4004. WORKSHEET S-2 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

This worksheet consists of two parts:

Part I - Hospital and Hospital Health Care Complex Identification Data
Part II - Hospital and Hospital Health Care Complex Reimbursement Questionnaire

4004.1 Part I - Hospital and Hospital Health Care Complex Identification Data.--The information required on this worksheet is needed to properly identify the provider. The responses to all lines are Yes or No unless otherwise indicated.

Line descriptions

Lines 1 and 2--Enter the street address, post office box (if applicable), the city, state, ZIP code, and county of the hospital.

Lines 3 through 18--Enter on the appropriate lines and columns indicated the component names, CMS certification numbers (CCN), core based statistical area (CBSA) codes of the physical location of the provider's primary operations (non-CBSA (rural) codes are assembled by placing the digits "999" in front of the two-digit state code, e.g., for the State of Maryland the non-CBSA code is 99921), provider type, and certification dates of the hospital and its various components, if any. Indicate for each health care program (titles V, XVIII, or XIX), the payment system applicable to the hospital and its various components by entering P, T, O, or N in the appropriate column to designate PPS, TEFRA, OTHER, or NOT APPLICABLE, respectively. The "PPS" payment systems include the Inpatient Prospective Payment System (IPPS), the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS), the Long Term Care Hospital Prospective Payment System (LTCH PPS) and the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), and the Rural Emergency Hospital (REH) Outpatient Prospective Payment System (OPPS). The "TEFRA" payment system includes long term care hospitals (LTCH) classified as extended neoplastic disease care hospitals (previously referred to as "subclause (II)" LTCHs), children's hospitals, cancer hospitals, Religious Non-Medical Health Care Institutions (RNHCIs), and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (i.e., hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). The "OTHER" payment system includes cost reimbursed hospitals such as critical access hospitals (CAHs) and new TEFRA hospitals exempt from the rate of increase limits.

Column 4--Indicate, as applicable, the number listed below which best corresponds with the type of services provided.

1 = General Short Term (includes CAHs)
2 = General Long Term
3 = Cancer
4 = Psychiatric
5 = Rehabilitation
6 = Religious Non-Medical Health Care Institution
7 = Children
8 = Reserved for future use
9 = Other
10 = Extended Neoplastic Disease Care
11 = Indian Health Service
12 = Rural Emergency Hospital

If your hospital services various types of patients, indicate "General - Short Term" or "General - Long Term," as appropriate.

NOTE: LTCHs are hospitals organized to provide long term treatment programs with average lengths of stay greater than 25 days. Some hospitals may be certified as other than LTCHs, but also have average lengths of stay greater than 25 days.

If your hospital cares for only a special type of patient (such as cancer patients), indicate the special group served. If you are not one of the hospital types described in items 1 through 8 above, indicate 9 for "Other."

Line 3--This is an institution which meets the requirements of §1861(e) or §1861(mm)(1) of the Act and participates in the Medicare program or is a federally controlled institution approved by CMS.

Line 4--The distinct part IPF is a portion of a hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient psychiatric PPS. Effective for cost reporting periods beginning on or after October 1, 2019, an IPF is permitted to have an IRF subunit, however, an IPF may not have an IPF subunit. (See 42 CFR 412.25(d).)

Line 5--The distinct part IRF is a portion of a hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient rehabilitation PPS. Effective for cost reporting periods beginning on or after October 1, 2019, an IRF is permitted to have an IPF subunit, however, an IRF may not have an IRF subunit. (See 42 CFR 412.25(d).)

Line 6--This is a portion of a general hospital defined as non-Medicare certified and not included in lines 4 through 18, which offers a clearly different type of service from the remainder of the hospital.

Line 7--Medicare swing-bed services are paid under the skilled nursing facility (SNF) PPS system (indicate payment system as "P"). CAHs are reimbursed on a cost basis for swing-bed services and should indicate "O" as the payment system. Rural hospitals with fewer than 100 beds may be approved by CMS to use these beds interchangeably as hospital and skilled nursing facility beds with payment based on the specific care provided, as authorized by §1883 of the Act. (See CMS Pub. 15-1, chapter 22, §§2230-2230.6.)

Line 8--Swing-bed NF services are not payable under the Medicare program but are payable under State Medicaid programs if included in the Medicaid State plan. Rural hospitals with fewer than 100 beds that have a Medicare swing-bed agreement approved by CMS and that are approved by the State Medicaid agency to use these beds interchangeably as hospital and other nursing facility beds, with payment based on the specific level of care provided, as authorized by §1913 of the Act.

Line 9--This is a distinct part SNF (including a distinct part SNF based in a REH) that has been issued an SNF identification number and which meets the requirements of §1819 of the Act. A hospital complex cannot contain more than one hospital-based SNF (includes a composite distinct part) or hospital-based NF. (See 42 CFR 483.5(2)(v).)

Line 10--This is a distinct part nursing facility which has been issued a separate identification number and which meets the requirements of §1905 of the Act. (See 42 CFR 441.400 for standards for other nursing facilities, for other than facilities for individuals with intellectual disabilities, and for facilities for individuals with intellectual disabilities.) If your State recognizes only one level of care (i.e., skilled), do not complete any lines designated as NF and report all activity on the SNF line for all programs. The NF line is used by facilities having two levels of care (i.e., either 100 bed facility all certified for NF and partially certified for SNF or 50 beds certified for SNF only and 50 beds certified for NF only). The contractor will reject a cost report attempting to report more than one nursing facility.

If the facility operates an intermediate care facility for individuals with intellectual disabilities (ICF/IID), subscript line 10 to 10.01 and enter the data on that line. Note: Subscripting is allowed only for the purpose of reporting an ICF/IID.

Line 11--This is any other hospital-based long term care facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX. The data on this line cannot be used for Medicare reimbursement. Treat this as a nonreimbursable cost center since it is not part of the Medicare certified hospital.

Line 12--This is a distinct part HHA that has been issued an HHA identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one hospital-based HHA, subscript this line, and report the required information for each HHA.

Line 13--This is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and which meets the conditions for coverage in 42 CFR 416, Subpart B. The ambulatory surgery center (ASC) operated by a hospital must be a separately identifiable entity which is physically, administratively, and financially independent and distinct from other operations of the hospital. (See 42 CFR 416.30(f).) Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible. (See 42 CFR 416.120(a).)

Line 14--This is a distinct part hospice and separately certified component of a hospital which meets the requirements of §1861(dd) of the Act. No payment designation is required in columns 6, 7, and 8.

Lines 15 and 16--Enter the applicable information for hospital-based rural health clinics (RHCs) on line 15 and for hospital-based federally qualified health centers (FQHCs) on line 16. These lines are used by hospital-based RHCs and/or FQHCs which have been issued a CCN and meet the requirements of §1861(aa) of the Act. If you have more than one hospital-based RHC, report them on subscripts of line 15. If you have more than one hospital-based FQHC, report them on subscripts of line 16. Report the required information in the appropriate column for each.

Hospital-based RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-02 (Medicare Claims Processing Manual), chapter 13, §80.2. Do not subscript lines 15 or 16 to report RHCs or FQHCs affiliated with the consolidated group that elects to file under the consolidated cost reporting method; report only the hospital-based primary RHC and/or hospital-based primary FQHC of the consolidated group on lines 15 and/or 16, as applicable. A new RHC/FQHC that begins after the start of a cost reporting period cannot be added to the consolidated worksheets until the subsequent full cost reporting period. A written request to consolidate the new RHC/FQHC must be submitted to the contractor in advance of the reporting period and must be approved by the contractor prior to the start of the reporting period to be reported as consolidated. In order to qualify for consolidated reporting, all RHCs/FQHCs in the group must be owned, leased, or through any other device, controlled by one organization. Once the election to use a consolidated cost report is made, the RHC/FQHC may not revert to individual reporting without the prior approval of the contractor. See §§4010 and 4010.1 for further instructions.

Line 17--This line is used by hospital-based community mental health centers (CMHCs). Subscript this line as necessary to accommodate multiple CMHCs (lines 17.00 through 17.09). Also subscript this line to accommodate CORFs (lines 17.10 through 17.19), OPTs (lines 17.20 through 17.29), OOTs (lines 17.30 through 17.39) and OSPs (line 17.40 through 17.49). (See §4095, Exhibit 2, Table 4, Part III.)

Line 18--If this facility operates a renal dialysis facility (CCN XX-2300 through XX-2499), a renal dialysis satellite (CCN XX-3500 through XX-3699), and/or a special purpose renal dialysis facility (CCN XX-3700 through XX-3799), enter in column 2 the applicable CCN. Subscript this line as applicable.

Line 19--For any component type not identified on lines 3 through 18, enter the required information in the appropriate column.

Line 20--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12-month period of your operations. (See CMS Pub. 15-2, chapter 1, §§102.1-102.3, for situations where you may file a short period cost report.)

Line 21--Indicate the type of control under which the hospital operates:

1 = Voluntary Nonprofit, Church	8 = Governmental, City-County
2 = Voluntary Nonprofit, Other	9 = Governmental, County
3 = Proprietary, Individual	10 = Governmental, State
4 = Proprietary, Corporation	11 = Governmental, Hospital District
5 = Proprietary, Partnership	12 = Governmental, City
6 = Proprietary, Other	13 = Governmental, Other
7 = Governmental, Federal	

Line 22--Does your facility qualify and is it currently receiving payments for disproportionate share (DSH) hospital adjustment, in accordance with 42 CFR 412.106? Enter in column 1, "Y" for yes or "N" for no. Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle Amendment hospitals)? Enter in column 2, "Y" for yes or "N" for no.

Line 22.01--For cost reporting periods that overlap or begin on or after October 1, 2013, did this hospital receive interim uncompensated care payments (UCPs), including supplemental UCPs as described in 42 CFR 412.106(h)? Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period beginning on or after October 1. For cost reporting periods that begin on October 1, enter "N" for no in column 1 and complete column 2; however, when the cost reporting period begins on October 1 and overlaps October 1 of the subsequent year, complete column 1 for the first period (October 1 through September 30) and complete column 2 for the remainder of the cost reporting period.

Line 22.02--Is this a newly merged hospital that requires final UCPs to be determined at cost report settlement? Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on and after October 1. For a newly merged hospital as defined in the IPPS FY 2015 final rule, 79 FR 50022 (August 22, 2014), the final Factor 3 would be recalculated based on the Medicaid days and SSI days reported on the cost report used for the applicable fiscal year since the Factor 3 that was published in the final rule did not reflect the merger. For example, for a newly merged hospital that merged in FY 2015, the numerator of its Factor 3 would be recalculated based on the FY 2015 SSI days and the Medicaid days reported on its 2015 cost report. See 79 FR 50021 (August 22, 2014).

For the purpose of this question, a merger is defined as an acquisition where the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider. We would not consider a merger to be an acquisition where a new owner voluntarily terminates the provider agreement of the hospital it purchased by rejecting assignment of the previous owner's provider agreement.

Line 22.03--For cost reporting periods ending on or after October 1, 2014, and before October 1, 2016, 42 CFR 412.102 provides for a 2-year transition to a rural DSH payment amount from an urban DSH payment amount, for hospitals that received a geographic reclassification from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY 2015. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2015 and 1/3 of the difference between the urban and rural operating DSH for FY 2016. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY 2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Does this hospital contain at least 100, but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Line 22.04--For cost reporting periods ending on or after October 1, 2020, and before October 1, 2022, the FY 2021 IPPS final rule (CMS-1735-F; 85 FR 58746, September 18, 2020) provides for a 2-year transition (in accordance with 42 CFR 412.102) to a rural DSH payment

amount from an urban DSH payment amount, for hospitals that received a geographic reclassification from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY 2021. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2021 and 1/3 of the difference between the urban and rural operating DSH for FY 2022. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Does this hospital contain at least 100, but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Line 23--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2, "Y" for yes or "N" for no.

NOTE **FOR LINES 24 AND 25:** Columns 1 through 6 are mutually exclusive. For example, if patient days are entered in column 1, those days may not be entered in any other column. Effective for cost reporting periods beginning on or after October 1, 2018, a cost report will be rejected when submitted without listings supporting the DSH eligible days reported on lines 24 and 25 (42 CFR 413.24(f)(5)). Exhibit 3A presents the standardized format for the information required for cost reporting periods beginning on or after October 1, 2022, to support the DSH eligible days reported (see 42 CFR 412.106(b)(4), and exhibit for instructions and listing presented at the end of §4004.1.) Submit separate listings for the DSH eligible days reported on lines 24 and 25. Report days for each column as follows:

Column 1: Enter the number of in-state Medicaid paid days. An in-state Medicaid paid day is an in-state day of inpatient care furnished to a patient eligible for inpatient benefits under an approved State Medicaid plan or eligible for inpatient benefits, or regarded as such, under a waiver authorized under section 1115(a)(2) of the Act on that day and for which the hospital received payment from Medicaid. These patients cannot also be entitled to Medicare Part A.

Column 2: Enter the number of in-state Medicaid eligible unpaid days. An in-state Medicaid eligible unpaid day is an in-state day of inpatient care furnished to a patient eligible for inpatient benefits under an approved State Medicaid plan or eligible for inpatient benefits, or regarded as such, under a waiver authorized under section 1115(a)(2) of the Act on that day and for which the hospital has not received payment from Medicaid. These patients cannot also be entitled to Medicare Part A. Reasons for non-payment could be related to the provider not billing timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party.

Column 3: Enter the number of out-of-state Medicaid paid days. An out-of-state Medicaid paid day is an out-of-state day of inpatient care furnished to a patient eligible for inpatient benefits under an approved State Medicaid plan or eligible for inpatient benefits, or regarded as such, under a waiver authorized under section 1115(a)(2) of the Act on that day and for which the hospital received payment from Medicaid. These patients cannot also be entitled to Medicare Part A.

Column 4: Enter the number of out-of-state Medicaid eligible unpaid days. An out-of-state Medicaid eligible unpaid day is an out-of-state day of inpatient care furnished to a patient eligible for inpatient benefits under an approved State Medicaid plan or eligible for inpatient benefits, or regarded as such, under a waiver authorized under section 1115(a)(2) of the Act on that day and for which the hospital has not received payment from Medicaid. These patients cannot also be entitled to Medicare Part A. Reasons for non-payment could be related to the provider not billing timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party.

Column 5: Enter the number of Medicaid health maintenance organization (HMO) days, both in-state and out-of-state. A Medicaid HMO day is a paid and/or eligible but unpaid day of inpatient care furnished to a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under title XIX through a HMO or a managed care organization (MCO). These patients cannot also be entitled to Medicare Part A.

Column 6: Enter other Medicaid days. Other Medicaid days are only labor and delivery days reported on Worksheet S-3, Part I, column 7, line 32.

Line 24--If line 23, column 1, is "3" and this is an IPPS provider, enter the in-state Medicaid paid days in column 1 (report these days on Worksheet S-3, Part I, column 7, line 1, and lines 8 through 13, as applicable), the in-state Medicaid eligible but unpaid days in column 2 (report these days on Worksheet S-3, Part I, column 7, line 2, for adult and pediatric patients and line 13 for nursery patients, as applicable), the out-of-state Medicaid paid days in column 3 (report these days on Worksheet S-3, Part I, column 7, line 2, for adult and pediatric patients and line 13 for nursery patients, as applicable), the out-of-state Medicaid eligible but unpaid days in column 4 (report these days on Worksheet S-3, Part I, column 7, line 2, for adult and pediatric patients and line 13, for nursery patients, as applicable), the in-state and out-of-state Medicaid HMO paid and in-state and out-of-state Medicaid HMO eligible but unpaid days in column 5 (report these days on Worksheet S-3, Part I, column 7, line 2, for adult and pediatric patients and line 13, for nursery patients, as applicable). Enter only labor and delivery days (reported on Worksheet S-3, Part I, column 7, line 32) as "Other Medicaid days" in column 6. If line 23, column 1, is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I. Do not include swing-bed, observation or hospice days in any columns on this line. See 42 CFR 412.106(a)(1)(ii) and 412.106(b)(4).

Line 25--If line 23, column 1, is "3" and this provider is an IRF or contains an IRF unit, enter the in-state Medicaid paid days in column 1, (report IRF days on Worksheet S-3, Part I, column 7, line 1, or IRF unit days on Worksheet S-3, Part I, column 7, line 17), the in-state Medicaid eligible but unpaid days in column 2 (report IRF days on Worksheet S-3, Part I, column 7, line 2, or IRF unit days on Worksheet S-3, Part I, column 7, line 4), the out-of-state Medicaid paid days in column 3 (report IRF days on Worksheet S-3, Part I, column 7, line 2, or IRF unit days on Worksheet S-3, Part I, column 7, line 4), the out-of-state Medicaid eligible but unpaid days in column 4 (report IRF days on Worksheet S-3, Part I, column 7, line 2, or IRF unit days on Worksheet S-3, Part I, column 7, line 4), the in-state and out-of-state Medicaid HMO paid and in-state and out-of-state Medicaid HMO eligible but unpaid days in column 5 (report IRF days on Worksheet S-3, Part I, column 7, line 2, or IRF unit days on Worksheet S-3, Part I, column 7, line 4). Do not enter any days in column 6 for cost reporting periods beginning on or after October 1, 2012. If line 23, column 1, is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I. Do not include swing-bed, observation or hospice days in any columns on this line.

Line 26--For the Standard geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.

Line 27--For the Standard geographic classification (not wage), what is your status at the end of the cost reporting period. Enter "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.

Lines 28 through 34--Reserved for future use.

Line 35--If this is a sole community hospital (SCH), enter the number of periods (0, 1, or 2) within this cost reporting period that SCH status was in effect.

Line 36--Enter the beginning and ending dates of SCH status during this cost reporting period. Subscript line 36 if more than one period is identified for this cost reporting period and enter multiple dates. Multiple dates are created where there is a break in the date between SCH status (i.e., for calendar year provider SCH status dates are 1/1/2010 through 6/30/2010 and 9/1/2010 through 12/31/2010).

Line 37--If this is a Medicare-dependent, small rural hospital (MDH), enter the number of periods within this cost reporting period that MDH status was in effect.

Line 37.01--Did this hospital lose their MDH status because they are no longer in a rural area due to the implementation of the new OMB delineations in FY 2015, and they did not reclassify from urban to rural under the regulations at §412.103 before January 1, 2016? Enter "Y" for yes or "N" for no. If yes, calculate the MDH transition payment on Worksheet E, Part A, for portions of the current cost reporting period that overlap or fall within January 1, 2016, and September 30, 2017. Do not respond to this question for cost reporting periods that begin on or after October 1, 2017.

Line 38--If line 37 is 1, enter the beginning and ending date of MDH status during this cost reporting period. If line 37 is greater than 1, subscript this line and enter the applicable beginning and ending dates accordingly.

Line 39--For cost reporting periods that overlap or begin on or after October 1, 2010, does the hospital qualify for the inpatient hospital adjustment for low-volume hospitals for a portion of the cost reporting period? Enter in column 1 "Y" for yes or "N" for no. If column 1 is "Y", does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2, "Y" for yes or "N" for no. Hospitals are required to request low-volume status in writing to their contractor and provide documentation that they meet the mileage criteria.

The response to these questions determines the completion of the low-volume calculation adjustment.

NOTE: 42 CFR 412.101(c)(1) provides for a low-volume adjustment for qualifying hospitals for federal fiscal years (FFYs) 2005 through 2010, and FFY 2025 and subsequent federal fiscal years. Qualifying hospitals, those hospitals more than 25 road miles from the nearest subsection (d) hospital and with fewer than 200 total discharges, receive a payment adjustment of an additional 25 percent for each Medicare discharge.

42 CFR 412.101(c)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2011 through 2018:

- Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each Medicare discharge; and,
- Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each Medicare discharge. This adjustment is calculated using the formula [(4/14) - (Medicare discharges/5600)].

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- Be more than 15 road miles from the nearest subsection (d) hospital; and,
- Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data as determined by CMS.

42 CFR 412.101(c)(3) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2019 through FFY 2024 as follows:

- Those hospitals with 500 or fewer total discharges will receive an adjustment of an additional 25 percent for each Medicare discharge; and,
- Those with more than 500 and fewer than 3,800 total discharges will receive an adjustment of an additional percentage for each Medicare discharge. This adjustment is calculated using the formula [(95/330) - (total discharges/13,200)].

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- Be more than 15 road miles from the nearest subsection (d) hospital; and,
- Have fewer than 3,800 total discharges based on the hospital's most recently submitted cost report.

Line 40--Section 3008 of the Affordable Care Act (ACA 2010) established the Hospital Acquired Condition (HAC) Reduction Program, beginning in FFY 2015. Enter in column 1, "Y" for yes or "N" for no if your hospital is subject to the HAC reduction adjustment for discharges occurring prior to October 1. For cost reporting periods that overlap October 1, 2014, enter "N" in column 1. Enter in column 2, "Y" for yes or "N" for no if your hospital is subject to the HAC reduction adjustment for discharges occurring on or after October 1.

Lines 41 through 44--Reserved for future use.

Line 45--Does your facility qualify and receive capital payments for disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no.

Line 46--Are you eligible for the exception payment for extraordinary circumstances pursuant to 42 CFR 412.348(f)? Enter "Y" for yes or "N" for no. If yes, complete Worksheets L, Part III, and L-1.

Line 47--Is this a new hospital under 42 CFR 412.300(b) (PPS capital)? Enter "Y" for yes or "N" for no for the respective programs.

Line 48--If line 47 is yes, do you elect full federal capital payment? Enter "Y" for yes or "N" for no for the respective programs.

Lines 49 through 55--Reserved for future use.

NOTE: CAHs complete question 107 in lieu of question 57.

Line 56--Is this a hospital involved in training residents in approved graduate medical education (GME) programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), a hospital must enter "Y" for yes and report FTE residents on Worksheet E-4 if the hospital trained at least 1.0 FTE in an approved program(s) in the cost reporting period. Additionally, if the hospital trained less than 1.0 FTE residents in an approved program(s) and this training resulted from the hospital's participation in a Medicare GME affiliation agreement (as defined under 42 CFR 413.75(b)), then the hospital must also enter "Y" for yes and report FTE residents on Worksheet E-4. The BBRA provided that payments that are made to teaching hospitals for costs of direct GME associated with services to Medicare Advantage (MA) enrollees will be reduced by an estimated percentage in each calendar year (CY). For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and you are impacted by Change Request (CR) 11642 (or applicable CRs) MA direct GME payment reduction, enter "Y" for yes; otherwise, enter "N" for no in column 2.

Line 57--For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period in which you are training residents in approved programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, were residents training during the first month of the cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is yes, complete Worksheet E-4. If column 2 is "N", complete Worksheets D, Parts III and IV, and D-2, Part II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56, column 1, is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Line 58--If line 56, column 1, is "Y" for yes, did you elect cost reimbursement for physician direct medical and surgical services as defined in 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-5.

Line 59--Are you claiming costs of interns and residents (I&R) in unapproved programs on Worksheet A, column 7, line 100? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-2, Part I.

Line 60--Are you claiming nursing and allied health education (NAHE) costs for any programs approved in accordance with 42 CFR 413.85(e)? Enter "Y" for yes or "N" for no in column 1. If your hospital does not have an approved NAHE program that meets the criteria in 42 CFR 413.85(e), or if all the NAHE costs are for educational activities treated as normal operating costs as defined in 42 CFR 413.85(h)(6), enter "N" for no. Additionally, 42 CFR 413.87 provides for additional payments to hospitals for costs of NAHE services to MA enrollees. If the response to column 1 is "Y", are you impacted by CR 11642 (or applicable CRs) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If the response to line 60 is no, do not complete subscripts for line 60.

Effective for cost reporting periods ending on or after September 30, 2017, if the response to line 60, column 1, is yes, subscript this line for each program, beginning with line 60.01. Enter in column 2, the Worksheet A line number on which the costs of the NAHE program were reported. Enter in column 3, the appropriate code that identifies the criterion under which the NAHE program costs qualify for pass-through payment or are treated as normal operating costs. Select from the following list:

(1) - NAHE program is a provider operated program that meets the criteria under 42 CFR 413.85(f).
(2) - NAHE program is a nonprovider operated program that meets the criteria under 42 CFR 413.85(g)(2). However, under 42 CFR 413.85(g)(2)(iii), the pass-through costs are limited to the percentage of total allowable provider cost attributable to NAHE clinical training costs reported in the most recent cost reporting period ending on or before October 1, 1989.
(3) - NAHE program is a nonprovider operated program that meets the criteria under 42 CFR 413.85(g)(3).
(4) - NAHE program is a nonprovider operated program where costs are treated as normal operating costs under 42 CFR 413.85(h)(6).

For each subscript of line 60 beginning with line 60.01, if the entry in column 3 is "1", "2", or "3", report the NAHE program costs in the applicable column of Worksheet D, Parts III and IV, to separately identify nursing program and allied health education costs from all other medical education costs. For any subscript of line 60 where the entry in column 3 is "4", do not transfer the costs to Worksheet D, Part III, or Part IV.

Requirements During Five Year Period Following Implementation of Increases to Hospitals' FTE Resident Caps Under Section 5503 of the Affordable Care Act (ACA), Line 61 and Subscripts--Section 5503 of the ACA states that a hospital that receives an increase to its FTE resident cap under section 5503 shall ensure, during the 5-year period beginning on July 1, 2011, that:

(I) The number of FTE primary care residents is not less than the average number of FTE primary care residents during the three most recent cost reporting periods ending prior to the date of enactment of section 5503; and,

(II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency.

Failure to comply with either of these two requirements, known as the 3-year primary care average requirement (I) and the 75 percent test (II), means permanent removal of all section 5503 slots from the earliest applicable cost reporting period under the regulations at 42 CFR 413.79(n)(2).

Line 61--Did your hospital receive FTE slots under section 5503 of the ACA? Enter "Y" for yes or "N" for no in column 1. If "Y", enter the number of IME section 5503 slots awarded in column 4 and direct GME section 5503 slots awarded in column 5. The number of IME and/or direct GME slots entered here should be the amounts on the award letter from CMS. Complete the subscripts of line 61 for portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016. If "N" for no, do not complete columns 4 or 5 and subscripts of line 61.

NOTE: Effective for portions of cost reporting periods occurring on or after July 1, 2011, do not complete line 61, columns 2 and 3. This information is now reported on line 61.01, columns 2 and 3.

Line 61.01--Effective for portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016, enter the average unweighted number of primary care FTE residents from the hospital's three most recent cost reports ending and submitted to the contractor before March 23, 2010. See 42 CFR 413.75(b) for the definition of "primary care resident". Enter the 3-year primary care average for IME in column 2. The source of the primary care IME FTE residents is the rotation schedules submitted by the provider to support its cost reports for the three most recent cost reports ending and submitted to the contractors prior to March 23, 2010. Any audit adjustments to these IME primary care FTE residents must be taken into account in computing the 3-year average. Exclude OB/GYN and general surgery FTE residents. This primary care average is based on the hospital's total primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If any of the three cost reports is not a 12-month cost report, enter the 12-month equivalent FTE count.

Enter the average unweighted number of primary care FTE residents for direct GME in column 3. This primary care average is based on the hospital's total unweighted primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If the hospital did not train any OB/GYN residents in its three most recent cost reports ending and submitted prior to March 23, 2010, convert the weighted primary care FTE counts from line 3.19 of Worksheet E-3, Part IV, of Form CMS-2552-96, to unweighted FTE counts, compute a 3-year average, and report the average in column 3. If the hospital did train OB/GYN FTE residents in its three most recent cost reports ending and submitted prior to March 23, 2010, subtract the OB/GYN FTE counts from line 3.19 of Worksheet E-3, Part IV, of Form CMS-2552-96, convert the remaining primary care FTE counts to unweighted FTE counts, compute a 3-year average, and report the average in column 3. Exclude general surgery FTE residents. If any of the three cost reports is not a 12-month cost report, enter the 12-month equivalent FTE count.

Line 61.02--Enter the current cost reporting period total unweighted primary care FTE count (excluding obstetrics and gynecology and general surgery), which is used to determine compliance with the 3-year primary care average requirement. In accordance with section 5503 of the ACA, which states that the 3-year primary care average requirement must be met by "excluding any additional positions" added as a result of the section 5503 FTE cap increase, also exclude from this unweighted primary care FTE count any primary care FTEs added in the current cost reporting period specific to new or expanded programs under section 5503 (see 75 FR 72198-72199 dated November 24, 2010). Enter the unweighted IME FTE count in column 2 and the direct GME FTE count in column 3. If the current cost report is not a 12-month cost report, enter the 12-month equivalent FTE count. These current cost reporting period unweighted primary care FTE counts are compared to the 3-year primary care average amounts in line 61.01.

Line 61.03--Enter the baseline FTE count for primary care and/or general surgery residents that is used for determining compliance with the 75 percent requirement. These primary care and/or general surgery FTEs would be a part of the unweighted allopathic and osteopathic FTE count from the hospital's 12-month (or prorated equivalent) cost report that immediately precedes the cost report that includes July 1, 2011. Report the IME primary care and/or general surgery baseline FTE count in column 2 and the direct GME baseline primary care and/or general surgery FTE count in column 3. (For example, the baseline cost report for June 30 providers would be July 1, 2010 through June 30, 2011; for December 31 providers, this would be January 1, 2010, through December 31, 2010; for September 30 providers, this would be October 1, 2009 through September 30, 2010). (On the Form CMS-2552-96, the baseline FTE primary care and/or general surgery count is included and commingled in the allopathic and osteopathic FTEs reported on line 3.08 of Worksheet E, Part A, and on line 3.05 of Worksheet E-3, Part IV. On the Form CMS-2552-10, the baseline primary care and/or general surgery FTE count is included and commingled in the allopathic and osteopathic FTEs reported on line 10 of Worksheet E, Part A, and on line 6 of Worksheet E-4). Use the rotation schedules from the hospital's 12-month (or prorated equivalent) cost report that immediately precedes the cost report that includes July 1, 2011, as the source for the primary care and/or general surgery FTEs.

Line 61.04--Enter the total number of unweighted primary care and/or general surgery allopathic and/or osteopathic FTEs in the current cost reporting period. If the cost report is not a 12-month cost report, enter the 12-month equivalent FTE count. Exclude OB/GYN FTEs. (These FTEs are part of the current year FTE count, and are included on Form CMS-2552-10, line 10 of Worksheet E, Part A, and line 6 of Worksheet E-4). Report the unweighted IME FTE count in column 2 and the direct GME FTE count in column 3.

Line 61.05--Determination of Compliance with 75 Percent Requirement--For portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016, enter the difference between the baseline primary care and/or general surgery FTE counts and the current year primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). Report the IME FTE count difference in column 2 and the direct GME FTE count difference in column 3. (If the difference is less than or equal to zero, enter a zero).

The section 5503 FTE cap slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (direct GME), are dependent upon this difference on line 61.05 (for portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016), because of the requirement that 75 percent of the section 5503 FTE cap award be **used** for primary care and/or general surgery FTEs in new or expanded programs. If the difference on line 61.05 is greater than zero, then it must be at least 75 percent of the section 5503 FTE cap award to be reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME). For example, if a hospital was awarded a total of 10 slots, but the difference reported on line 61.05 is 5, then the section 5503 FTE slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME), cannot be more than 6.67 (that is, 5 divided by 75 percent). Therefore, determine that the difference on line 61.05 is at least 75 percent of the section 5503 award amount that is reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME).

Line 61.06--Enter the amount of the ACA section 5503 award FTEs that are being used for cap relief, if any, and/or that are nonprimary care or non-general surgery FTEs. Report the IME amount in column 2 and the direct GME amount in column 3. For portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016, the amount reported on this line can be no more than 25 percent of the section 5503 FTE cap slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME). If the amount on line 61.05, columns 2 or 3, is greater than or equal to the section 5503 cap award reported on line 61, columns 4 or 5, respectively, report zero on this line.

If the amount on line 61.05 is less than the section 5503 cap award, and the hospital either is training FTE residents over its existing FTE cap or has added nonprimary care and non-general surgery FTEs in the current cost reporting period, report on this line the difference of the section 5503 cap slots on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME), and the amount reported on line 61.05. For example, if a hospital was awarded a total of 10 slots, and 5 is reported on line 61.05, and the section 5503 FTE slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME) is 6.67 FTEs, then the amount reported on line 61.06 cannot exceed 1.67 FTEs which is the difference between the amount on line 61.05, and the amount reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME). If 10 is reported on line 61.05, then report 0 (zero) on line 61.06. If 8 is reported on line 61.05 and the hospital added 2 or more nonprimary care FTEs in the current cost reporting period, then report 2 on this line.

Lines 61.07 through 61.09--Reserved for future use.

Line 61.10--Of the FTEs in line 61.05, specify each new primary care or general surgery program specialty, if any, and the number of FTE residents for each new program. Use subscripted lines 61.11 through 61.19 for each additional new program. Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 the direct GME FTE unweighted count.

Line 61.20--Of the additional FTEs in line 61.05, specify each expanded primary care or general surgery program specialty, if any, and the number of FTE residents for each program expansion. Use subscripted lines 61.21 through 61.29 for each additional program expansion. Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 the direct GME FTE unweighted count.

Lines 62 and 62.01--Provisions Affecting the Health Resources and Services Administration (HRSA)--These provisions are effective for the Health Resources and Services Administration (HRSA) Primary Care Residency Expansion (PCRE) program and the Teaching Health Center (THC) program.

Line 62--Effective for services rendered on or after September 30, 2010, enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (Sections 4002 and 5301 of the ACA.)

Line 62.01--Effective for services rendered on or after October 1, 2010, enter the number of FTE residents that rotated from a THC into your hospital during this cost reporting period under the HRSA THC program. (Section 5508 of the ACA and §301(c) of the Consolidated Appropriations Act of 2021 (CAA 2021).)

Line 63--Has your facility trained residents in a nonprovider setting during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. (See 75 FR 72139-72140 (November 24, 2010).) If column 1 is "Y" for yes, complete lines 64 through 67 and applicable subscripts. If "N" for no, but your facility trained residents in a nonprovider setting during the base year period (cost reporting period that begins on or after July 1, 2009, and before June 30, 2010), complete lines 64 and 65, and applicable subscripts effective for cost reporting periods beginning on or after July 1, 2010.

Lines 64 and 65--Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--The base year is your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010.

Line 64--If line 63 is yes or your facility trained residents in the base year period, enter in column 1, for cost reporting periods that begins on or after July 1, 2009, and before June 30, 2010, the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2, the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.

Line 65--If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. (See 42 CFR 413.75(b) for the definition of "primary care resident.") Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5, the ratio of column 3 divided by the sum of columns 3 and 4. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.

NOTE: The sum of the FTE counts on line 64, columns 1 and 2, and line 65, columns 3 and 4, should approximate the sum of the FTE counts on Form CMS-2552-96, Worksheet E-3, Part IV, lines 3.05 and 3.11, for your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.

Lines 66 and 67--Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010.

Line 66--If line 63 is yes, enter in column 1, the unweighted number of nonprimary care FTE residents attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number of unweighted nonprimary care FTE residents in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.

Line 67--If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5, the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program.

If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.

NOTE: The sum of the FTE counts on line 66, columns 1 and 2, and line 67, columns 3 and 4, should approximate the sum of the FTE counts on Worksheet E-4, lines 6 and 10, for this current cost reporting period.

Line 68--For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the DGME formula in accordance with the FY 2023 IPPS final rule, 87 FR 49065-49072 (August 10, 2022)? Enter "Y" for yes; otherwise, enter "N" for no. Do not complete the question for cost reporting periods beginning on or after October 1, 2022.

Line 69--Reserved for future use.

Line 70--Are you an IPF or do you contain an IPF subprovider? Enter in column 1 "Y" for yes or "N" for no.

Line 71--For column 1, if this facility is an IPF or contains an IPF subprovider (response to line 70, column 1, is "Y" for yes), did the facility train residents in graduate medical education programs **in the most recent cost report filed on or before November 15, 2004?** Enter "Y" for yes or "N" for no.

For column 2, did the facility train residents in a new graduate medical education program in the current cost reporting period, or in a prior cost reporting period, in accordance with 42 CFR 412.424(d)(1)(iii)(D)? Enter in column 2, "Y" for yes or "N" for no. (Note: If column 1 is "Y," then column 2 must be "N." Columns 1 and 2 cannot be "Y" simultaneously; however, columns 1 and 2 can be "N" simultaneously.)

For column 3, if column 2 is yes, indicate which program year began in this cost reporting period. New programs that began before October 1, 2012, have a 3-year new program growth period for the first new program, while new programs that began on or after October 1, 2012, have a 5-year new program growth period for the first new program. For new programs that began before October 1, 2012 (see 42 CFR 413.79(e)(1)), enter a 1, 2, or 3, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that began during the current cost reporting period, or enter a 6 to indicate this cost reporting period includes the beginning of the program year following the 3-year new program growth period of the first new program, or the program is beyond the new program growth period. For new programs that began on or after October 1, 2012 (see 42 CFR 413.79(e)(1)), enter a 1, 2, 3, 4, or 5, in column 3 to correspond to the I&R academic year in the first 5 program years of the first new program's existence that began during the current cost reporting period, or enter a 6 to indicate this cost reporting period includes the beginning of the program year following the 5-year new program growth period of the first new program, or the program is beyond the new program growth period. If column 2 is no, make no entry in column 3.

Lines 72 through 74--Reserved for future use.

Line 75--Are you an IRF or do you contain an IRF subprovider? Enter in column 1 "Y" for yes or "N" for no.

Line 76--For column 1, if this facility is an IRF or contains an IRF subprovider (response to line 75, column 1, is "Y" for yes), did the facility train residents in graduate medical education programs **in the most recent cost reporting period ending on or before November 15, 2004?** Enter "Y" for yes or "N" for no.

For column 2, did the facility train residents in a new graduate medical education program in the current cost reporting period, or in a prior cost reporting period, in accordance with 70 FR 47929 (August 15, 2005)? Enter in column 2, "Y" for yes or "N" for no. (Note: If column 1 is "Y", then column 2 must be "N." Columns 1 and 2 cannot be "Y" simultaneously; however, columns 1 and 2 can be "N" simultaneously.)

For column 3, if column 2 is yes, indicate which program year began in this cost reporting period. New programs that began before October 1, 2012, have a 3-year new program growth period for the first new program, while new programs that began on or after October 1, 2012, have a 5-year new program growth period for the first new program. For new programs that began before October 1, 2012 (see 42 CFR 413.79(e)(1)), enter a 1, 2, or 3, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that began during the current cost reporting period, or enter a 6 to indicate this cost reporting period includes the beginning of the program year following the 3-year new program growth period of the first new program, or the program is beyond the new program growth period. For new programs that began on or after October 1, 2012 (see 42 CFR 413.79(e)(1)), enter a 1, 2, 3, 4, or 5, in column 3 to correspond to the I&R academic year in the first 5 program years of the first new program's

existence that began during the current cost reporting period, or enter a 6 to indicate this cost reporting period includes the beginning of the program year following the 5-year new program growth period of the first new program, or the program is beyond the new program growth period. If column 2 is no, make no entry in column 3.

Lines 77 through 79--Reserved for future use.

Line 80--Are you a freestanding LTCH? Enter in column 1 “Y” for yes or “N” for no. LTCHs can only exist as independent/freestanding facilities. To be considered as independent or a freestanding facility, a LTCH located within another hospital must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e).

Line 81--Are you an independent or freestanding LTCH located within another hospital, subject to the special payment provisions of 42 CFR 412.534? Enter “Y” for yes or “N” for no. To be considered as independent or a freestanding facility, a LTCH located within another hospital must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22.

Lines 82 through 84--Reserved for future use.

Line 85--Is this a new hospital under 42 CFR 413.40(f)(1)(i) (TEFRA)? Enter “Y” for yes or “N” for no.

Line 86--Have you established a new “Other” subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter “Y” for yes or “N” for no in column 1. If there is more than one subprovider, subscript this line. Do not complete this line.

Line 87--Is this hospital a LTCH classified under section 1886(d)(1)(B)(vi) (referred to as extended neoplastic disease care hospitals)? Enter “Y” for yes or “N” for no.

Line 88--For a cost reporting period beginning on or after October 1, 2022, is this provider approved for a permanent adjustment to the TEFRA target amount per discharge? Enter “Y” for yes or “N” for no in column 1. If column 1 is “Y”, in column 2, enter the number of approved permanent adjustments, and complete line 89. See CMS Pub. 15-1, chapter 30, §3004.1 and §3004.2, for clarification on permanent adjustments.

Line 89--If line 88, column 1, is yes, complete columns 1, 2, and 3, for the earliest (first) approved permanent adjustment. In column 1, enter the Worksheet A line number upon which the approval of the permanent adjustment to the TEFRA target amount per discharge was based; in column 2, enter the cost reporting period beginning date that the permanent adjustment to the TEFRA target amount per discharge was effective, if available; and in column 3, enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge approved as of the date in column 2. If the number on line 88, column 2, is greater than one (the hospital received multiple approvals for permanent adjustments to the TEFRA target amount per discharge), subscript this line consecutively as necessary to report each additional approved permanent adjustment in chronological order. Report the earliest (first) approved permanent adjustment on line 89, and report each subsequently approved permanent adjustment on lines 89.01, 89.02, etc. See CMS Pub. 15-1, chapter 30, §3004.1 and §3004.2, for clarification on permanent adjustments.

Lines 90--Do you provide title V and/or XIX inpatient hospital services? Enter “Y” for yes or “N” for no in the applicable column.

Line 91--Is this hospital reimbursed for title V and/or XIX through the cost report in full or in part? Enter “Y” for yes or “N’ for no in the applicable column.

Line 92--If all of the nursing facility beds were certified for title XIX, and there were also title XVIII certified beds (dual certified), were any of the title XVIII beds occupied by title XIX patients during the cost reporting period? Enter “Y” for yes or “N” for no in the applicable column. Complete a separate Worksheet D-1 for title XIX for each level of care.

Line 93--Do you operate an ICF/IID facility for purposes of title XIX? Enter "Y" for yes or "N" for no.

Line 94--Does title V and/or XIX reduce capital costs? Enter "Y" for yes or "N" for no in the applicable column.

Line 95--For each column, if line 94 is "Y" for yes, enter the percentage by which capital costs are reduced.

Line 96--Does title V and/or XIX reduce operating costs? Enter "Y" for yes or "N" for no in the applicable column.

Line 97--For each column, if line 96 is "Y" for yes, enter the percentage by which operating costs are reduced.

Line 98**--**Does title V or XIX follow Medicare for the interns and residents post step-down adjustments on Worksheet B, Part I, column 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.01--Does title V or XIX follow Medicare for the reporting of charges on Worksheet C, Part I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.02--Does title V or XIX follow Medicare for the calculation of observation bed costs on Worksheet D-1, Part IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.03--Does title V or XIX follow Medicare for a CAH reimbursed 101 percent of cost for inpatient services? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.04--Does title V or XIX follow Medicare for a CAH reimbursed 101 percent of cost for outpatient services? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.05--Does title V or XIX follow Medicare and add back the reasonable compensation equivalent (RCE) disallowance on Worksheet C, Part I, column 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.06--Does title V or XIX follow Medicare when cost reimbursed for Worksheet D, Parts I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Lines 99 through 104--Reserved for future use.

Line 105--If this hospital qualifies as a CAH, enter "Y" for yes in column 1. Otherwise, enter "N" for no, and skip to line 108. (See 42 CFR 485.606ff.)

Line 106--If line 105 is yes, has this CAH elected the all-inclusive method of payment for outpatient services? Enter "Y" for yes or "N" for no. If yes, an adjustment for the professional component is still required on Worksheet A-8-2.

NOTE: If the facility elected the all-inclusive method for outpatient services, professional component amounts are excluded from deductible and coinsurance amounts and are not included on Worksheet E-1.

Line 107--If line 105 is yes, is this CAH eligible for 101 percent reasonable cost reimbursement for I&R in approved training programs? Enter a "Y" for yes or an "N" for no in column 1. If column 1 is yes, the GME elimination is **not** made on Worksheet B, Part I, column 25, and the program is cost reimbursed. If yes, complete Worksheet D-2, Part II.

If column 1 is yes and line 70 and/or line 75 is yes, do I&Rs in approved medical education programs train in the CAH's excluded IPF and/or IRF unit? Enter a "Y" for yes or an "N" for no in column 2. If column 2 is yes, complete Worksheet E-4, to calculate GME reimbursement for CAH subproviders.

Line 108--Is this a rural hospital qualifying for an exception to the certified registered nurse anesthetist (CRNA) fee schedule? (See 42 CFR 412.113(c).) Enter "Y" for yes or "N" for no, in column 1.

Line 109--If this hospital qualifies as a CAH (response to line 105 is yes) or is a cost reimbursed provider, are therapy services provided by outside suppliers? Enter "Y" for yes or "N" for no under the corresponding physical, occupational, speech and/or respiratory therapy services as applicable.

Line 110--Did this facility participate in the Rural Community Hospital Demonstration Project (also known as the §410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no. If "Y", complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, line 200 through 215, as applicable.

Line 111--If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response in column 1 is "Y", enter in column 2, the integration prong of the FCHIP demonstration in which this CAH is participating. Enter all that apply: "A" for ambulance services reimbursed at 101 percent of reasonable costs; "B" for additional beds used only for SNF and/or NF level of care; and/or "C" for telehealth services reimbursed at 101 percent of reasonable costs.

NOTE FOR LINE 111: If the entry in column 2 is "C", a telemedicine cost center must exist on Worksheet A, line 93 (Other Outpatient Service (specify)), or a subscript thereof, to report the telehealth originating site cost and/or telehealth destination site cost of CAHs participating in the FCHIP demonstration with a cost center code of "04050" (see §4095, Table 5).

Line 112--Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the cost reporting period? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", in column 2, enter the beginning date for the portion of the cost reporting period the hospital began participation in the PARHM demonstration; and, in column 3, enter the ending date for the portion of the cost reporting period the hospital ceased participation in the PARHM demonstration, when applicable. If the hospital participated in the PARHM demonstration for the entire cost reporting period enter the beginning and ending dates accordingly. The PARHM demonstration is effective for outpatient services and inpatient discharges ending on or after January 29, 2019.

If column 1 is "Y" and the hospital participated in the PARHM demonstration for the entire cost reporting period, complete all hospital worksheets by selecting the "PARHM Demonstration" indicator box at the top of each worksheet. If column 1 is "Y" and any portion of the cost reporting period the hospital did not participate in the PARHM demonstration, complete the hospital worksheets as "Hospital" for the period of non-participation and complete a separate set of hospital worksheets as "PARHM Demonstration" for the period of participation.

Lin*es 113 and* 114--Reserved for future use.

Line 115--Is this an all-inclusive rate provider (see instructions in CMS Pub. 15-1, chapter 22, §2208). Enter “Y” for yes or “N” for no in column 1. If yes, enter the applicable method (A, B, or E only) in column 2. If column 2 is “E”, enter the inpatient Medicare calculation percentage in column 3. Enter “93” for short-term hospitals where over 50 percent of all patients admitted stay less than 30 days or “98” for long-term hospitals where over 50 percent of all patients stay 30 days or more. (See CMS Pub. 15-1, chapter 22, §2208.1.E.)

Line 116--Are you classified as a referral center? Enter “Y” for yes or “N” for no. See 42 CFR 412.96.

Line 117--Are you legally required to carry malpractice insurance? Enter “Y” for yes or “N” for no. Malpractice insurance, sometimes referred to as professional liability insurance, is insurance purchased by physicians and hospitals to cover the cost of being sued for malpractice.

Line 118--Is the malpractice insurance a claims-made or occurrence policy? A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. If the policy is claims-made, enter 1. If the policy is occurrence, enter 2.

Line 118.01--Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self-insurance paid in column 3.

Line 118.02--Indicate if malpractice premiums and paid losses are reported in a cost center other than the Administrative and General (A&G) cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the provider against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the healthcare provider to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the provider where the healthcare provider acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often providers will manage their own funds or purchase a policy referred to as captive insurance, which protects providers for excess protection that may be unavailable or cost-prohibitive at the primary level.

Line 119--This question is eliminated and this line must not be used.

Line 120--If this is an SCH (or EACH), that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 1. If this is a rural hospital with 100 or fewer beds, that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 2. The ACA §3121 was amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, §108; the Temporary Payroll Tax Cut Continuation Act of 2011, §308; and the Middle Class Tax Relief and Job Creation Act of 2012, §3002. Note that for SCHs and EACHs, the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012, regardless of bed size, and from March 1, 2012, through December 31, 2012, for SCHs and EACHs with 100 or fewer beds. Rural hospitals with 100 or fewer beds are also extended through December 31, 2012. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.

Line 121--Did this facility incur and report costs (direct or indirect) in the "Implantable Devices Charged to Patients" (line 72) cost center as indicated in the 73 FR 48462 (August 19, 2008), bearing the revenue codes established by the National Uniform Billing Committee (NUBC) for high cost implantable devices? Enter "Y" for yes or "N" for no.

Line 122--Does the cost report contain health care related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If the answer in column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.

Line 123--For a cost reporting period beginning on or after October 1, 2022, did the facility 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? In column 1, enter "Y" for yes or "N" for no. If column 1 is yes, 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? In column 2, enter "Y" for yes or "N" for no.

Line 124--Reserved for future use.

Line 125--Is this facility a Medicare-certified transplant center? Enter "Y" for yes or "N" for no in column 1. If yes, enter the certification date and, if applicable, the termination date on lines 126 through 132, as applicable.

Line 126--If this is a Medicare-certified kidney transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also complete Worksheet D-4.

Line 127--If this is a Medicare-certified heart transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also complete Worksheet D-4.

Line 128--If this is a Medicare-certified liver transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also complete Worksheet D-4.

Line 129--If this is a Medicare-certified lung transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 130--If Medicare pancreas transplants are performed, enter the more recent date of July 1, 1999, (coverage of pancreas transplants) or the certification date for kidney transplants in column 1 and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 131--If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 132--If this is a Medicare-certified islet transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 133--Removed and reserved.

Line 134--If this hospital operates a hospital-based organ procurement organization (OPO), enter the OPO CCN in column 1, and termination date, if applicable, in column 2.

Lines 135 through 139--Reserved for future use.

Line 140--Are there any related organization or home office costs claimed as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, complete Worksheet A-8-1. If this facility is part of a chain and you are claiming home office costs, enter in column 2, the home office chain number and complete lines 141 through 143. See CMS Pub. 15-1, chapter 21, §2150, for a definition of a chain organization.

Line 141--Enter the name of the chain home office in column 1, the home office contractor name in column 2, and the home office contractor number in column 3.

Line 142--Enter the street address and P. O. Box (if applicable) of the home office.

Line 143--Enter the city, State, and ZIP code, of the home office.

Line 144--Are provider-based physicians' costs included in Worksheet A? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-2.

Line 145--If costs for renal dialysis services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. No response is required in column 1 or column 2 unless Worksheet A, column 7, line 74, is greater than zero. If column 1 is yes, or column 2 is no, do not complete Worksheet S-5 or the Worksheet I series for renal dialysis services.

Line 146--Have you changed your cost allocation methodology from the previously filed cost report? Enter "Y" for yes or "N" for no. If yes, enter the approval date in column 2.

Line 147--Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.

Line 148--Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.

Line 149--Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.

Lines 150 through 154--Reserved for future use.

Lines 155 through 161--If you are a hospital (public or non-public) that qualifies for an exemption from the application of the lower of cost or charges principle as provided in 42 CFR 413.13, indicate the component and/or services for titles V, XVIII and XIX that qualify for the exemption by entering in the corresponding box a "Y" for yes, if you qualify for the exemption, or an "N" for no, if you do not qualify for the exemption. Subscript as needed for additional components. For title XVIII providers, a response of "Y" does not subject the provider to the LCC principle.

Lines 162 through 164--Reserved for future use.

Line 165--Is the hospital part of a multi-campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. (For purposes of this question, only answer yes if the main campus and the off-site campus(es) are classified as section 1886(d) hospitals, or they are located in Puerto Rico).

Line 166--If you responded "Y" for yes to question 165, enter information for each campus (including the main campus) as follows: name in column 0, county in column 1, State in column 2, ZIP code in column 3, geographic CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary. Enter the information in columns 0 through 5 for the main campus first, and then enter the information in each column for the subordinate campuses, in any order. For example, for the main campus, enter on line 166 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. For the first subordinate campus, enter on line 166.01 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. Report only FTE information associated with IPPS areas and not the FTE information for excluded areas (i.e., hospital-based IPF and hospital-based IRF).

Line 167--Is this hospital/campus a meaningful user of electronic health record (EHR) technology in accordance §1886(n) of the Social Security Act as amended by the section 4102 of the American Recovery and Reinvestment Act (ARRA) of 2009 or the CAA of 2016, Division O, Title VI, §602? Enter "Y" for yes or "N" for no. A CAH that is not a meaningful user beginning in FFY 2015 is subject to a payment adjustment as defined in 42 CFR 413.70(a)(6)(i). A CAH may, on a case-by-case basis, be granted an exception from this adjustment if CMS or its Medicare contractor determines, on an annual basis, that a significant hardship exists, such as in the case of a CAH in a rural area without sufficient internet access. However, in no case may a CAH be granted an exception for more than 5 years.

Line 168--If this provider is a CAH (line 105 is "Y" for yes) and is also a meaningful EHR technology user (line 167 is "Y" for yes), enter, if applicable, the reasonable acquisition cost incurred for EHR assets either purchased or initially rented under a virtual purchase lease (see 42 CFR 413.130(b)(5) and (8), and CMS Pub. 15-1, chapter 1, §110.B.1.b) in the current cost reporting period. If applicable, also enter the un-depreciated cost (i.e., net book value) as of the beginning of the current cost reporting period, for assets purchased or initially rented under a virtual purchase lease in prior cost reporting period(s) which were used for EHR purposes in the current cost reporting period. Do not enter on this line any cost for EHR assets which was already claimed for the same assets in previous cost reporting period(s). The reasonable acquisition cost incurred is for depreciable assets such as computers and associated hardware and software necessary to administer certified EHR technology. (See 75 FR 44461 (July 28, 2010) and 42 CFR 495.106(a) and (c)(2).)

Additionally, if the amount on this line is greater than zero, submit a listing of the EHR assets showing the following information for each asset: (1) nature of each asset and acquisition cost; (2) an annotation whether the asset was purchased or leased under a virtual purchase lease (42 CFR 413.130(b)(8)); (3) date of purchase or date the virtual purchase lease was initiated; (4) name(s) of original purchaser (e.g., CAH, CAH's home office, group of unrelated providers); (5) information regarding the asset's use (i.e., indication whether the asset (hardware of software)) will be shared with CAH's non-EHR systems; and, (6) tag number and location (department unit). For cost reporting periods beginning on or after October 1, 2016, do not complete this line.

Line 168.01--If this provider is a CAH (line 105 is "Y") and is not a meaningful user (line 167 is "N"), does this provider qualify for a hardship exception under 42 CFR 413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. If no, the CAH is subject to a payment adjustment. The CAH's reasonable costs in providing inpatient services are adjusted as defined in 42 CFR 413.70(a)(6)(i) for cost reporting periods that begin in or after FFY 2015. Specifically, sections 1814(l)(4)(A) and (B) of the Act provide that, if a CAH does not demonstrate meaningful use of certified EHR technology for an applicable EHR reporting period, then for a cost reporting period beginning in FFY 2015, the CAHs reasonable costs shall be adjusted from 101 percent to 100.66 percent. For a cost reporting period beginning in FFY 2016, the CAH's reasonable costs shall be adjusted to 100.33 percent. For a cost reporting period beginning in FFY 2017 and each subsequent FFY, the CAH's reasonable costs shall be adjusted to 100 percent.

Line 169--If this is a §1886(d) provider that responded "N" for no to question 105 and "Y" for yes to question 167, enter the transition factor to be used in the calculation of your EHR incentive payment. For cost reporting periods where the transition factor is zero, enter "9.99" for software programming purposes. For hospitals that qualify for the EHR incentive payment under ARRA 2009, §4120, this question is not applicable for cost reporting periods beginning on or after October 1, 2016. For Puerto Rico hospitals that qualify for the EHR incentive payment under CAA 2016, §602, this question is not applicable for cost reporting periods beginning on or after October 1, 2021.

See 75 FR 44458-44460 (July 28, 2010) and CAA 2016, §602. The transition factor equals:

If a subsection (d) hospital first becomes a meaningful EHR user in fiscal year 2011, 2012 or 2013; or if a subsection (d) Puerto Rico hospital first becomes a meaningful EHR user in fiscal year 2016, 2017, or 2018:

- The first year transition factor is 1.00
- The second year transition factor is 0.75
- The third year transition factor is 0.50
- The fourth year transition factor is 0.25
- Any succeeding transition year is 0

If a subsection (d) hospital first becomes a meaningful EHR user in fiscal year 2014; or if a subsection (d) Puerto Rico hospital first becomes a meaningful EHR user in fiscal year 2019:

- The first year transition factor is 0.75
- The second year transition factor is 0.50
- The third year transition factor is 0.25
- Any succeeding transition year is 0

If a subsection (d) hospital first becomes a meaningful EHR user in fiscal year 2015; or if a subsection (d) Puerto Rico hospital first becomes a meaningful EHR user in fiscal year 2020:

- The first year transition factor is 0.50
- The second year transition factor is 0.25
- Any succeeding transition year is 0

Line 170--If line 167 is "Y", enter the EHR reporting period. Enter in column 1, the reporting period beginning date and, in column 2, the ending date in accordance with 42 CFR 495.4. The EHR reporting period may be a full federal fiscal year or, if this is the first payment year, any continuous 90-day period within a federal fiscal year. If the EHR reporting period ending date is on or after April 1, 2013, the EHR incentive payment will be subject to the 2 percent sequestration adjustment. The response to this question impacts the sequestration calculation on Worksheet E-1, Part II, line 9. For cost reporting periods beginning on or after October 1, 2016, do not complete this line except for Puerto Rico hospitals.

Line 171--If this provider is a meaningful EHR technology user (line 167 is "Y"), the days associated with individuals enrolled in section 1876 Medicare cost plans must be included in the calculation of the incentive payment. Indicate if you have section 1876 days included in the days reported on Worksheet S-3, Part I, line 2, column 6, by entering "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2.

Exhibit 3A -- Listing of Medicaid Eligible Days for a DSH Eligible Hospital

If reporting Medicaid days on Worksheet S-2, Part I, line 24, or line 25, for a cost reporting period beginning on or after October 1, 2022, complete a separate Exhibit 3A listing for each CCN. If a SCH is eligible to receive a DSH payment adjustment but Worksheet E, Part A, line 48, is greater than line 47, do not complete an Exhibit 3A listing; however, if Worksheet E, Part A, line 47, is greater than line 48, the SCH must submit an Exhibit 3A listing. Enter dates in the MM/DD/YYYY format.

Enter the provider name, CCN, CRP beginning and ending dates, the line number of Worksheet S-2, Part I, that the listing supports, the sum of the days for columns 10 and 12, and the sum of the days for column 11.

Columns 1 through 5--From the Medicaid patient's claim, enter the patient name, dates of service, and patient account or unique identification number, that correlate to the Medicaid eligible days reported in columns 10 and 11, in columns 1 through 5, respectively.

Column 6--Enter the Medicaid recipient identification number that correlates to the Medicaid eligible days reported in columns 10 and 11. For a newborn baby born to a Medicaid eligible mother, enter the mother's Medicaid identification number that correlates to the Medicaid eligible days reported in columns 10 and 12.

Column 7--Enter the applicable State plan eligibility code number, if available. To report more than one code, report the additional State plan eligibility codes in column 18.

Column 8--Enter a unique patient population code to identify a restricted or unrestricted Medicaid eligible day. For restricted eligibility, use code R1 for pregnancy/labor and delivery services; use code R2 for emergency services; or use a code R3 through R9 for user-defined restricted Medicaid eligibility and provide the definition for the code in column 18. For unrestricted Medicaid eligibility, use code U1 for general or use a code U2 through U9 for user-defined unrestricted Medicaid eligibility and provide the definition for the code in column 18.

Column 9--For each entry in columns 10 and 12, or column 11, enter the Worksheet S-2, Part I, column number where the days were reported.

Column 10--Enter the number of Medicaid eligible days during the dates of service entered in columns 3 and 4, including the number of days for a newborn baby remaining in the hospital after the Medicaid eligible mother's date of discharge (see column 12 instructions for reporting newborn baby days prior to the Medicaid eligible mother's date of discharge). (See §4004.1 "Note for lines 24 and 25" for definitions of the eligible Medicaid days.) The sum of the days in this column must equal the sum of the days reported on Worksheet S-2, Part I, line 24 or 25, as applicable, columns 1 through 5. In addition, the sum of the days summarized by each column reported in column 9 must equal the days reported in the respective column on Worksheet S-2, Part I, line 24 or 25, as applicable. For example, if the listing supports days for Worksheet S-2, Part I, line 24, then the sum of the days reported in column 10 of the exhibit must equal the days reported on Worksheet S-2, Part I, line 24, sum of columns 1 through 5; and, if the days reported on Worksheet S-2, Part I, line 24, column 3, equals 25, then the sum of the days entered in column 10 where column 9 is 3, must equal 25.

Column 11--Enter the number of labor and delivery days, defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking; the maternity patient is not included in the census count of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see CMS Pub. 15-1, chapter 22, §2205.2). The days reported in this column must equal the number of days reported on Worksheet S-2, Part I, line 24, column 6.

Column 12--Enter the number of newborn baby days occurring prior to the Medicaid eligible mother's date of discharge for a baby born to a Medicaid eligible mother. These newborn baby days are in addition to the mother's days reported in column 10. If the Medicaid eligible mother was discharged and the newborn baby remained in the hospital, do not report the newborn baby days occurring after the date of the mother's discharge in this column; report the days on a separate line in column 10.

Columns 13 and 14--Enter in column 13 the name of the insurance company or other payer with primary responsibility for paying the claim. If applicable, enter in column 14 the name of the insurer or other payer with secondary responsibility.

Column 15--Enter either "A" or "B" to indicate the patient's Medicare eligibility during the dates of service in columns 3 and 4; otherwise, if the patient was eligible for neither Part A nor Part B, leave the column blank. If the patient was eligible for Medicare, enter "A" or "B" as follows:

- if eligible for only Medicare Part A, enter "A"
- if eligible for both Part A and Part B, enter "A"
- if eligible for only Medicare Part B, enter "B"

Columns 16 and 17--If the entry in column 15 is either "A" or "B", enter the date that the patient's Medicare eligibility started in column 16 and, if applicable, enter the date that the patient's Medicare eligibility ended in column 17.

Column 18--Enter optional comments and/or additional information as needed. To decrease patients' vulnerability to identity theft, do not report a patient's date of birth or social security number.

EXHIBIT 3A

TITLE	MEDICAID ELIGIBLE DAYS FOR A DSH ELIGIBLE HOSPITAL
PROVIDER NAME	
CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
WS S-2, PT. I, LINE #	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMNS 10 &12	
TOTAL COLUMN 11	

PATIENT CLAIM INFORMATION							
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	MEDICAID NUMBER	STATE ELIGIBILITY CODE	PATIENT POPU-LATION CODE
1	2	3	4	5	6	7	8

MEDICAID DAYS				INSURANCE OR OTHER PAYER NAME		MEDICARE ELIGIBILITY			
WKST S-2, PART I COLUMN NUMBER	ELIGIBLE DAYS	LABOR & DELIVERY ROOM DAYS	NEWBORN BABY DAYS	PRIMARY	SECONDARY	A/B INDICATOR	START DATE	END DATE	COMMENTS
9	10	11	12	13	14	15	16	17	18