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

FORM CMS-2540-96 (5/06) (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)

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
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: Ifline 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 pevious 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