Line 12--If the response to line 11 is yes, indicate in column 1, the type of grant that was awarded from the list below. Enter the date of the grant award in column 2, and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.

1 = Community Health Center (§330(e), PHS Act)
2 = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
3 = Health Care for the Homeless Health Centers (§330(h), PHS Act)
4 = Health Centers for Residents of Public Housing (§330(i), PHS Act)
5 = Other

Line 13--Indicate if your hospital-based FQHC submitted an initial deeming or annual redeeming application for medical malpractice coverage to HRSA under the Federal Tort Claims Act (FTCA). Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.

Line 14--Indicate if the hospital-based FQHC received a THC development grant authorized under Part C of title VII of the PHS Act from HRSA for the purpose of establishing new accredited or expanded primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter the number of FTE residents your hospital-based FQHC trained using THC funding in column 2, and the total number of visits performed by such residents in column 3, during this cost reporting period.

4010.3. Part II - Hospital-Based FQHC Consolidated Cost Report Participant Identification Data--For each hospital-based FQHC that is included on Worksheet S-11, Part I, line 9, and its subscripts, a separate Worksheet S-11, Part II, must be completed in the identical sequence that the consolidated hospital-based FQHCs are reported on Worksheet S-11, Part I, line 9, and its subscripts. Do not complete this worksheet for the primary hospital-based FQHC reported on Worksheet S-11, Part I, line 1.

Line 1--Enter the hospital-based FQHC site name in column 1 and the certification date in column 2. Indicate the type of control under which the hospital-based FQHC operates by entering a number from the list below in column 3.

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

Enter the date the hospital-based FQHC terminated its participation in the Medicare program (if applicable) in column 4. In column 5, enter a "V" for a voluntary termination or an "I" for an involuntary termination.

If the hospital-based FQHC changed ownership immediately prior to the beginning of the cost reporting period enter the date of the change of ownership in column 6. Also submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2--Enter the hospital-based FQHC's street address in column 1 and the post office box in column 2 (if applicable).

Line 3--Enter the city in column 1, state in column 2, ZIP code in column 3, county in column 4, and the appropriate designation ("U" for urban or "R" for rural) in column 5. See CMS Pub. 100-04, chapter 9, §20.6.2, for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor.

Line 4--There are three types of organizations that are eligible to enroll in Medicare as a hospital-based FQHC. Indicate in column 1, the type of organization this hospital-based FQHC is by entering a number from the list below. If your response in column 1 is "1" or "3", enter any or all of the alpha characters associated with the response in column 2. For example, if you entered "1" in column 1, enter in column 2, "A", "B", "C" and/or "D". An organization receiving a grant under §330 of the PHS Act or an outpatient health program/facility can operate as any or all of the subcategories listed under the respective numeric options below.

1) An organization receiving a grant(s) under §330 of the PHS Act:
   A) Community Health Centers
   B) Migrant and Seasonal Agricultural Workers Health Centers
   C) Health Care for the Homeless Health Centers
   D) Health Centers for Residents of Public Housing
2) Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of "Health Center" under §330 of the PHS Act, but not receiving grant funding under §330; or,
3) Outpatient health program/facility operated by:
   A) A tribe or tribal organization under the Indian Self-Determination Act
   B) An urban Indian organization under title V of the Indian Health Care Improvement Act
   C) Other

Line 5--Indicate if your hospital-based FQHC received a grant under §330 of the PHS Act during this cost reporting period. Enter "Y" for yes or "N" for no.

Line 6--If the response to line 5 is yes, indicate in column 1, the type of grant that was awarded from the list below. Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.

1 = Community Health Center (§330(e), PHS Act)
2 = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
3 = Health Care for the Homeless Health Center (§340(d), PHS Act)
4 = Health Centers for Residents of Public Housing ((§330(i), PHS Act)
5 = Other

Line 7--Indicate if this hospital-based FQHC submitted an initial deeming or annual redeeming application for medical malpractice coverage to HRSA under the FTCA. Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.

Line 8--Indicate if the hospital-based FQHC received a THC development grant authorized under Part C of title VII of the PHS Act from HRSA for the purpose of establishing new accredited or expanded primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter the number of FTE residents your FQHC trained using THC funding in column 2.