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 CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN:	PERIOD : FROM ____________ TO ______________	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronic filed cost report Date:___________ Time:___________
2. [ ] Manually submitted cost report
3. If this is an amended report enter the number of times the provider resubmitted this cost report. _______

Contractor use only:

4. [ ] Cost Report Status
   - [1] As Submitted:
   - [2] Settled without audit
   - [3] Settled with audit
   - [4] Reopened
   - [5] Amended
5. Date Received ____________
6. Contractor No. ____________
7. [ ] First Cost Report for this Provider CCN
8. [ ] Last Cost Report for this Provider CCN
9. NPR Date: __________
10. If line 4, column 1 is "4": Enter number of times reopened ______
11. Contractor Vendor Code ________

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 THIS REPORT WERE PROVIDED 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 PROVIDERS)

I HEREBY CERTIFY that I have read the above *certification* 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 Provider CCN(s)} for the cost reporting period beginning _______________ and ending _______________ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and 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.

OFFICER OR ADMINISTRATOR OF PROVIDER

Printed Name____ Signed____

Title____ Date____

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	SKILLED NURSING FACILITY					1
2	NURSING FACILITY					2
3	I C F-Mentally Retarded					3
4	SNF - BASED HHA					4
5	SNF - BASED RHC					5
6	SNF - BASED FQHC					6
7	SNF - BASED CMHC					7
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 control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, 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 suggestions 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.

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD : FROM ______________ TO ______________	WORKSHEET S-2 PART I

	Skilled Nursing Facility and Skilled Nursing Facility Complex Address:				
1	Street:	P.O. Box:			1
2	City:	State:	ZIP Code		2
3	County:	CBSA Code:	Urban / Rural:		3

SNF and SNF - Based Component Identification:

	Component	Component Name	Provider CCN	Date Certified	Payment System (P, O or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
4	S N F							4
5	Nursing Facility							5
6	I C F - Mentally Retarded							6
7	SNF-Based HHA							7
8	SNF-Based RHC							8
9	SNF-Based FQHC							9
10	SNF-Based CMHC							10
11	SNF-Based OLTC							11
12	SNF-Based HOSPICE							12
13	OTHER (specify)							13
14	Cost Reporting Period (mm/dd/yyyy) From:	To:						14
15	Type of Control (see instructions)							15

	Type of Freestanding Skilled Nursing Facility	Y / N	
16	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?		16
17	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?		17
18	Are there any costs included in Worksheet A *that* resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.		18

	Miscellaneous Cost Reporting Information		
19	Is this a low Medicare utilization cost report, enter "Y" for yes or "N" for no.		19
19.01	If the response to line 19 is "Y", does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)		19.01

	Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on lines 20 - 22.		
20	Straight Line		20
21	Declining Balance		21
22	Sum of the Year's Digits		22
23	Sum of line 20 through 22		23
24	If depreciation is funded, enter the balance as of the end of the period.		24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)		25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)		26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y?N)		27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)		28

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4104)

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM____________ TO____________	WORKSHEET S-2 PART I

	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	
29	Skilled Nursing Facility				29
30	Nursing Facility				30
31	I C F / M R				31
32	SNF-Based HHA				32
33	SNF-Based RHC				33
34	SNF-Based FQHC				34
35	SNF-Based CMHC				35
36	SNF-Based OLTC				36

		Y / N			
37	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 & XIX patients. (Y/N)				37
38	Are you legally required to carry malpractice insurance? (Y/N)				38
39	Is the malpractice a "claims-made" or "occurence" policy? If the policy is "claims-made," enter 1. If the policy is "occurence", enter 2.				39

		Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:				41

		Y / N					
42	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If "Y", check box, and submit supporting schedule listing cost centers and amounts.						42
43	*Are there any home office costs as defined in CMS Pub. 15-1, chapter 10?*						43
44	If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1.						44

If this facility is part of a chain organization, enter the name and address of the home office on the lines below.

45	Name:			Contractor Name:	Contractor Number:	45
46	Street:	P.O. Box:				46
47	City	State	*ZIP Code*			47

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4104)

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN:	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 dates responses, use the format mm/dd/yyyy.

Completed by All Skilled Nursing Facilities

	Provider Organization and Operation	Y/N 1	Date 2	
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

		Y/N 1	Date 2	V/I 3	
2	Has the provider terminated participation in the Medicare Program? If column 1 is "Y", 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	Y/N 1	Type 2	Date 3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, 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	Y/N 1	Y/N 2	
6	Column 1: Were costs claimed for nursing school? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)			6
7	Were costs claimed for allied health programs? (Y/N) (see instructions)			7
8	Were approvals and/or renewals obtained during the cost reporting period for nursing school and/or allied health program? (Y/N) (see instructions)			8

	Bad Debts	Y/N 1	
9	Is the provider seeking reimbursement for bad debts? (Y/N) (see instructions)		9
10	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		10
11	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		11

	Bed Complement		
12	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		12

	PS&R Report Data	Y/N Part A 1	Date Part A 2	Y/N Part B 3	Date Part B 4	
13	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)					13
14	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 of the PS&R used to prepare this cost report in columns 2 and 4.					14
15	If line 13 or 14 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.					15
16	If line 13 or 14 is "Y", were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16
17	If line 13 or 14 is "Y", were adjustments made to PS&R data for Other? Describe the other adjustments:_________________________________					17
18	Was the cost report prepared only using the provider's records? If "Y", see instructions.					18

FORM CMS-2540-10 (05/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4104.1)

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA	PROVIDER CCN:	PERIOD : FROM _____________ TO _____________	WORKSHEET S-3 PART I

PART I - STATISTICAL DATA

	Component	Number of Beds	Bed Days Available	Inpatient Days / Visits					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	Nursing Facility													2
3	ICF-Mentally Retarded													3
4	Home Health Agency													4
5	Other Long Term Care													5
6	SNF-Based CMHC													6
7	Hospice													7
8	Total (sum of lines 1-7)													8

	Component	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	Nursing Facility												2
3	ICF - Mentally Retarded												3
4	Home Health Agency												4
5	Other Long Term Care												5
6	SNF-Based CMHC												6
7	Hospice												7
8	Total (sum of lines 1-7)												8

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4105)

SNF WAGE INDEX INFORMATION	PROVIDER CCN:	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)	
		1	2	3	4	5	
SALARIES							
1	Total salary (see instructions)						1
2	Physician salaries-Part A						2
3	Physician salaries-Part B						3
4	Home office personnel						4
5	Sum of lines 2 through 4						5
6	Revised wages (line 1 minus line 5)						6
7	Other Long Term Care						7
8	Home Health Agency						8
9	CMHC						9
10	Hospice						10
11	Other excluded areas						11
12	Subtotal excluded salary (sum of lines 7 through 11)						12
13	Total adjusted salaries (line 6 minus line 12)						13
OTHER WAGES AND RELATED COSTS							
14	Contract Labor: Patient Related & Mgmt						14
15	Contract Labor: Physician services-Part A						15
16	Home office salaries & wage related costs						16
WAGE RELATED COSTS							
17	Wage related costs core (see Pt. IV)						17
18	Wage related costs other (see Pt. IV)						18
19	Wage related costs (excluded units)						19
20	Physicians Part A - WRC						20
21	Physicians Part B - WRC						21
22	Total adjusted wage related cost (see instructions)						22

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	Nursing and Allied Health Ed. Act.						12
13	Other General Service (specify _______________)						13
14	Total (sum lines 1 through 13)						14

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4105.1 - 4105.2)

SNF WAGE RELATED COSTS	PROVIDER CCN:	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 Organizations)			
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

FORM CMS-2540-10 (05/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4105.3)

SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER CCN:	PERIOD : FROM ______________ TO ______________	WORKSHEET S-3 PART V

	OCCUPATIONAL CATEGORY	Amount Reported 1	Fringe Benefits 2	Adjusted Salaries (col. 1 + col. 2) 3	Paid Hours Related to Salary in col. 3 4	Average Hourly Wage (col. 3 ÷ col. 4) 5	
	Direct Salaries						
	Nursing Occupations						
1	Registered Nurses (RNs)						1
2	Licensed Practical Nurses (LPNs)						2
3	Certified Nursing Assistants/Nursing Assistants/Aides						3
4	Total Nursing (sum of lines 1 through 3)						4
5	Physical Therapists						5
6	Physical Therapy Assistants						6
7	Physical Therapy Aides						7
8	Occupational Therapists						8
9	Occupational Therapy Assistants						9
10	Occupational Therapy Aides						10
11	Speech Therapists						11
12	Respiratory Therapists						12
13	Other Medical Staff						13
	Contract Labor						
	Nursing Occupations						
14	Registered Nurses (RNs)						14
15	Licensed Practical Nurses (LPNs)						15
16	Certified Nursing Assistants/Nursing Assistants/Aides						16
17	Total Nursing (sum of lines 14 through 16)						17
18	Physical Therapists						18
19	Physical Therapy Assistants						19
20	Physical Therapy Aides						20
21	Occupational Therapists						21
22	Occupational Therapy Assistants						22
23	Occupational Therapy Aides						23
24	Speech Therapists						24
25	Respiratory Therapists						25
26	Other Medical Staff						26

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4105.4)

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SNF - BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER CCN: HHA CCN:	PERIOD : FROM ______ TO ______	WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

1	County		1

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

	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)	Staff 1	Contract 2	Total 3	
4	Enter the number of hours in your normal work week				4
5	Administrator and Assistant Administrator(s)				5
6	Directors and Assistant Director(s)				6
7	Other Administrative Personnel				7
8	Direct Nursing Service				8
9	Nursing Supervisor				9
10	Physical Therapy Service				10
11	Physical Therapy Supervisor				11
12	Occupational Therapy Service				12
13	Occupational Therapy Supervisor				13
14	Speech Pathology Service				14
15	Speech Pathology Supervisor				15
16	Medical Social Service				16
17	Medical Social Service Supervisor				17
18	Home Health Aide				18
19	Home Health Aide Supervisor				19
20	Other (specify)				20

HOME HEALTH AGENCY CBSA CODES

21	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		21
22	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 22 contains the first code).		22

	PPS ACTIVITY DATA	Full Episodes Without Outliers 1	Full Episodes With Outliers 2	LUPA Episodes 3	PEP only Episodes 4	Total (cols. 1 through 4) 5	
23	Skilled Nursing Visits						23
24	Skilled Nursing Visit Charges						24
25	Physical Therapy Visits						25
26	Physical Therapy Visit Charges						26
27	Occupational Therapy Visits						27
28	Occupational Therapy Visit Charges						28
29	Speech Pathology Visits						29
30	Speech Pathology Visit Charges						30
31	Medical Social Service Visits						31
32	Medical Social Service Visit Charges						32
33	Home Health Aide Visits						33
34	Home Health Aide Visit Charges						34
35	Total Visits (sum of lines 23, 25, 27, 29, 31, and 33)						35
36	Other Charges						36
37	Total Charges (sum of lines 24, 26, 28, 30, 32, 34 and 36)						37
38	Total Number of Episodes (standard/non outlier)						38
39	Total Number of Outlier Episodes						39
40	Total Non-Routine Medical Supply Charges						40

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4106)

SNF - BASED RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	PROVIDER CCN: COMPONENT CCN :	PERIOD : FROM ____________ TO ______________	WORKSHEET S-5

Check applicable box: [ ] RHC [ ] FQHC

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

		1	2	
10	Does the facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate the number of other operations in column 2.			10

Facility hours of operations (1)

	Type of Operation	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	
11	Clinic															11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (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.

			1	2	
12	Have you received an approval for an exception to the productivity standard?				12
13	Is this a consolidated cost report in accordance with IOM CMS Pub. 100-04, Chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. 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

SKILLED NURSING FACILITY BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REAHBILITATION PROVIDER STATISTICAL DATA	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM ______________ TO ________________	WORKSHEET S-6

Check applicable box: [ ] CMHC [ ] CORF [ ] OPT [ ] OOT [ ] OSP

Enter the number of hours in your normal workweek ________

NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

		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	Other (specify)				19

FORM CMS-2540-10 (05/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4108)

PROSPECTIVE PAYMENT FOR SNF STATOSTOCA; DATA	PROVIDER CCN:	PERIOD : FROM ______________ TO ______________	WORKSHEET S-7

	GROUP	Days	
	1	2	
1	RUX		1
2	RUL		2
3	RVX		3
4	RVL		4
5	RHX		5
6	RHL		6
7	RMX		7
8	RML		8
9	RLX		9
10	RUC		10
11	RUB		11
12	RUA		12
13	RVC		13
14	RVB		14
15	RVA		15
16	RHC		16
17	RHB		17
18	RHA		18
19	RMC		19
20	RMB		20
21	RMA		21
22	RLB		22
23	RLA		23
24	ES3		24
25	ES2		25
26	ES1		26
27	HE2		27
28	HE1		28
29	HD2		29
30	HD1		30
31	HC2		31
32	HC1		32
33	HB2		33
34	HB1		34
35	LE2		35
36	LE1		36
37	LD2		37
38	LD1		38
39	LC2		39
40	LC1		40
41	LB2		41
42	LB1		42
43	CE2		43
44	CE1		44
45	CD2		45
46	CD1		46
47	CC2		47
48	CC1		48
49	CB2		49
50	CB1		50

FORM CMS-2540-10 (05/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4109)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER CCN:	PERIOD: FROM ________ TO __________	WORKSHEET S-7

	GROUP	Days	
	1	2	
51	CA2		51
52	CA1		52
53	SE3		53
54	SE2		54
55	SE1		55
56	SSC		56
57	SSB		57
58	SSA		58
59	IB2		59
60	IB1		60
61	IA2		61
62	IA1		62
63	BB2		63
64	BB1		64
65	BA2		65
66	BA1		66
67	PE2		67
68	PE1		68
69	PD2		69
70	PD1		70
71	PC2		71
72	PC1		72
73	PB2		73
74	PB1		74
75	PA2		75
76	PA1		76
99	AAA		99
100	Total		100

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. For lines 101 through 106: Enter in column 1 the amount of 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 1 column3. 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. (If column 2 is zero, enter N/A in column 3) (see instructions)

		Expenses	Percentage	Y/N	
		1	2	3	
101	Staffing				101
102	Recruitment				102
103	Retention of employees				103
104	Training				104
105	Other (Specify)				105
106	Total SNF revenue (Wkst. G-2, Pt. I, line 1, col. 3)				106

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4109 - 4109.1)

HOSPICE IDENTIFICATION DATA	PROVIDER CCN: HOSPICE *CCN*:	PERIOD : FROM ______________ TO ________________	WORKSHEET S - 8

PART I - ENROLLMENT DAYS

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col. 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 col. 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

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4110)