HOSPITAL-BASED FQHC IDENTIFICATION DATA	PROVIDER CCN: _____ COMPONENT CCN: _____ SUBCOMPONENT CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S-11 PART II

PART II - HOSPITAL-BASED FQHC CONSOLIDATED COST REPORT PARTICIPANT IDENTIFICATION DATA

	1				Date Certified 2	Type of control (see instructions) 3	Date Decertified 4	V/I Decertification 5	Date of CHOW 6	
1	Site Name:									1
2	Street:	P.O. Box:								2
3	City:	State:	ZIP Code:	County:		Designation - Enter "R" for rural or "U" for urban:				3

Hospital-Based FQHC Operations		1	2	3	
4	What type of organization is this hospital-based FQHC? If you operate as more than one sub-type of an organization, enter only the applicable alpha characters in column 2. (see instructions)				4
5	Did this hospital-based FQHC receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 6)				5
6	If the response to line 5 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). 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.				6
Medical Malpractice					
7	Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? 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.				7
Interns and Residents					
8	Did this hospital-based FQHC receive a THC development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions)				8