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/IID							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

2020 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/IID				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 "occurrence" policy? If the policy is "claims-made," enter 1. If the policy is "occurrence", 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