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
EXPIRES 09-30-2025

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 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
4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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
10. NPR Date:_____
11. Contractor's Vendor Code: _____
12. [ ] If line 5, column 1, is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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 OR PROCURED 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 PROVIDER(S)

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 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, 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	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name:			2
3	Signatory Title:			3
4	Signature date:			4

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL						1
1.01	HOSPITAL-PARHM						1.01
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING-BED SNF						5
5.01	SWING-BED PARHM (CAH ONLY)						5.01
6	SWING-BED NF						6
7	SNF						7
8	NF, ICF/IID						8
9	HOME HEALTH AGENCY						9
10	HOSPITAL-BASED RHC						10
11	HOSPITAL-BASED 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.