	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA *(Form CMS-2552-96, Transmittal #22)*		PROVIDER NO.: ____________		PERIOD: FROM____________ TO______________	WORKSHEET S-2			2552-96 Line #	2552-10 Line #	**WORKSHEET S-2 PART I** **Form CMS-2552-10, Transmittal #1** **Line description**
											UNUSED LINE NUMBER RANGES: 28-34, 39-44, 48-54, 63-69, 72-74, 77-79, 87-89, 98-104, 110-114, 121-124, 134-139, 150-154,162-164
Hospital and Hospital Health Care Complex Address:											
1.00	Street:		P.O. Box:						1.00	1.00	Street, P.O. Box
1.01	City:	State:	Zip Code:		County:				1.01	2.00	City, State, ZIP, County
Hospital and Hospital-Based Component Identification:						Payment System (P, T, O, or N)					
	Component	Component Name	Provider Number		Date Certified	V	XVIII	XIX			
	0	1	2		3	4	5	6			
2.00	Hospital								2.00	3.00	Hospital
3.00	Subprovider								3.00	4.00	Subprovider - IPF
3.01	Subprovider II								3.01	5.00	Subprovider - IRF
3.02	Subprovider III								3.02	6.00	Subprovider - (Other) - subscript as needed for additional subproviders
4.00	Swing Beds-SNF								4.00	7.00	Swing Beds-SNF
5.00	Swing Beds-NF								5.00	8.00	Swing Beds-NF
6.00	Hospital-Based SNF								6.00	9.00	Hospital-Based SNF
7.00	Hospital-Based NF								7.00	10.00	Hospital-Based NF
8.00	Hospital-Based OLTC								8.00	11.00	Hospital-Based OLTC
9.00	Hospital-Based HHA								9.00	12.00	Hospital-Based HHA - subscript as needed for additional HHAs
11.00	Separately Certified ASC								11.00	13.00	Seperately Certified ASC - subscript as needed for additional ASCs
12.00	Hospital-Based Hospice								12.00	14.00	Hospital-Based Hospice - subscript as needed for additional Hospices
14.00	Hospital-Based Health Clinic (specify)								14.00	15.00	Hospital-Based Health Clinic - RHC - subscript as needed for additional RHCs
										16.00	Hospital-Based Health Clinic - FQHC - subscript as needed for additional FQHCs
15.00	Outpatient Rehab. Clinic (specify)								15.00	17.00	Hospital-Based (CMHC, CORF, OPT, OOT, OSP) - subscript as needed - up to 10 of each
16.00	Renal Dialysis								16.00	18.00	Renal Dialysis - subscript as needed for additional locations
										19.00	Other - line cannot be subscripted
17.00	Cost Reporting Period (mm/dd/yyyy)		From: ____________		To:	___________			17.00	20.00	Cost Reporting Period
						1	2				
18.00	Type of Control (see instructions)								18.00	21.00	Type of Control
Type of hospital/subprovider (see instructions)											
19.00	Hospital								19.00		**HOSPITAL AND SUBPROVIDER TYPES ARE ENTERED ON LINES 3-6, COLUMN 4 ON 2552-10 S-2 PART I**
20.00	Subprovider								20.00		
Other Information											
21.00	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.								21.00		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
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	22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR 412.106 or low income payment in accordance with 42 CFR 412.624(e)(2)? In column 1, enter "Y" for yes and "N" for no. Is this facility subject to 42 CFR 412.06(c)(2) (Pickle amendment hospital)? Y/N
											SEE LINE 23 BELOW, CROSS-REFERENCED TO 2552-96 LINE 21.08
										24.00	If line 22 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO dyas in col. 5, and other Medicaid days in col. 6
										25.00	If line 22 is "yes", and this provider is an IRF, then enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO dyas in col. 5, and other Medicaid days in col. 6
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		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
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 contains 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		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I** **CBSA CODES ARE ENTERED ON LINES 3-10, 12-19, COLUMN 3 ON 2552-10 S-2 PART I**

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA *(Form CMS-2552-96, Transmittal #22)*		PROVIDER NO.: ______________	PERIOD: FROM______________ TO________________	WORKSHEET S-2	2552-96 Line #	2552-10 Line #	**WORKSHEET S-2 PART I** **Form CMS-2552-10, Transmittal #1** **Line description**
						UNUSED LINE NUMBER RANGES: 28-34, 39-44, 48-54, 63-69, 72-74, 77-79, 87-89, 98-104, 110-114, 121-124, 134-139, 150-154,162-164	
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	26.00	Enter your standard geographic classification (not wage) at the beginning of the cost reporting period. Enter "1" for urban and "2" for rural.
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	27.00	Enter your standard geographic classification (not wage) at the end of the cost reporting period. Enter "1" for urban and "2" for rural.
21.06	Does this hospital qualify for the three -year transition of hold harmless payments for small rural hospital under the prospective payment system for hospital outpatient services under DRA Section 5105 or MIPPA§147? (see instructions) Enter "Y" for yes, and "N" for no.				21.06		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
21.07	Does this hospital qualify as a SCH with 100 or fewer beds under MIPPA§147? Enter in column 1 "Y" for yes or "N" for no (see instructions) Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Section 3121? Enter in colun 2 "Y" for yes or "N" for no.(See instructions)				21.07	120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA 3121? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with 100 or fewer beds that qualifies for the Outpatient Hold Harmless provision in ACA 3121? Enter in column 2 "Y" for yes or "N" for no.
21.08	Which method is used to determine Medicaid days? Enter in column 1, 1 if it is based on date of admission 2 if it is based on census days, or 3 if it is based on date of discharge. Is this method different than the method used in the last cost reporting period ? Enter in column 2,"Y" for yes and "N" for no.				21.08	23.00	Which method is used to determine Medicaid days on Worksheet S-3, Part I, line 32, column 7? In column 1, enter 1 if date of admission, 2 if census days, 3 if date of discharge. Is this method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? Y/N
22.00	Are you classified as a referral center?				22.00	116.00	Is this facility calssified as a referral center?
23.00	Does this facility operate a transplant center? If yes, enter certification date(s) (mm/dd/yyyy) below.				23.00	125.00	Does this facility operate a transplant center? Enter "Y" or "N". If yes, enter cert dates below
23.01	If this is a Medicare certified kidney transplant center, enter the certification date in col 2 and termination date in col 3				23.01	126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2
23.02	If this is a Medicare certified heart transplant center, enter the certification date in col 2 and termination date in col 3				23.02	127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2
23.03	If this is a Medicare certified liver transplant center, enter the certification date in col 2 and termination date in col 3				23.03	128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2
23.04	If this is a Medicare certified lung transplant center, enter the certification date in col 2 and termination date in col 3				23.04	129.00	If this is a Medicare certified lung transplant cetner, enter the certification date in column 1 and termination date, if applicable, in column 2
23.05	If Medicare pancreas transplant are performed see instructions for entering certification date and termination date.				23.05	130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2
23.06	If this is a Medicare certified intestinal transplant center, enter the certification date in col 2 and termination date in col 3				23.06	131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2
23.07	If this is a Medicare certified islet transplant center, enter the certification date in col 2 and termination date in col 3				23.07	132.00	If this is a Medicare certified islet transplant cetner, enter the certification date in column 1 and termination date, if applicable, in column 2
						133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2
24.00	If this is an organ procurement organization (OPO), enter the OPO number in col 2 and termination date in col 3				24.00	134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.
24.01	If this is a Medicare Translpant Center, enter CCN (provider number) in col 2, the certification or recertification date (after 12/26/2007) in column 3 (mm/dd/yyyy)				24.01		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
25.00	Is this a teaching hospital or affiliated with a teaching hospital and you are receiving payments for I & R?				25.00	55.00	Is this a teaching hospital? Enter "Y" for yes or "N" for no.
25.01	Is this teaching program approved in accordance with CMS Pub. 15-I, chapter 4?				25.01	56.00	If line 55 is yes, is this teaching program approved in accordance with CMS Pub 15-I, Ch. 4?
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	57.00	If line 56 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-4. If no, complete Worksheet D, Part III & IV and D-2, Part II, if applicable
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	58.00	If line 55 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-I, section 2148? If yes, complete Worksheet D-5 (2552-96 D-9)
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Worksheet D-2, Part I.				25.04	59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2 Part I.
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	60.00	Has this facility's direct GME FTE cap (column 1) or IME FTE cap (column 2) been reduced under 42 CFR 413.79(c)(3) or 42 CFR 412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable columns (see instructions)
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	61.00	Has this 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)
26.00	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.				26.00	35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period
26.01	Enter the applicable SCH dates: (see instructions) Beginning:_________ Ending:				26.01	36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.
26.02	Enter the applicable SCH dates: (see instructions) Beginning:_________ Ending:				26.02		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
(Form CMS-2552-96, Transmittal #22)

PROVIDER NO.: ______________ | PERIOD: FROM______________ TO________________ | WORKSHEET S-2

WORKSHEET S-2 PART I
Form CMS-2552-10, Transmittal #1

Line	Description	1	2	3	2552-96 Line #	2552-10 Line #	2552-10 Line description
							UNUSED LINE NUMBER RANGES: 28-34, 39-44, 48-54, 63-69, 72-74, 77-79, 87-89, 98-104, 110-114, 121-124, 134-139, 150-154,162-164
27.00	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.				27.00		**THIS QUESTION IS ON 2552-10 WORKSHEET S-7, LINE 2, COLUMNS 1 AND 2**
28.00	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.				28.00		**THIS QUESTION IS ON 2552-10 WORKSHEET S-7, LINE 1, COLUMN 1**
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		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
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 In column 3, enter the SNF MSA code or two character state code if a Rural based facility. code if Rural based facility. In column 4, enter the SNF CBSA code or two character state code if a Rural based facility				28.02		**SNF CBSA CODES FOR BEGINNING AND END OF COST REPORTING PERIOD ARE ON 2552-10 WORKSHEET S-7, LINE 201**
	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)						**2552-96 S-2 LINES 28.03-28.07 ARE ON 2552-10 WORKSHEET S-7, LINES 202-206**
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		
29.00	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?				29.00		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
30.00	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access Hospital (CAH)? (see 42 CFR 485.606ff)				30.00	105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?
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		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
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	106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructiions)
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		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
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 complete Worksheet D-2, Part II.				30.04	107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement in I&R training programs? "Y" or "N". If yes, the GME elimination would not be on Wkst B Pt I If yes complete Wkst D-2 Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical ducation program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" or "N" (see instructions)
31.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c).				31.00	108.00	Is this a rural hospital qualifying for an exemption to the CRNA fee schedule?
	Miscellaneous Cost Reporting information						
32.00	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.				32.00	115.00	Is this an all-inclusive rate provider? Enter "Y" or "N". Enter the method (A,B,E) in Col 2
33.00	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.				33.00	47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes and "N" for no in column 1. Is the facility electing full federal payment? Enter "Y" for yes and "N" for no in column 2.
34.00	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA?				34.00	85.00	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" or "N"
35.00	Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)?				35.00	86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes, and "N" for no - subscript as needed
		V	XVIII	XIX			
	Prospective Payment System (PPS)-Capital	1	2	3			
36.00	Do you elect fully prospective payment methodology for capital costs? (See instructions)				36.00		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
36.01	Does your facility qualify and receive payment for disproportionate share in accordance with 42 CFR 412.320 ? (see instructions)				36.01	45.00	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions)
37.00	Do you elect hold harmless payment methodology for capital costs? (See instructions)				37.00		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal rate?				37.01		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
	Title XIX inpatient services						
38.00	Do you have title XIX inpatient hospital services?				38.00	90.00	Does this facility have title V and/or XIX inpatient services? Enter "Y" or "N" in app col.
38.01	Is this hospital reimbursed for title XIX through the cost report either in full or in part?				38.01	91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes and "N" for no in the applicable column.
38.02	Does the title XIX program reduce capital following the Medicare methodology?				38.02	94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes or "N" for no in applicable col.
						95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.
						96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in app. col
						97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions)				38.03	92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification) "Y" or "N"

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA *(Form CMS-2552-96, Transmittal #22)*	PROVIDER NO.: ______________	PERIOD: FROM______________ TO________________	WORKSHEET S-2	**2552-96 Line #**	**2552-10 Line #**	**WORKSHEET S-2 PART I** **Form CMS-2552-10, Transmittal #1** **Line description**

UNUSED LINE NUMBER RANGES: 28-34, 39-44, 48-54, 63-69, 72-74, 77-79, 87-89, 98-104, 110-114, 121-124, 134-139, 150-154,162-164

Line	Description						2552-96 Line #	2552-10 Line #	Line description
38.04	Do you operate an ICF/MR facility for purposes of title XIX?						38.04	93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? "Y" or "N"
40.00	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.						40.00	140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-I, chapter 10? Enter "Y" for yes and "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)
40.01	Name: FI/Contractor's Name:			FI/Contractor's Number:			40.01	141.00	Name, contractor's name, contractor's number
40.02	Street:			P. O. Box			40.02	142.00	Street, P.O. box
40.03	City:			State:	Zip Code:		40.03	143.00	City, state, ZIP code
41.00	Are provider based physicians' costs included in Worksheet A?						41.00	144.00	Are provider based physicians' costs included in Worksheet A?
42.00	Are physical therapy services provided by outside suppliers?						42.00	109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for each therapy. **NOTE: 2552-96 lines 42, 42.01, 42.02 and 42.03 replaced by 2552-10 line 109, columns 1-4, each labeled with the appropriate therapy discipline.**
42.01	Are occupational therapy services provided by outside suppliers?						42.01		
42.02	Are speech pathology services provided by outside suppliers?						42.02		
43.00	Are respiratory therapy services provided by outside suppliers?						43.00		
44.00	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?						44.00	145.00	If costs for renal services are claimed on Wkst A, are they costs for inpatient services only?
45.00	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.						45.00	146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" or "N" in column 1. If yes, enter the approval date (mm/dd/yyyy) in column 2.
45.01	Was there a change in the statistical basis?						45.01	147.00	Was there a change in the statistical basis?
45.02	Was there a change in the order of allocation?						45.02	148.00	Was there a change in the order of allocation?
45.03	Was the change to the simplified cost finding method?						45.03	149.00	Was the change to the simplified cost finding method?
46.00	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).						46.00		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
	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.)								Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B
		Part A 1	Part B 2	Outpatient ASC 3	Outpatient Radiology 4	Outpatient Diagnostic 5			
47.00	Hospital						47.00	155.00	Hospital
48.00	Subprovider						48.00	156.00	Subprovider - IPF
								157.00	Subprovider - IRF
								158.00	Subprovider - Other - subscript as needed
49.00	SNF						49.00	159.00	SNF
50.00	HHA						50.00	160.00	HHA - subscript as needed
51.00	Outpatient Rehab. Providers (specify)						51.00	161.00	CMHC, CORF, OPT, OOT, OSP - subscript as needed, up to 10 of each type
52.00	Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? (see instructions)						52.00		**2552-96 LINES 52 AND 52.01 BOTH REPLACED BY 2552-10 LINE 46**
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	46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR 412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.
53.00	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.						53.00	37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.
								38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.
53.01	MDH period beginning:_______________ ending: ______________						53.01		
54.00	List amounts of malpractice premiums and paid losses: Premiums:____________________, Paid losses:_______________, and/or Self insurance:____________________						54.00	117.00	Is this facility legally-required to carry malpractice insurance?
								118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claims-made. Enter 2 if the policy is occurrence.
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	119.00	What is the liablity limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.
55.00	Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no.						55.00		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
56.00	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	56.00		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
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		**NO EQUIVALENT LINE IN 2552-10 S-2 PART I**
57.00	Are you claiming nursing and allied health costs? (see instructions)						57.00	62.00	Are costs claimed for nursing and alled health costs? (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA ***(Form CMS-2552-96, Transmittal #22)***	PROVIDER NO.: _____________	PERIOD: FROM_____________ TO_______________	WORKSHEET S-2	**2552-96 Line #**	**2552-10 Line #**	**WORKSHEET S-2 PART I** **Form CMS-2552-10, Transmittal #1** **Line description**
						UNUSED LINE NUMBER RANGES: 28-34, 39-44, 48-54, 63-69, 72-74, 77-79, 87-89, 98-104, 110-114, 121-124, 134-139, 150-154,162-164
58.00 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.				58.00	75.00	Is this faclity an Inpatient Rehabilitation Facility (IRF) or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.
58.01 If line 58 column 1 is Y, does the facility 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 page 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	76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before 11/15/2004? Enter "Y" or "N". Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424(d)(1)(iii)(D)? Enter "Y" or "N". Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3 (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 (see inst)
59.00 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 for 100% Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. (see instructions)				59.00	80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.
60.00 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)				60.00	70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes and "N" for no.
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 the facility training residents in a new teaching programs in accordance with 42 CFR Sec. 412.424 (d)(1)(iii)(2)(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	71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before 11/15/2004? Enter "Y" or "N". Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424(d)(1)(iii)(D)? Enter "Y" or "N". Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3 (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 (see inst)
Multicampus						
61.00 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.				61.00	165.00	Is this hospital part of a multicampus that has one or more campuses in different CBSAs? "Y" or "N"
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		166.00	If line 165 is yes, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.
62.00 Name:				62.00		
Settlement data						
63.00 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)				63.00		**2552-96 LINE 63 REPLACED BY 2552-10 WORKSHEET S-2 PART II, LINES 16-21**
						2552-10 LINES 167-169 ADDED FOR HEALTH INFORMATION TECHNOLOLGY INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT (HIT)
					167.00	Is this provider a meaningful user under 1886(n)? Enter "Y" for yes or "N" for no
					168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets. (see instructions)
					169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor (see instructions)