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. 0938-0463

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT	PROVIDER NO. _____	PERIOD: FROM _____ TO _____	WORKSHEET S PARTS I & II

Intermediary use only:	[ ] Audited [ ] Desk Reviewed	Date Received _____ Intermediary No. _____	[ ] Intial [ ] Final	[ ] Re-opened

PART I - CERTIFICATION

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

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THE COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ANDMINISTRATIVE ACTION, FINE AND / OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS COST 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 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 XVIII			
		TITLE V	A	B	TITLE XIX	
		1	2	3	4	
1.	SKILLED NURSING FACILITY					1.
2.						2
3.	NURSING FACILITY					3
3.1	I C F / M R					3.1
4.	SNF - BASED H H A					4
5.	SNF - BASED OUTPATIENT REHABILITATION PROVIDERS					5
6.	SNF - BASED RHC / FQHC					6
7.	TOTAL					7

The above amounts represent "due to" or "due from" the applicable Program for the element of the above complex indicated. (Indicate Overpayments in Brackets.)

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY COMPLEX IDENTIFICATION DATA	PROVIDER NO.: ____ _____	PERIOD FROM_____ TO_____	WORKSHEET S - 2

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:		P.O Box:			1
2	City:		State:	Zip Code:		2
3	County:	MSA Code:	CBSA Code:	Urban / Rural:		3
3.1	Facility Specific Rate:		Transition Period - enter 1, 2, 3 or 100			3.1
3.2	Wage Index Adjustment Factor: Before October 1		After Sept 30			3.2

SNF and SNF-Based Component Identification:

	Component	Component Name	Provider No.	NPI\ Number	Date Certified	Payment System (P, O, or N) V	XVIII	XIX	
	0	1	2	2.01	3	4	5	6	
4	S N F								4
5									5
6	Nursing Facility								6
6.1	I C F / M R								6.1
7	SNF-Based O.L.T.C.								7
8	SNF-Based H.H.A.								8
9									9
10	SNF-Based Outpatient Rehabilitation Providers								10
11	SNF-Based R.H.C.								11
12	SNF-Based HOSPICE								12

13	Cost Reporting Period (mm/dd/yyyy)	From:	To:	13
14	Type of Control (See Instructions)			14

Type of Freestanding Skilled Nursing Facility		Y / N	
15	Is this an Entirely Participating Skilled Nursing Facility?		15
	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 1 column 3. Indicate in column 2 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care andrelated expenses for each category. (See instructions)		
15.01	Staffing		15.01
15.02	Recruitment		15.02
15.03	Retention of employees		15.03
15.04	Training		15.04
15.05	Other (Specify)		15.05
16	Is this a Partially Participating Skilled Nursing Facility?		16
17	Is this Skilled Nursing Facility Unit of a Domiciliary Institution?		17
18	Is this Skilled Nursing Facility Unit of a Rehabilitation Center?		18
19	Other (Specify)		19

Miscellaneous Cost Reporting information			
20	If this is a low or no Medicare utilization cost report, enter "L" for Low Medicare Utilization, or "N" for No Medicare Utilization.		20
21	If this is an All-Inclusive Provider, enter the method used. (See Instruction)		21
22	Is the difference between total interim payments and the net cost covered service included in the balance sheet?		22

Depreciation Enter the amount of depreciation reported in this SNF for the method indicated.			
23	Straight Line		23
24	Declining Balance		24
25	Sum of the Year's Digits		25
26	Sum of line 23 thru 25		26

FORM CMS-2540-96 (02/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 3508)

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY COMPLEX IDENTIFICATION DATA	PROVIDER NO.: ____ _____	PERIOD FROM_____ TO_____	WORKSHEET S - 2 (Continued)

27	If depreciation is funded, enter the balance as of the end of the period.					27
28	Were there any disposal of capital assets during the cost reporting period? (Y/N)					28
29	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					29
30	Was accelerated depreciation claimed on assets acquire on or after August 1, 1970 (1) (Y/N)					30
31	Did you cease to participate in the Medicare program at end of the period to which this cost report applies (1)					31
32	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports (1)					32
	If this facility contains a public or non-public 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.		Part A	Part B	Other	
33	Skilled Nursing Facility					33
34						34
35	Nursing Facility					35
35.1	I C F / M R					35.1
36	SNF-Based O.L.T.C.					36
37	SNF-Based H.H.A.					37
38						38
39	SNF-Based Outpatient Rehabilitation Providers					39
40	SNF-Based R.H.C.					40
41	Is this Skilled Nursing Facility exempt from the cost limits?					41
42	Is this Nursing Facility exempt from the cost limits?					42
43	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for titles V and XIX patients.					43
44	Did the provider participate in the NHCMQ Demonstration during the cost reporting period? (See instructions) If yes, enter Phase #					44
45	List malpractice premiums and paid losses:	Premiums	Paid Losses	Self insurance		45
46	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts					46
47	Are you claiming ambulance costs? Enter Y or N in column 1. If column 1 is Y, enter in column 2 whether this is your first year of operation for rendering ambulance services.					47
48	If line 47, column 1 is yes, enter in column 1 the payment limit provided from your intermediary. If your fiscal year is OTHER than a year beginning on October 1st, enter in column 1 the payment limit for the period prior to October 1, and enter in column 2 the payment limit for the period beginning October 1. NOTE: If line 47, column 2 is yes, no entry is required on line 48 (column 1 or 2).					48
49	Did you operate an Intermediate Care Facility for the Mentally Retarded (ICF/MR) under title XIX?					49
50	Did this facility report less than 1500 Medicare days in its previous year's cost report? (See instructions.)					50
51	If line 50 is yes, did you file your previous years cost report using the "Simplified" step-down method of cost finding? See instructions for qualifications to use the simplified step-down method before answering line 52.					51
52	Is this cost report being filed under 42 CFR 413.321, the "simplified" cost report? Enter "Y" for yes or "N" for no.					52
53	Are there any related organizations or home office costs as defined in CMS Pub. 15-1, chapter 10? If yes, and there are costs, for either, enter the applicable provider number		Y/N	Provider #		53
	If this facility is part of a chain organization, enter the name and address of the home office on the lines below					
54	Name:	FI/Contractor name		FI/Contractor Number		54
55	Street:			PO Box		55
56	City			State	Zip	56
57	*Was the cost report filed using the PS&R (either in its entirety or for total charges and days only)? Enter "Y" for yes or "N" for no.*					57
58	*If line 57 is "Y", enter the "paid through" date of the PS&R (mm/dd/yyyy)*					58

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA	PROVIDER NO.:	PERIOD FROM_____	WORKSHEET S-3 PART I

	Component	Number of Beds	Bed Days Available	Inpatient Days					Discharges					
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Facility													1
2														2
3	Nursing Facility													3
3.1	ICF/MR													3.1
4	Other Long Term Care													4
5	Home Health Agency													5
6														6
7	SNF-Based Outpatient Rehabilitation Providers													7
8	Hospice													8
9	Total (Sum of lines 1-8)													9
10	Ambulance Trips													10

		Average Length of Stay				Admissions					Full Time Equivalent		
		Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers	
		13	14	15	16	17	18	19	20	21	22	23	
1	Skilled Nursing Facility												1
2													2
3	Nursing Facility												3
3.1	ICF/MR												3.1
4	Other Long Term Care Facility												4
5	Home Health Agency												5
6													6
7	SNF-Based Outpatient Rehabilitation Providers												7
8	Hospice												8
9	Total (Sum of lines 1-8)												9
10	Ambulance trips												10

FORM CMS 2540-96 (02/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3509)

SNF WAGE INDEX INFORMATION | **PROVIDER NO.:** _____ | **PERIOD: FROM** _____ **TO** _____ | **WORKSHEET S-3 PARTS II & III**

PART II DIRECT SALARIES		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
		1	2	3	4	5	6	
1	Total salary (See Instructions)							1
2	Physician salaries-Part A							2
3	Physician salaries-Part B							3
4	Interns & Residents (approved)							4
5	Home office personnel							5
6	Sum of lines 2 thru 5							6
7	Revised wages (line 1 minus line 6)							7
8	Other Long Term Care							8
9	Other Inpatient Routine Service							9
10	Interns & Residents (Not In Approved Program)							10
11	HHA							11
12	Outpatient Rehabilitation Providers							12
13	Hospice							13
14	Non-reimbursable							14
15	Total Excluded salary (Sum of lines 8 through 14)							15
16	Subtotal (line 7 minus line 15)							16
17	Contract Labor: Patient Related & Mgmt						CMS 339	17
18	Home office salaries & wage related costs							18
19	Wage related costs (core)						CMS 339	19
20	Wage related costs (other)						CMS 339	20
21	Wage related costs (excluded units)						CMS 339	21
22	Subtotal (see instructions)							22
23	Total (see instructions)							23
24	Contract Labor: Physician services-Part A							24

PART III - OVERHEAD COST - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)		
		1	2	3	4	5		
1	Employee Benefits							1
2	Administrative & General							2
3	Plant Operation, Maintenance & Repairs							3
4	Laundry & Linen Service							4
5	Housekeeping							5
6	Dietary							6
7	Nursing Administration							7
8	Central Services and Supply							8
9	Pharmacy							9
10	Medical Records & Medical Records Library							10
11	Social Service							11
12	Interns & Records (Apprvd Tching Prog)							12
13	Other General Service (specify)							13
14	Total (sum lines 1 thru 13)							14

FORM CMS-2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3509.1 - 3509.2)

SNF - BASED HOME HEALTH AGENCY STATISTICAL DATA

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET S-4
PARTS I & II

Check One: [ ] Title V [ ] Title XVIII [ ] Title XIX

PART I - HOME HEALTH AGENCY VISITS

	DESCRIPTION	Program			Non-Program Data			Total			
		Hours	Visits	Patients	Hours	Visits	Patients	Hours	Visits	Patients	
		1	2	3	4	5	6	7	8	9	
1	Skilled Nursing										1
2	Physical Therapy										2
3	Occupational Therapy										3
4	Speech Pathology										4
5	Medical Social Services										5
6	Home Health Aide										6
7	All Other Services										7
8	Total Visits (Sum of lines 1 - 7)										8
9	Unduplicated Census Count Full Cost Repoting Period										9
9.01	Unduplicated Census Count Pre 10/01/2000										9.01
9.02	Unduplicated Census Count Post 09/30/2000										9.02

PART II - EMPLOYMENT DATA

Enter the number of hours in your normal work week. _____

HHA NO. OF FTE EMPLOYEES 2080 HRS

		Staff	Contract	(Sum of Cols. 1+2)
		1	2	3
1	Nurses - RNs (1)			
2	Nurses - LPN			
3	Nurses - LVN			
4	Physical Therapists			
5	Occupational Therapists			
6	Speech Pathologists			
7	Medical Social Workers			
8	Home Health Aides			
9	Homemaker			
10	Executive Administrative Personnel (2)			
11	Financial Administrative Personnel (3)			
12	General Administrative Personnel (4)			
13	Other (5)			
14				
15				

Footnotes:

1. This category includes all nurses, i.e., RNs, LPNs, LVNs. A nurse supervisor (if part of her time is spent performing visits) should be included in this category.
2. Includes administrators, assistant administrators, directors, assistant directors, and supervisors (if sole function is administrative).
3. Includes accountants, internal auditors, statisticians and other professional financial personnel.
4. Includes categories such as billing, payroll clerks, secretaries, telephone operators, personnel specialists, security personnel, maintenance staff, and other administrative employees.
5. All other employee classifications. These include, but are not limited to respiratory therapists, nutritionists, and any other employees not included in any of the other employee classifications.

		MSA	CBSA	
		1	1.01	
16	How many MSAs or CBSAs did you provide services to during this cost reporting period.			16
17	List the MSA or CBSA code(s) serviced during this cost reporting period (line 17 contains the first code). (Subscript this line for each MSA or CBSA code being reported.)			17

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

PART III PPS ACTIVITY DATA - Applicable for Services Rendered on and after October 1, 2000

	DESCRIPTION	Full Episodes Without Outliers	Full Episodes With Outliers	L U P A Episodes	P E P only Episodes	S C I C Within a P E P	S C I C Only Episodes	Totals	
		1	2	3	4	5	6	7	
1	Skilled Nursing Visits								1
2	Skilled Nursing Visit Charges								2
3	Physical Therapy Visits								3
4	Physical Therapy Visit Charges								4
5	Occupational Therapy Visits								5
6	Occupational Therapy Visit Charges								6
7	Speech Pathology Visits								7
8	Speech Pathology Visit Charges								8
9	Medical Social Service Visits								9
10	Medical Social Service Visit Charges								10
11	Home Health Aide Visits								11
12	Home Health Aide Visit Charges								12
13	Total Visits (Sum of lines 1, 3, 5, 7, 9, & 11)								13
14	Other Charges								14
15	Total Charges (Sum of lines 2, 4, 6, 8, 10, 12 & 14)								15
16	Total Number of Episodes								16
17	Total Number of Outlier Episodes								17
18	Total Non-Routine Medical Supply Charges								18

SNF - BASED RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	PROVIDER NO: _____ COMPONANT NO: _____	PERIOD: FROM_____ TO_____	WORKSHEET S - 5

Check applicable box: [ ] RHC [ ] FQHC

PART I - STATISTICAL DATA

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

	Source of Federal funds:	Grant Award	Date	
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

		Physician Name	Billing #	
10	Physician(s) furnishing services at the clinic or under agreement (See instructions)			10
		Physician Name	Hours	
11	Supervisory physician(s) and hours of supervision during period. (See instructions)			11

		1	2	
12	Does the facility operate as other than an RHC or FQHC? If yes, indicate the number of other operations in column 2. List other type(s) of operation(s) and hours on subscripts of line 13 below. NOTE: line 13 (Clinic) is to be completed reguardless of the response to line 13.			12

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		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	
13	Clinic															13
13.01																13.01
13.02																13.02
13.03																13.03

(1) List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

14	Have you received an approval for an exception to the productivity standard?		14
15	Is this a consolidated cost report in accordance with CMS Pub 27, section 508D. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers on subscripted lines below.		15
15.01	Provider Name	Provider Number	15.01
15.02	Provider Name	Provider Number	15.02
16	Have you provided all or substantially all GME cost. If yes, enter in column 2 the number of Medicare visits performed by I&R		16

SKILLED NURSING FACILITY BASED OUTPATIENT REHABILITATION STATISTICAL DATA	PROVIDER NO.: REHAB NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-6

Check Applicable Box: [ ] C.M.H.C [ ] OPT [ ] OSP
[ ] C.O.R.F. [ ] OOT

NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

	Employment Category: Enter the number of hours in your normal work week ( ).	Staff	Contract	Total	
		1	2	3	
1	Administrator and Assistant Administrators				1
2	Directors and Assistant Directors				2
3	Other Administrative Personnel				3
4	Directing 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	Psychological Service				16
17	Psychological Service Supervisor				17
18					18
19					19
20	*Is this component paid 100% under the established fee schedules*			*Y or N*	
	If "yes" you are not required to complete lines 1 through 19 above, nor the related "J" series worksheets for cost reporting periods ending on or after 06/30/2001.				*20*

NHCMQ DEMONSTRATION AND PPS STATISTICAL DATA	PROVIDER NO.	PERIOD: FROM _____ TO	WORKSHEET S-7 PART I

PART I - NHCMQ DEMONSTRATION STATISTICAL DATA

> > FOR COST REPORTING PERIODS BEGINNING PRIOR TO JULY 1, 1998 < <

	GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1ST (1)		SERVICES ON OR AFTER JANUARY 1ST (1)		TOTAL (See Instructions)	
			RATE	DAYS	RATE	DAYS		
	1	2	3	3.01	4	4.01	5	
1	RVC	9044						1
2	RVB	9043						2
3	RVA	9042						3
4	RHD	9041						4
5	RHC	9040						5
6	RHB	9039						6
7	RHA	9038						7
8	RMC	9037						8
9	RMB	9036						9
10	RMA	9035						10
11	RLB	9034						11
12	RLA	9033						12
13	SE3	9032						13
14	SE2	9031						14
15	SE1	9030						15
16	SSC	9029						16
17	SSB	9028						17
18	SSA	9027						18
19	CD2	9026						19
20	CD1	9025						20
21	CC2	9024						21
22	CC1	9023						22
23	CB2	9022						23
24	CB1	9021						24
25	CA2	9020						25
26	CA1	9019						26
27	IB2	9018						27
28	IB1	9017						28
29	IA2	9016						29
30	IA1	9015						30
31	BB2	9014						31
32	BB1	9013						32
33	BA2	9012						33
34	BA1	9011						34
35	PE2	9010						35
36	PE1	9009						36
37	PD2	9008						37
38	PD1	9007						38
39	PC2	9006						39
40	PC1	9005						40
41	PB2	9004						41
42	PB1	9003						42
43	PA2	9002						43
44	PA1	9001						44
45	Other Group	9000						45
46	TOTAL							46

(1) Calendar Year Providers: Complete columns 1, 2, 4, 4.01, and 5
Fiscal Year Providers - Rate change as of January 1st: Complete ALL column
Fiscal Year Providers - Rate DOES NOT change as of January 1st: Complete columns 1, 2, 3, 3.01, and 5

NHCMQ DEMONSTRATION AND PPS STATISTICAL DATA	PROVIDER NO. _____	PERIOD: FROM _____ TO _____	WORKSHEET S-7 PART II

PART II - PPS STATISTICAL DATA

> > FOR COST REPORTING PERIODS BEGINNING ON AND AFTER JULY 1, 1998 < <

	GROUP	REVENUE CODE	MEDICARE DAYS	
	1	2	3	
1	RUC	9044		1
2	RUB	9043		2
3	RUA	9042		3
4	RVC	9041		4
5	RVB	9040		5
6	RVA	9039		6
7	RHC	9038		7
8	RHB	9037		8
9	RHA	9036		9
10	RMC	9035		10
11	RMB	9034		11
12	RMA	9033		12
13	RLB	9032		13
14	RLA	9031		14
15	SE3	9030		15
16	SE2	9029		16
17	SE1	9028		17
18	SSC	9027		18
19	SSB	9026		19
20	SSA	9025		20
21	CC2	9024		21
22	CC1	9023		22
23	CB2	9022		23
24	CB1	9021		24
25	CA2	9020		25
26	CA1	9019		26
27	IB2	9018		27
28	IB1	9017		28
29	IA2	9016		29
30	IA1	9015		30
31	BB2	9014		31
32	BB1	9013		32
33	BA2	9012		33
34	BA1	9011		34
35	PE2	9010		35
36	PE1	9009		36
37	PD2	9008		37
38	PD1	9007		38
39	PC2	9006		39
40	PC1	9005		40
41	PB2	9004		41
42	PB1	9003		42
43	PA2	9002		43
44	PA1	9001		44
45	Other Group	9000		45
46	TOTAL			46

PPS STATISTICAL DATA	PROVIDER NO. _____	PERIOD: FROM _____ TO _____	WORKSHEET S-7 PART III

TRANSITION PERIOD: [ ] YEAR # 1 [ ] YEAR # 2 [ ] YEAR # 3 [ ] YEAR # 4 - 100% Federal Case Mix Rate

	HIPPS CODE GROUP	FACILITY SPECIFIC RATE	SERVICES PRIOR TO 10/01		SERVICES AFTER 9/30		SUBTOTAL		YR 1: Col. 9 = Col. 7 X 25% Col. 10 = Col. 8 X 75% YR 2: Col. 9 = Col. 7 X 50% Col. 10 = Col. 8 X 50% YR 3: Col. 9 = Col. 7 X 75% Col. 10 = Col. 8 X 25%		
			FEDERAL CASE MIX RATE	DAYS	FEDERAL CASE MIX RATE	DAYS	FEDERAL CASE MIX (Col. 3 X 4, PLUS Col . 5 X 6)	FACILITY SPECIFIC (Col. 4 + 6 X Col. 2)			
	1	2	3	4	5	6	7	8	9	10	
1	RUC										1
2	RUB										2
3	RUA										3
4	RVC										4
5	RVB										5
6	RVA										6
7	RHC										7
8	RHB										8
9	RHA										9
10	RMC										10
11	RMB										11
12	RMA										12
13	RLB										13
14	RLA										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

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PPS STATISTICAL DATA	PROVIDER NO. _____	PERIOD: FROM _____ TO _____	WORKSHEET S-7 PART III

TRANSITION PERIOD: [ ] YEAR # 1 [ ] YEAR # 2 [ ] YEAR # 3 [ ] YEAR # 4 - 100% Federal Case Mix Rate

	HIPPS CODE GROUP	FACILITY SPECIFIC RATE	SERVICES PRIOR TO 10/01		SERVICES AFTER 9/30		SUBTOTAL		YR 1: Col. 9 = Col. 7 X 25% Col. 10 = Col. 8 X 75% YR 2: Col. 9 = Col. 7 X 50% Col. 10 = Col. 8 X 50% YR 3: Col. 9 = Col. 7 X 75% Col. 10 = Col. 8 X 25%		
			FEDERAL CASE MIX RATE	DAYS	FEDERAL CASE MIX RATE	DAYS	FEDERAL CASE MIX (Col. 3 X 4, PLUS Col . 5 X 6)	FACILITY SPECIFIC (Col. 4 + 6 X Col. 2)			
	1	2	3	4	5	6	7	8	9	10	
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
75	TOTAL										75

FORM CMS-2540-96 (12/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3514.3)

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

	GROUP (1)	M3PI REVENUE CODE	SERVICES PRIOR TO October 1		SERVICES ON OR AFTER October 1		HIGH COST RUGs (2)	TOTAL (see instructions)	
			RATE	DAYS	RATE	DAYS	DAYS		
	1	2	3	3.01	4	4.01	4.05	5	
1	RUC								1
2	RUB								2
3	RUA								3
4	RVC								4
5	RVB								5
6	RVA								6
7	RHC								7
8	RHB								8
9	RHA								9
10	RMC								10
11	RMB								11
12	RMA								12
13	RLB								13
14	RLA								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) The RUG III category represents the PPS period. Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on or after October 1st.

(2) Enter in column 4.05 those days which are contained in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs receive a 20% payment increase added to the total in column 5.

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3508)

HOSPICE IDENTIFICATION DATA	PROVIDER NO.: / HOSPICE NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S - 8

PART I

	Enrollment Days	Title XVIII Unduplicated Medicare Days	Title XIX Unduplicated Medicaid Days	Title XVIII Unduplicated Skilled Nursing Facility Days	Title XIX Unduplicated Nursing Facility Days	Other Unduplicated Days	Total Unduplicated Days	
		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

		Title XVIII	Title XIX	Title XVIII Skilled Nursing facility	Title XIX Nursing Facility	Other	Total	
		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							8
9	Unduplicated Census Count							9