Are respiratory therapy services provided by outside suppliers?					43
44	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?					44
45	Have you changed your cost allocation methodology from the previously filed cost report? See CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in column 2.					45
45.01	Was there a change in the statistical basis?					45.01
45.02	Was there a change in the order of allocation?					45.02
45.03	Was the change to the simplified cost finding method?					45.03
46	If you are participating in the NHCMQ demonstration project (must have a hospital-based SNF) during this cost reporting period, enter the phase (see instructions).					46

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 the exemption. Enter "N" if not exempt. (See 42 CFR 413.13.)

		Part A 1	Part B 2	Outpatient ASC 3	Outpatient Radiology 4	Outpatient Diagnostic 5	
47	Hospital						47
48	Subprovider						48
49	SNF						49
50	HHA						50
51	Outpatient Rehab. Providers (specify)						51

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

		_____ TO _____					
52	Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? (see instructions)						52
52.01	If you are a fully prospective or hold harmless provider are you eligible for the special exceptions payment pursuant to 42 CFR 412.348(g)? If yes, complete Worksheet L, Part IV						52.01
53	If you are a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in this C/R period. Enter beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 for number of periods in excess of one and enter subsequent dates.						53
53.01	MDH period beginning:_____ ending: _____						53.01
54	List amounts of malpractice premiums and paid losses: Premiums:_____, Paid losses:_____, and/or Self insurance:_____						54
54.01	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.						54.01
55	Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no.						55
56	Are you claiming ambulance costs? If yes, enter in column 2 the payment limit provided from your fiscal intermediary and the applicable dates for those limits in column 0. If this is the first year of operation no entry is required in column 2. If column 1 is Y, enter Y or N in column 3 whether this is your first year of operations for rendering ambulance services. Enter in column 4, if applicable, the fee schedules amounts for the period beginning on or after 4/1/2002.	Date 0	Y or N 1	Limit 2	Y or N 3	Fees 4	56
56.01	Enter subsequent ambulance payment limit as required. Subscript if more than 2 limits apply. Enter in column 4 the fee schedules amounts for initial or subsequent periods as applicable.						56.01
56.02							
57	Are you claiming nursing and allied health costs? (see instructions)						57
58	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. If yes have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y for yes and "N" for no. This option is only available for cost reporting periods beginning on or after 1/1/2002 and before 10/1/2002.						58
58.01	If line 58 column 1 is Y, does this IRF 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 FR Vol. 70, No. 156 dated August 15, 2005 pg 47929? 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 new teaching program in existence, enter 5 . (see instructions)						58.01
59	Are you a Long Term Care Hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. If yes have you made an election for100% Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. (see instructions)						59
60	Are you an Inpatient Psychiatric Facility (IPF), or do you contain an IPF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, is the IPF or IPF subprovider a new facility? Enter in column 2 "Y for yes and "N" for no. (see instructions)						60
60.01	If line 60 column 1 is "Y", and the facility is an IPF subprovider, were residents training in this facility in its most recent cost reporting period filed before November 15, 2004? Enter "Y" for yes or "N" for no. Is this facility training residents in a new teaching programs in accordance with 42 CFR Sec. 412.424 (d)(1)(iii)? 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 new teaching program in existence, enter 5 . (see instr.)						60.01
Multicampus							
61	Is this facility part of a Multicampus hospital that has one or more campuses in different CBSA? Enter "Y" for yes and "N" for no.						61
	If line 61 is yes, enter the name in col. 0, County in col. 1, state in col. 2, Zip in col 3, CBSA in col. 4 and FTE/Campus in col. 5.	County 1	State 2	Zip Code 3	CBSA 4	FTE/ Campus 5	
62	Name:						62
Settlement data							
63	Was the cost report filed using the PS&R (either in its entirety or for total charges and days only)? Enter "Y" for yes and "N" for no in column 1. If column 1 is "Y", enter the "paid through" date of the PS&R in column 2 (mm/dd/yyyy)						63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
STATISTICAL DATA

PROVIDER NO.: _____

PERIOD
FROM _____
TO _____

WORKSHEET S-3, PART I

	Component	No. of Beds	Bed Days Available	I/P Days / O/P Visits / Trips						Interns & Residents FTEs			Full Time Equivalent		Discharges				
				Title V	Title XVIII	Title XIX													
						Total Title XIX	Obs. Beds Admitted	Obs. Beds Not Adm	Total All Patients	Obs. Beds Admitted	Obs. Beds Not Adm	Total	Less I & R Replacing Non-Phys. Anesthetists	Net	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	5.01	5.02	6	6.01	602	7	8	9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 3, 4, 5 and 6, exclude Swing Bed, Observation Bed and Hospice days)																				1
2	HMO																				2
3	Hospital Adults & Peds. Swing Bed SNF																				3
4	Hospital Adults & Peds. Swing Bed NF																				4
5	Total Adults and Peds. (exclude observation beds) (see instructions)																				5
6	Intensive Care Unit																				6
7	Coronary Care Unit																				7
8	Burn Intensive Care Unit																				8
9	Surgical Intensive Care Unit																				9
10	Other Special Care																				10
11	Nursery																				11
12	Total (see instructions)																				12
13	RPCH\CAH visits																				13
14	Subprovider																				14
15	Skilled Nursing Facility																				15
16	Nursing Facility																				16
17	Other Long Term Care																				17
18	Home Health Agency																				18
20	ASC (Distinct Part)																				20
21	Hospice (Distinct Part)																				21
23	Outpatient Rehab. Provider (specify)																				23
24	RHC/FQHC (specify)																				24
25	Total (sum of lines 12-24)																				25
26	Observation Bed Days																				26
27	Ambulance Trips																				27
28	Employee discount days (see instru.)																				28
29	*Labor & delivery days (see instructions)*																				*29*

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

PART II - WAGE DATA

		Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
		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
4.01	Teaching physician salaries (see instructions)							4.01
5	Physician-Part B							5
5.01	Non-physician-Part B							5.01
6	Interns & residents (in an approved program)							6
6.01	Contract services, I&R (see instructions)							6.01
7	Home office personnel							7
8	SNF							8
8.01	Excluded area salaries (see instructions)							8.01
	OTHER WAGES & RELATED COSTS							
9	Contract labor (see instructions)							9
9.01	Pharmacy services under contract							9.01
9.02	Laboratory services under contract							9.02
9.03	Management and administrative services							9.03
10	Contract labor: physician-Part A							10
10.01	Teaching physician under contract (see instru.)							10.01
11	Home office salaries & wage-related costs							11
12	Home office: physician Part A							12
12.01	Teaching physician salaries (see instructions)							12.01
	WAGE-RELATED COSTS							
13	Wage-related costs (core)						CMS 339	13
14	Wage-related costs (other)						CMS 339	14
15	Excluded areas						CMS 339	15
16	Non-physician anesthetist Part A						CMS 339	16
17	Non-physician anesthetist Part B						CMS 339	17
18	Physician Part A						CMS 339	18
18.01	Part A teaching physicians (see instructions)						CMS 339	18.01
19	Physician Part B						CMS 339	19
19.01	Wage-related costs (RHC/FQHC)						CMS 339	19.01
20	Interns & residents (in an approved program)						CMS 339	20

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

PART II - WAGE DATA

		Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
		1	2	3	4	5	6	
	OVERHEAD COSTS - DIRECT SALARIES							
21	Employee Benefits							21
22	Administrative & General							22
22.01	Administrative & General under contract (see inst.)							22.01
23	Maintenance & Repairs							23
24	Operation of Plant							24
25	Laundry & Linen Service							25
26	Housekeeping							26
26.01	Housekeeping under contract (see instructions)							26.01
27	Dietary							27
27.01	Dietary under contract (see instructions)							27.01
28	Cafeteria							28
29	Maintenance of Personnel							29
30	Nursing Administration							30
31	Central Services and Supply							31
32	Pharmacy							32
33	Medical Records & Medical Records Library							33
34	Social Service							34
35	Other General Service							35

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	Net salaries (see instructions)							7
8	Excluded area salaries							8
9	Subtotal salaries (line 7 minus line 8)							9
10	Subtotal other wages & related costs (see inst.)							10
11	Subtotal wage-related costs (see inst.)							11
12	Total (sum of lines 9 thru 11)							12
13	Total overhead costs (see inst.)							13

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
###	Unduplicated Census Count (see instructions)						###

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 MSA CODES			
		1	1.01	
19	How many MSAs in column 1 or CBSAs in column 1.01 did you provide services to during this cost reporting period.			19
20	List those MSA code(s) in column 1 and CBSA code(s) in column 1.01 serviced during this cost reporting period (line 20 contains the first code).			20

PPS ACTIVITY DATA - Applicable for Medicare Services Rendered on or after October 1, 2000

		Full Episodes							
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	SCIC within a PEP	SCIC only Episodes	Total (cols. 1-6)	
		1	2	3	4	5	6	7	
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

EPOIETIN

13	Net costs of Epoietin furnished to all maintenance dialysis patients by the provider.		13
13.01	Epoietin amount from Worksheet A for Home Dialysis program		13.01
14	Number of EPO units furnished relating to the renal dialysis department		14
14.01	Number of EPO units furnished relating to the home dialysis department		14.01

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

15	MCP_____ INITIAL METHOD_____	15

ARANESP

16	Net costs of Aranesp furnished to all maintenance dialysis patients by the provider.		16
17	Aranesp amount from Worksheet A for Home Dialysis program		17
18	Number of Aransep units furnished relating to the renal dialysis department		18
19	Number of Aransep units furnished relating to the home dialysis department		19

HOSPITAL-BASED OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO. _____	PERIOD: FROM_____ TO_____	WORKSHEET S-6

OUTPATIENT REHABILITATION PROVIDER - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

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

19	Is this component paid 100% under established fee schedules? If yes, enter "Y" , if no, enter "N". If "Yes" you are not required to complete lines 1 through 18 above nor the related J series worksheets for cost reporting periods beginning on or after 4/1/2001.		19

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

PROVIDER NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET S-7

		M3PI	SERVICES PRIOR TO October 1st		SERVICES ON OR AFTER October 1st		Services through (1) 4/1/2001 - 9/30/2001		High Cost (2) April 1, 2000	Swing Bed SNF	TOTAL	
	GROUP	REVENUE CODE	Rate	Days	Rate	Days	Rate	Days	Days	Days	(see instructions)	
	1	2	3	3.01	4	4.01	4.02	4.03	4.05	4.06	5	
1	RUC											1
2	RUB											2
3	RUA											3
3.01	RUX											3.01
3.02	RUL											3.02
4	RVC											4
5	RVB											5
6	RVA											6
6.01	RVX											6.01
6.02	RVL											6.02
7	RHC											7
8	RHB											8
9	RHA											9
9.01	RHX											9.01
9.02	RHL											9.02
10	RMC											10
11	RMB											11
12	RMA											12
12.01	RMX											12
12.02	RML											12
13	RLB											13
14	RLA											14
14.01	RLX											14
15	SE3											15
16	SE2											16
17	SE1											17
18	SSC											18
19	SSB											19
20	SSA											20
21	CC2											21
22	CC1											22
23	CB2											23
24	CB1											24
25	CA2											25
26	CA1											26
27	IB2											27
28	IB1											28
29	IA2											29
30	IA1											30
31	BB2											31
32	BB1											32
33	BA2											33
34	BA1											34
35	PE2											35
36	PE1											36
37	PD2											37
38	PD1											38
39	PC2											39
40	PC1											40
41	PB2											41
42	PB1											42
43	PA2											43
44	PA1											44
45	Default rate											45
46	TOTAL											46

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additonal 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

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
1.01	City: State: Zip Code: County:	1.01
2	Designation (for FQHCs only) - Enter "R" for rural or "U" for urban	2

Source of Federal Funds:		Grant Award	Date	
		1	2	
3	Community Health Center (Section 330(d), PHS Act)			3
4	Migrant Health Center (Section 329(d), PHS Act)			4
5	Health Services for the Homeless (Section 340(d), PHS Act)			5
6	Appalachian Regional Commission			6
7	Look-Alikes			7
8	Other (specify)			8

Physician Information:		Physician name	Billing No.	
9	Physician(s) furnishing services at the clinic or under agreement (see instructions)			9

		Physician name	Hours	
10	Supervisory physician(s) and hours of supervision during period (see instructions)			10

11	Does this facility operate as other than an RHC or FQHC? 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.)			11

Facility hours of operations (1)

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

(1) Enter clinic hours of operation on line 12 and other type operations on subscripts of line 12 (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.

13	Have you received an approval for an exception to the productivity standard?			13
14	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.			14
15	Provider name: _____ Provider number: _____			15

			V	XVIII	XIX	
16	Have you provided all or substantially all GME costs. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents. (See instructions)					16
17	Has the hospitals' bed size changed to less than 50 beds during the year for cost reporting periods overlapping 7/1/2001? Enter "Y" for yes and "N" for no. If yes. see instructions.					17

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

PART I - ENROLLMENT DAYS

		Unduplicated Days					
	Enrollment 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						
2	Routine Home Care						
3	Inpatient Respite Care						
4	General Inpatient Care						
5	Total Hospice Days						

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						
7	Total Number of Unduplicated Countinuous Care Hours Billable to Medicare						
8	Average Length of Stay (line 5/line 6)						
9	Unduplicated Census Count						

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

HOSPITAL UNCOMPENSATED CARE DATA		PROVIDER NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET S-10	
Uncompensated Care Information					
1	Do you have a written charity care policy ?				1
2	Are patients write-offs identified as charity? If yes answer lines 2.01 thru 2.04				2
2.01	Is it at the time of admission?				2.01
2.02	Is it at the time of first billing?				2.02
2.03	Is it after some collection effort has been made?				2.03
2.04	Other methods of write-offs (specify)				2.04
3	Are charity write-offs made for partial bills?				3
4	Are charity determinations based upon administrative judgment without financial data?				4
5	Are charity determinations based upon income data only?				5
6	Are charity determinations based upon net worth (assets) data ?				6
7	Are charity determination based upon income and net worth data ?				7
8	Does your accounting system separately identify bad debt and charity care? If yes answer 8.01				8
8.01	Do you separately account for inpatient and outpatient services?				8.01
9	Is discerning charity from bad debt a high priority in your institution? If no answer 9.01 thru 9.04				9
9.01	Is it because there is not enough staff to determine eligibility?				9.01
9.02	Is it because there is no financial incentive to separate charity from bad debt?				9.02
9.03	Is it because there is no clear directive policy on charity determination?				9.03
9.04	Is it because your institution does not deem the distinction important?				9.04
10	If charity determinations are made based upon income data, what is the maximum income that can be earned by patients (single without dependent) and still determined to be a charity write off?				10
11	If charity determinations are made based upon income data, is the income directly tied to Federal poverty level? If yes answer lines 11.01 thru 11.04				11
11.01	Is the percentage level used less than 100% of the Federal poverty level?				11.01
11.02	Is the percentage level used between 100% and 150% of the Federal poverty level?				11.02
11.03	Is the percentage level used between 150% and 200% of the Federal poverty level?				11.03
11.04	Is the percentage level used greater than or equal 200 % of the Federal poverty level?				11.04
12	Are partial write-offs given to higher income patients on a gradual scale?				12
13	Is there charity consideration given to high net worth patients who have catastrophic or other extraordinary medical expenses?				13
14	Is your hospital State or local government owned? If yes answer line 14.01 and 14.02				14
14.01	Do you receive direct financial support from that government entity for the purpose of providing uncompensated care?				14.01
14.02	What percentage of the amount on line 14.01 is from government funding?				14.02
15	Do you receive restricted grants for rendering care to charity patients?				15
16	Are other non-restricted grants used to subsidize charity care?				16
Uncompensated Care Revenues					
17	Revenues from uncompensated care				17
17.01	Gross Medicaid Revenues				17.01
18	Revenues from State and local indigent care programs				18
19	Revenues related to SCHIP (see instructions)				19
20	Restricted grants				20
21	Non-restricted grants				21
22	Total Gross Uncompensated Care Revenues				22
Uncompensated Care Costs					
23	Total charges for patients covered by State and local indigent care programs				23
24	Cost to Charge Ratio (Wkst C, Part I, column 3 line 103, divided by column 8, line 103)				24
25	Total State and local indigent care program cost (line 23 x line 24)				25
26	Total SCHIP charges from your records				26
27	Total SCHIP cost, (line 24 x line 26)				27
28	Total gross Medicaid charges from your records				28
29	Total gross Medicaid cost (line 24 x line 28)				29
30	Other uncompensated care charges from your records (see instructions)				30
31	Uncompensated care cost (line 24 x line 30)				31
32	Total uncompensated cost to the hospital (Sum of lines 25, 27, and 29)				32