

IDENTIFICATION DATA	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2
---------------------	------------------------	-------------------------------------	---------------

SNF / SNF HEALTHCARE COMPLEX INFORMATION

		STREET ADDRESS	P O BOX	
		1	2	
1	ADDRESS LINE 1			1

		CITY	STATE	ZIP CODE	COUNTY	
		1	2	3	4	
2	ADDRESS LINE 2					2

	COMPONENT TYPE	COMPONENT NAME	CCN	CBSA	RURAL OR URBAN	DATE CERTIFIED MEDICARE	DATE CERTIFIED MEDICAID	
	1	2	3	4	5	6	7	
3	SNF							3
4	NF							4
5	ICF / IID							5
6	SNF-BASED HHA							6
7	SNF-BASED HOSPICE							7
8	OUTPATIENT REHAB (SPECIFY)							8

		FROM	TO	
		1	2	
9	COST REPORTING PERIOD			9

		TOC CODE	SPECIFY OTHER	
		1	2	
10	TYPE OF CONTROL			10

SNF ORGANIZATION AND OPERATION

11	Is the SNF a distinct part SNF that meets the requirements set forth in 42 CFR section 483.5?		1	11
12	Is the SNF a composite distinct part SNF that meets the requirements set forth in 42 CFR 483.5?			12

		COMPONENT NAME	STREET ADDRESS	P O BOX	CITY	STATE	ZIP CODE	
		1	2	3	4	5	6	
13	Non-contiguous component locations							13

		Y/N	DATE	V OR I	
		1	2	3	
14	COLUMN 1: Did the SNF terminate participation in the Medicare Program? COLUMN 2: Termination date. COLUMN 3: Voluntary (V) or involuntary (I) termination.				14
15	COLUMN 1: Did the SNF change ownership (CHOW) immediately prior to the beginning of the cost reporting period? COLUMN 2: CHOW date.				15

IDENTIFICATION DATA							PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2	
							1	2		
16	COLUMN 1: Is the SNF part of a HO/CO as defined in CMS Pub. 15-1, chapter 21, §2150? COLUMN 2: Enter the number of HO/COs allocating costs to this SNF.								16	
							1	2		
17	HO/CO ALLOCATING TO SNF	HO/CO NAME 1	STREET ADDRESS 2	P O BOX 3	CITY 4	STATE 5	ZIP CODE 6	HO/CO CCN 7	HO/CO CONTRACTOR # 8	17
18	Did the total number of available beds permanently maintained for lodging inpatients change from the prior cost reporting period?							1	18	
19	Did this SNF operate a ventilator care unit?								19	
SNF OWNED SERVICES								1	2	
20	COLUMN 1: Did the SNF and/or SNF-based HHA operate a Medicare approved laboratory with its own CLIA number or a CLIA certificate of waiver that meets the requirements in 42 CFR 493? COLUMN 2: Enter the CLIA ID number.								20	
21	Did the SNF operate a radiological department that meets the standards required of a hospital furnishing such services under the program at 42 CFR 482.26 or the standards to provide portable x-ray services?								21	
22	COLUMN 1: Did this SNF operate an institutional based ambulance service? COLUMN 2: Enter the ambulance provider number.								22	
23	Is this SNF involved in business transactions, including management contracts, with individuals or entities 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?							1	23	
PROFESSIONAL SERVICES PURCHASED BY THE SNF								1	2	
29	COLUMN 1: Did the SNF and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? COLUMN 2: Were the majority of the expenses (i.e., greater than 50 percent of the total professional services expenses) for services purchased from unrelated organizations located outside of the main hospital's local area labor market?								24	
SNF-BASED HHA THERAPY COSTS								1		
31	Did the SNF-based HHA contract with outside suppliers for physical therapy services?								31	
32	Did the SNF-based HHA contract with outside suppliers for occupational therapy services?								32	
33	Did the SNF-based HHA contract with outside suppliers for speech therapy services?								33	
MEDICAL MALPRACTICE COST								1	2	
34	Is the SNF legally required to carry malpractice insurance?								34	
35	If line 34 is Y, is the malpractice policy a claims-made or occurrence policy? Enter 1 for claims-made, or enter 2 for occurrence based policy.								35	
36	If line 34 is Y, enter the total amount of malpractice premiums paid in column 1, the total amount of paid losses in column 2, and the total amount of self-insurance paid in column 3.								36	
37	Are malpractice premiums and paid losses reported in other than the A&G cost center?								37	
LOWER OF COST OR CHARGE EXEMPTION								PART A	PART B	
							1	2		
40	Did the SNF qualify for an exemption from the application of the lower of costs or charges?								40	
41	Did the SNF-based HHA qualify for an exemption from the application of the lower of costs or charges?								41	

IDENTIFICATION DATA		PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2
---------------------	--	------------------------	-------------------------------------	---------------

FINANCIAL STATEMENTS		1	2	3	
50	COLUMN 1: Were the financial statements prepared by a CPA? COLUMN 2: If column 1 is Y, enter "A" for audited, "C" for complied, or "R" for reviewed in column 2. COLUMN 3: If complete copy of the financial statements not submitted with cost report, enter data available.				50
51	Do total expenses and total revenues reported on the cost report differ from those on the filed financial statements? If "Y", submit a reconciliation.				51

BAD DEBTS		1		
52	Is the SNF seeking reimbursement for Medicare bad debts?			52
53	If line 52 is Y, did the SNF change its bad debt collection policy during this cost reporting period?			53
54	If line 52 is Y, did the SNF waive patient deductibles and/or coinsurance?			54

PS&R REPORT DATA		PART A Y/N	PART A DATE	PART B Y/N	PART B DATE	
		1	2	3	4	
55	Is this cost report prepared using only the PS&R? 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.					55
56	Is this cost report prepared using the PS&R for totals and the provider's records to prepare this cost report in cols. 2 and 4?					56
57	If line 55 or 56 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?					57
58	If line 55 or 56 is Y, were adjustments made to PS&R data for corrections of other PS&R Report information?					58
59	If line 55 or 56 is Y, were adjustments made to PS&R data for other reasons? If Y, describe the other adjustment: _____					59
60	Is this cost report prepared using only the provider's records?					60

COST REPORT PREPARER CONTACT INFORMATION		FIRST NAME	LAST NAME	TITLE	
		1	2	3	
70	PREPARER				70
		NAME			
		1			
71	EMPLOYER				71
		TELEPHONE NUMBER	EMAIL ADDRESS		
		1	2		
72	CONTACT INFORMATION				72