HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO _____	PERIOD: FROM_____ TO_____	WORKSHEET S-2 (CONT.)

Hospital and Hospital Health Care Complex Address:

1	Street: P.O. Box:		1
1.01	City: State: Zip Code: County:		1.01

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	NPI Number	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	2.01	3	4	5	6	
2	Hospital								2
3	Subprovider								3
4	Swing Beds-SNF								4
5	Swing Beds-NF								5
6	Hospital-Based SNF								6
7	Hospital-Based NF								7
8	Hospital-Based OLTC								8
9	Hospital-Based HHA								9
11	Separately Certified ASC								11
12	Hospital-Based Hospice								12
14	Hospital-Based Health Clinic (specify)								14
15	Outpatient Rehab. Clinic (specify)								15
16	Renal Dialysis								16

17	Cost Reporting Period (mm/dd/yyyy) From: _____ To: _____				17
		1	2	3	
18	Type of Control (see instructions)				18
	Type of hospital/subprovider (see instructions)				
19	Hospital				19
20	Subprovider				20
	Other Information				
21	Indicate if your hospital is either (1) urban or (2) rural at the end of the cost reporting period in column 1. If your hospital is geographically classified or located in a rural area, is your bed size in accordance with CFR 42 412.105 less than or equal to 100 beds, enter in column 2 "Y" for yes or "N" for no.				21
21.01	Does your facility qualify and is currently receiving payment for disproportionate share 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.				21.01
21.02	Has your facility received a new geographic reclassification status change after the first day of the cost reporting period from rural to urban and vice versa? Enter "Y" for yes and "N" for no. If yes, enter in column 2 the effective date (mm/dd/yyyy). (see instructions)				21.02
21.03	Enter in column 1 your geographic location either (1) urban (2) rural. If you answered urban in column 1, indicate if you received either a wage or standard geographic reclassification to a rural location, enter in column 2 "Y" for yes and "N" for no. If column 2 is yes enter in column 3 the effective date (mm/dd/yyyy). (see instruction) Does your facility contain 100 or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 "Y" for yes and "N" for no. Enter in column 5 the providers actual MSA or CBSA.				21.03
21.04	For standard geographic classification (not wage), what is your status at the beginning of the cost reporting period? Enter (1) urban and (2) rural.				21.04
21.05	For standard geographic classification (not wage), what is your status at the end of the cost reporting period? Enter (1) urban and (2) rural.				21.05
21.06	Does this hospital qualify for the three-year transition *(or applicable extension)* of hold harmless payments for small rural hospital under the prospective payment system for hospital outpatient services under DRA §5105, MIPPA §147, *ACA §3121, or MMEA §108* ? (see instructions). Enter "Y" for yes or "N" for no.				21.06
21.07	Does this hospital qualify as *an* SCH with 100 or fewer beds under MIPPA§147? Enter in column 1 "Y" for yes or "N" for no. (see instructions) Is this *an* SCH or EACH that qualifies for the outpatient hold harmless provision in ACA §3121 or MMEA §108? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				21.07
21.08	Which method is used to determine Medicaid days on S-3, Part I, column 5? Enter in column 1, "1" if it is based on date of admission, "2" if it based on census days, or "3" if it is based on date of discharge. Is this method differen than the method used in the preceding cost reporting period? Enter in column 2,"Y" for yes or "N" for no.				21.08
22	Are you classified as a referral center?				22

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO _____	PERIOD: FROM_____ TO_____	WORKSHEET S-2 (CONT.)

23	Does this facility operate a transplant center? If yes, enter certification date(s) in column 2 and termination date(s) in column 3 (mm/dd/yyyy) below:					23
23.01	If this is a Medicare certified kidney transplant center, enter the certification date in col. 2 and termination in col. 3					23.01
23.02	If this is a Medicare certified heart transplant center, enter the certification date in col. 2 and termination in col. 3					23.02
23.03	If this is a Medicare certified liver transplant center, enter the certification date in col. 2 and termination in col. 3.					23.03
23.04	If this is a Medicare certified lung transplant center, enter the certification date in col. 2 and termination in col. 3.					23.04
23.05	If Medicare pancreas transplant are performed see instructions for entering certification and termination date.					23.05
23.06	If this is a Medicare certified intestinal transplant center, enter the certification date in col. 2 and term. in col. 3					23.06
23.07	If this is a Medicare certified islet transplant center, enter the certification date in col. 2 and termination in col. 3.					23.07
24	If this is an organ procurement organization (OPO), enter the OPO number in col.2 and termination date in col 3					24
24.01	If this is a Medicare Transplant Center, enter CCN in col. 2, the certification or recertification date after (12/26/2007) in column 3 (mm/dd/yyyy).					24.01
25	Is this a teaching hospital or affiliated with a teaching hospital and you are receiving payments for I & R?					25
25.01	Is this teaching program approved in accordance with CMS Pub. 15-I, chapter 4?					25.01
25.02	If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? If yes, complete Worksheet E-3, Part IV. If no, complete Worksheet D, Parts III and IV and D-2, Part II if applicable.					25.02
25.03	As a teaching hospital, did you elect cost reimbursement for physicians' services as defined in CMS Pub. 15-I, section 2148? If yes, complete Worksheet D-9.					25.03
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Worksheet D-2, Part I.					25.04
25.05	Has your facility direct GME FTE cap (column 1) or IME FTE cap (column 2) been reduced under 42 CFR §413.79(c)(3) or42 CFR §412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable columns. (see instructions)					25.05
25.06	Has your facility received additional direct GME FTE resident cap slots or IME FTE residents cap slots under 42 CFR §413.79(c)(4)or 42 CFR §412.105(f)(1)(iv)(C)? Enter "Y" for yes and "N" for no in the applicable columns (see instructions).					25.06
25.07	Has your facility trained residents in non-provider setting during the cost reporting period? Enter "Y" for yes or "N" for no in column 1.					25.07
25.08	If line 25.07 is yes, enter in column 1 the weighted number of non-primary care FTE residents attributable to rotations occurring in all non-provider settings.					25.08
25.09	If line 25.07 is yes, use lines 25.09 through 25.59 as necessary to identify the program name in column 1, the program code in column 2, and the number unweighted primary care residents FTEs by program in column 3 for each primary care specialty program in which residents are trained.(see instructions)					25.09
26	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the C/R period. Enter beginning and ending dates of SCH status on line 26.01. Subscript line 26.01 for number of periods in excess of one and enter subsequent dates.					26
26.01	Enter the applicable SCH dates: (see instructions) Beginning:_____ Ending:					26.01
26.02	Enter the applicable SCH dates: (see instructions) Beginning:_____ Ending:					26.02
27	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? If yes, enter the agreement date (mm/dd/yyyy) in column 2.					27
28	If this facility contains a hospital-based SNF, are all patients under managed care or there were no Medicare utilization enter "Y" , if "N" complete lines 28.01 and 28.02.					28
28.01	If hospital based SNF, enter appropriate transition period 1, 2, 3, or 100 in column 1. Enter in columns 2 and 3 the wage index adjustment factor before and on or after the October 1st (see instructions)					28.01
28.02	Enter in column 1 the hospital based SNF facility specific rate (from your fiscal intermediary) if you have not transitioned to 100% SNF PPS payment. In column 2 enter the facility classification Urban(1) or Rural(2). In column 3, enter the SNF MSA code or two character state code if a Rural based facility. In column 4, enter the SNF CBSA code or two character state code if a Rural based facility					28.02
	A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. Enter in column 1 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. Indicate in column 2 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (See instructions)					
28.03	Staffing					28.03
28.04	Recruitment					28.04
28.05	Retention of employees					28.05
28.06	Training					28.06
28.07	Other (Specify)					28.07
29	Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional method of reimbursement?					29

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO _____	PERIOD: FROM_____ TO_____	WORKSHEET S-2 (CONT.)

30	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access Hospital (CAH)? (see 42 CFR 485.606ff)				30
30.01	If so, is this the initial 12 month period for the facility operated as an RPCH/CAH? See 42 CFR 413.70.				30.01
30.02	If this facility qualifies as an RPCH/CAH, has it elected the all-inclusive method of payment for outpatient services?(See instructions)				30.02
30.03	If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulance services? If yes, enter in column 2 the date of eligibility determination (date must be on or after 12/21/2000).				30.03
30.04	If this facility qualifies as a CAH is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes and "N" for no. If yes, the GME elimination would not be on Worksheet B, Part I, column 26 and the program would be cost reimbursed. If yes, also complete Worksheet D-2, Part II, if applicable.				30.04
31	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c).				31

Miscellaneous Cost Reporting information

32	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.				32
33	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes and "N" for no in column 1. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100% Federal capital payment? Enter "Y for yes and "N" for no in column 2.				33
34	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA?				34
35	Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)?				35

		V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital	1	2	3	
36	Do you elect fully prospective payment methodology for capital costs? (See instructions)				36
36.01	Does your facility qualify and receive payment for disproportionate share in accordance with 42 CFR 412.320 ? (see instructions)				36.01
37	Do you elect hold harmless payment methodology for capital costs? (See instructions)				37
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal rate?				37.01

Title XIX inpatient services

38	Do you have title XIX inpatient hospital services?				38
38.01	Is this hospital reimbursed for title XIX through the cost report either in full or in part?				38.01
38.02	Does the title XIX program reduce capital following the Medicare methodology?				38.02
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions)				38.03
38.04	Do you operate an ICF/MR facility for purposes of title XIX?				38.04
40	Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? If yes, and this facility is part of a chain organization, enter in col. 2 the chain home office chain number. (See inst.) If this facility is part of a chain organization enter the name and address of the home office on lines 40.01-40.03.				40
40.01	Name: FI/Contractor's Name: _____	FI/Contractor's Number: _____			40.01
40.02	Street:	P. O. Box			40.02
40.03	City:	State:	Zip Code:		40.03
41	Are provider based physicians' costs included in Worksheet A?				41
42	Are physical therapy services provided by outside suppliers?				42
42.01	Are occupational therapy services provided by outside suppliers?				42.01
42.02	Are speech pathology services provided by outside suppliers?				42.02
43	Are respiratory therapy services provided by outside suppliers?				43
44	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?				44
45	Have you changed your cost allocation methodology from the previously filed cost report? See CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in column 2.				45
45.01	Was there a change in the statistical basis?				45.01
45.02	Was there a change in the order of allocation?				45.02
45.03	Was the change to the simplified cost finding method?				45.03
46	If you are participating in the NHCMQ demonstration project (must have a hospital-based SNF) during this cost reporting period, enter the phase (see instructions).				46

If this facility contains a provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption. Enter "N" if not exempt. (See 42 CFR 413.13.)

		Part A 1	Part B 2	Outpatient ASC 3	Outpatient Radiology 4	Outpatient Diagnostic 5	
47	Hospital						47
48	Subprovider						48
49	SNF						49
50	HHA						50
51	Outpatient Rehab. Providers (specify)						51

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO _____	PERIOD: FROM_____ TO_____	WORKSHEET S-2 (CONT.)

52	Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? (see instructions)						52
52.01	If you are a fully prospective or hold harmless provider are you eligible for the special exceptions payment pursuant to 42 CFR 412.348(g)? If yes, complete Worksheet L, Part IV						52.01
53	If you are a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in this C/R period. Enter beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 for number of periods in excess of one and enter subsequent dates.						53
53.01	MDH period beginning:_____ ending: _____						53.01
54	List amounts of malpractice premiums and paid losses: Premiums:_____, Paid losses:_____, and/or Self insurance:_____						54
54.01	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.						54.01
55	Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no.						55
56	Are you claiming ambulance costs? If yes, enter in column 2 the payment limit provided from your fiscal intermediary and the applicable dates for those limits in column 0. If this is the first year of operation no entry is required in column 2. If column 1 is Y, enter Y or N in column 3 whether this is your first year of operations for rendering ambulance services. Enter in column 4, if applicable, the fee schedules amounts for the period beginning on or after 4/1/2002.	Date 0	Y or N 1	Limit 2	Y or N 3	Fees 4	56
56.01	Enter subsequent ambulance payment limit as required. Subscript if more than 2 limits apply. Enter in column 4 the fee schedules amounts for initial or subsequent periods as applicable.						56.01
57	Are you claiming nursing and allied health costs? (see instructions)						57
58	Are you an Inpatient Rehabilitation Facility (IRF), or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y for yes and "N" for no. This option is only available for cost reporting periods beginning on or after 1/1/2002 and before 10/1/2002.						58
58.01	If line 58 column 1 is Y, does this IRF have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in a new teaching programs in accordance with FR Vol. 70, No. 156 dated August 15, 2005 pg 47929? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)						58.01
59	Are you a Long Term Care Hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. If yes have you made an election for100% Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. (see instructions)						59
60	Are you an Inpatient Psychiatric Facility (IPF), or do you contain an IPF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, is the IPF or IPF subprovider a new facility? Enter in column 2 "Y for yes and "N" for no. (see instructions)						60
60.01	If line 60 column 1 is "Y", and the facility is an IPF subprovider, were residents training in this facility in its most recent cost reporting period filed before November 15, 2004? Enter "Y" for yes or "N" for no. Is this facility training residents in a new teaching programs in accordance with 42 CFR Sec. 412.424 (d)(1)(iii)(C)? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instr.)						60.01
Multicampus							
61	Is this facility part of a Multicampus hospital that has one or more campuses in different CBSA? Enter "Y" for yes and "N" for no.						61
	If line 61 is yes, enter the name in col. 0, County in col. 1, state in col. 2, Zip in col 3, CBSA in col. 4 and FTE/Campus in col. 5.	County 1	State 2	Zip Code 3	CBSA 4	FTE/ Campus 5	
62	Name:						62
Settlement data							
63	Was the cost report filed using the PS&R (either in its entirety or for total charges and days only)? Enter "Y" for yes and "N" for no in column 1. If column 1 is "Y", enter the "paid through" date of the PS&R in column 2 (mm/dd/yyyy)						63

Miscellaneous data

64	*Did this facility incur and report costs for implantable devices charged to patient? Enter in column 1 "Y" for yes or "N" for no.*		*64*