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
Expires: 12/31/2021

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. [ ] *Electronically prepared* cost report Date:_____ Time:_____	
	2. [ ] Manually *prepared* cost report	
	3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report.	
	3.01. [ ] No Medicare Utilization. Enter "Y" for yes or leave blank for no.	
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 _____ 12. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization

PART II - CERTIFICATION *OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR*

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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF *FACILITY*

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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR 1		*CHECKBOX* 2	*ELECTRONIC SIGNATURE STATEMENT*	
1				I have read and agree with the above certification statemen I certify that I intend my electronic signature on this certification be the legally binding equivalent of my signature.	*1*
2	*Signatory Printed Name*				*2*
3	*Signatory Title*				*3*
4	*Signature date*				*4*

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
		1	A 2	B 3		
1	SKILLED NURSING FACILITY					1
2	NURSING FACILITY					2
3	I C F / IID					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.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.