

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. 0938-0050

HOSPITAL AND HOSPITAL 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 filed cost report
- 2. Manually submitted cost report
- 3. If this is an amended report enter the number of times the provider resubmitted this cost report
- 4. Medicare Utilization. Enter "F" for full or "L" for low.

Date: _____ Time: _____

Contractor use only

- 5. Cost Report Status
 - (1) As Submitted
 - (2) Settled without audit
 - (3) Settled with audit
 - (4) Reopened
 - (5) Amended
- 6. Date Received: _____
- 7. Contractor No.: _____
- 8. Initial Report for this Provider CCN
- 9. Final Report for this Provider CCN

This is the "official" date and time used for this filed cost report. This will impact the date and time of eligibility of clinics, as well as the termination information.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE CAUSAL TO CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A FEDERAL AGENCY, ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 Number(s)) for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, it is a true, correct and complete statement 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 identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1	HOSPITAL					1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF					5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC					10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)					12
200	TOTAL					200

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 0938-0050. The time required to complete this information collection is estimated 673 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.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 4003.1-4003.3)