HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-8

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

Clinic Address and Identification:

1	Street:	1
2	City: State: Zip Code: County:	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	3

Source of Federal Funds:

		Grant Award 1	Date 2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate the number of other operations in column 2.			10

Facility hours of operations[1]

	Type Operation	Sunday from	Sunday to	Monday from	Monday to	Tuesday from	Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday to	Friday from	Friday to	Saturday from	Saturday to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic															11

Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation).
List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?			12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			13
13.01	*If line 13, column 1, is "Y", are you reporting multiple consolidated RHC groupings (grandfathered consolidated RHC grouping or new consolidated RHC grouping)? See CMS Pub. 100-02, chapter 13, §80.2. Enter "Y" for yes or "N" for no. If yes, enter the number of consolidated RHC groupings in column 2 and complete a separate Worksheet S-8 for each consolidated RHC grouping. (see instructions)*			*13.01*
14	RHC/FQHC name: _____ CCN: _____			14

		Y/N 1	V 2	XVIII 3	XIX 4	Total Visits 5	
15	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15