



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Office of Health Care Quality

Spring Grove Center • Bland Bryant Building

55 Wade Avenue • Catonsville, Maryland 21228-4663

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

### **Renewal Application Packet For Acute General and Special Hospitals**

*The following licensure forms are to be completed and returned to the HMO and Hospital Quality Assurance Unit. Please note demographic information on the application will be used to update the CMS database. This information is used by "Hospital Compare" and the "Maryland Hospital Performance Guide." Include the license fee of \$3,000.00 for the three-year license period. For information or questions call (410) 402-8016.*

#### **A. Hospital Application Forms**

Please make sure the hospital's name, address, and telephone number are accurate and complete. For all Special Hospitals (chronic, rehabilitation, psychiatric, and pediatric,) include a room and bed breakdown. The Special Hospital categories are to be used only by hospitals with a "Special Hospital" license.

#### **B. Facility Ownership**

Attach a list of the hospital's Board of Directors.

#### **C. Workers' Compensation Law Questionnaire**

#### **D. Certificate of Compliance, as applicable**

There are specific conditions in which an employer is granted exemption from the Worker's Compensation Insurance. (See attached Form C-16R)

#### **E. "The Joint Commission" Report**

Include a copy of the hospital's initial "Survey Report" from The Joint Commission that is posted on the extranet. The "Evidence of Standards Compliance", the final report and the "Award Letter" should be forwarded to OHCQ once the hospital has received those reports at a later date.

#### **F. For hospitals also licensed as "Special Hospital – Rehabilitation", include a copy of the most recent survey report from the Commission Accreditation of Rehabilitation Facilities (CARF).**



HOSPITAL APPLICATION

APPLICANT INFORMATION

Name of Facility: \_\_\_\_\_
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_ County \_\_\_\_\_
Administrator \_\_\_\_\_ Title \_\_\_\_\_
Administrative e-mail address \_\_\_\_\_

Please select one of the following:

- Individual Partnership Corporation Association Government Unit

Application on behalf of a corporation, government unit or agency shall be made by two officers of the corporations, association or governmental unit or agency and names of their board members shall be submitted.

HOSPITAL TYPE
( Check all that apply )

- Acute General: Number of beds determined annually per Health General 19-309.1

For Hospitals Licensed as Special Hospitals only:

- Special-Psychiatric - Number of Beds: \_\_\_\_\_
Special Chronic Disease - Number of Beds: \_\_\_\_\_
Special - Pediatric - Number of Beds: \_\_\_\_\_
Special Rehabilitation - Number of Beds: \_\_\_\_\_
Communicable Disease - Number of Beds: \_\_\_\_\_

Application fee of \$3,000.00 is to be attached to the application (Fee is not refundable). Make check or money order payable to "Maryland State Department of Health and Mental Hygiene".

Have any owners, officers, director, agents, or managerial employees have been convicted of a criminal offense involving any of the programs under Title 18, 10, Or 20 of the Social Security Act?
Yes No

I/We \_\_\_\_\_
(please print)

Certify that I am/We are 18 years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a facility subject to the provisions of Health-General Article, Title 19, Subtitle 3. Annotated Code of Maryland, and to the regulations adopted thereunder by the Secretary of Health and Mental Hygiene.

- Signature of Applicant \_\_\_\_\_ Title \_\_\_\_\_
Signature of Applicant \_\_\_\_\_ Title \_\_\_\_\_

SEND COMPLETED APPLICATION TO:

Office of Health Care Quality
Bland Bryant Building, Spring Grove Center
Atten: Ella L. Wagner
55 Wade Avenue, 3 rd Floor
Catonsville, MD 21228

FOR OFFICIAL USE ONLY

Initial Date: \_\_\_\_\_ Amount Paid: \_\_\_\_\_
Renewal Check No.: \_\_\_\_\_ Coord Name: \_\_\_\_\_

## OWNERSHIP FORM

**Legal Name of Licensee (Disclosing entity)**

Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Trading Name of License: \_\_\_\_\_  
(Facility's Name)

<b>Type of Business Organization of Disclosing Entity (Check One):</b>			
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other (Specify)
Date of Charter _____		Date of Incorporation _____	

**Name(s), title(s) and address(es) of owners, partners, officer(s), director(s), stock holder(s), and percentage owned if 2% or more (attach additional information)**

Name & Title	Address	% Owned
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have any owners, officers, directors, agents, or managerial employees been convicted of a criminal offense involving any of the programs under Title 18, 19, or 20 of the Social Security Act?

Yes                       No

TYPE OF CONTROL				
Voluntary Non-profit	Proprietary	Government		
<input type="checkbox"/> Church	<input type="checkbox"/>	<input type="checkbox"/> State	<input type="checkbox"/> County	<input type="checkbox"/> City
<input type="checkbox"/> Other (Specify)				

**Leasing Arrangement**

If a disclosing entity operates the business under a lease, the following section shall be completed:

Lessee Name (s) and Address (es) \_\_\_\_\_

Lessor Name (s) and Address (es) \_\_\_\_\_

Expiration Date of Lease \_\_\_\_\_

**By signing this form, the signee indicates full understanding that a violation will constitute grounds for revoking the license to operate a hospital or related institution in the State of Maryland.**

\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Title

WORKERS' COMPENSATION LAW QUESTIONNAIRE

Name of Facility

\_\_\_\_\_  
(Please type or print)

Address of Facility

\_\_\_\_\_  
(Please type or print)

Do you have Workers' Compensation Insurance for your employees?  
(Check One)  YES  NO

If you have answered YES above; please provide the following information:

Policy Number \_\_\_\_\_

Binder Number \_\_\_\_\_

Insurance Company \_\_\_\_\_

Effective Date \_\_\_\_\_

Expiration Date \_\_\_\_\_

If you have answered NO, please attach a copy of your Certificate of Compliance in accordance with State Workers' Compensation Laws.  
(See attached form A52 and Instruction Sheet)

**Please note**

**Your License cannot be issued unless this form is completed, signed, dated and provided to this Administration along with your "Certificate of Compliance" if applicable.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**WORKERS' COMPENSATION COMMISSION**

10 East Baltimore Street  
Baltimore, Maryland 21202-1641  
TEL: (410) 864-5100 OR (1-800) 492-0479  
TTY USERS CALL VIA MARYLAND RELAY

Date Stamp - WCC Use Only

**EXCLUSION FORM**

Pursuant to the provisions of Labor & Employment Article § 9-206 of the Annotated Code of Maryland, officers or members of a Farm Corporation, Close Corporation, Professional Corporation, or Limited Liability Company are covered employees if the officer or member provides a service for monetary compensation. Such officers or members who satisfy the criteria of Labor & Employment Article § 9-206(b) may elect to become excluded from coverage by filing this Exclusion Form with the Commission.

To exercise this option, any officer or member from the aforementioned types of organizations wishing to be excluded must sign this document. **NOTE: By signing this Exclusion Form below, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officer's or member's knowledge, information, and belief.**

DATE: \_\_\_\_\_ DATE COMPANY NOTIFIED INSURANCE COMPANY: \_\_\_\_\_

NAME OF CORPORATION'S INSURANCE COMPANY: \_\_\_\_\_

NAME OF COMPANY: \_\_\_\_\_

TYPE OF COMPANY: (Circle One) Farm Corporation, Close Corporation, Professional Corporation, Limited Liability Company

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Typewritten Name and Title of Officer or Member Electing Exclusion	% of Ownership	Personal Signature

**IMPORTANT:** Submit original form to the Workers' Compensation Commission, a copy to the insurer of the corporation, and keep a copy for your files.

## INSTRUCTION SHEET

Please **REVIEW INSTRUCTIONS BEFORE** Completing the Certificate of Compliance Application

The Workers' Compensation Commission will accept only the original application, (Do not fax photocopy or electronically reproduce). Type or print **LEGIBLY** (or application may be returned without review). Complete application in its entirety.

**Line #1 Name of Company (If the company does not have a name leave blank)**

**Line #2 Owner's Name (If corporation, list the name of a contact person)**

**Line #3 Complete Business Address (P.O. Box Not Acceptable)**

**Line # 4 Complete Mailing Address**

**Line #5 Phone Number (Pager Number Not Acceptable) FEIN or Social Security Number required (If partnership, please initial & list the last four digits of SS # for each partner.) If using a FEIN #, SS #'s are not necessary.**

**Line #6 Check appropriate box (see back of application). Additionally, where indicated, please complete and attach Exclusion Form C-16R.**

**Line #7 Sign and Date (If partnership, all partners must sign.)**

**NOTE: Maryland Law § 9-201 requires an employer with one or more employees to carry workers' compensation insurance. Any employer with workers' compensation insurance is to submit proof (policy or binder number) of coverage to the Agency where they are applying for their license. DO NOT COMPLETE THE CERTIFICATE OF COMPLIANCE APPLICATION IF YOU HAVE INSURANCE COVERAGE. If you have any questions regarding the Certificate of Compliance, please call (410) 864-5297 or 1 (800) 492-0479 and ask to be transferred to extension 5297. If you do not follow the aforementioned instructions, it may cause a delay in the processing of your application. Thank you for your cooperation.**

# CERTIFICATE OF COMPLIANCE

Before a governmental unit may issue a license or permit to a business for the purpose of engaging in an activity in which the business might employ a covered employee, the business shall submit to the governmental unit:

- (1) a certificate of compliance with this title: or
- (2) the number of a workers' compensation insurance policy or binder.

If a business is not covered by a workers' compensation insurance policy, an application to secure a Certificate of Compliance shall be submitted to the Workers' Compensation Commission pursuant to Labor & Employment Article §9-105. The sole purpose of a Certificate of Compliance is to identify those businesses which are not required to carry workers' compensation insurance coverage and to enable that business to apply for and obtain a license or permit from a government agency that requires proof of workers' compensation insurance coverage. A Certificate of Compliance is **not** workers' compensation insurance and is not binding on the workers' Compensation Commission under any circumstance.

**NOTE: Maryland Annotated Code LE §9 -201 requires a business with one or more employees to carry workers' compensation insurance.**

**Eligibility:** A business may secure a Certificate of Compliance in the name of the business, only if:

- (a) the business is a sole proprietor with no employees;
- (b) the business is a partnership with no employees other than the individual partners;
- (c-f) the business is a Farm Corporation, a Maryland Close Corporation, a Professional Corporation or a Limited Liability Company with no employees other than corporate officers or limited liability company members who have elected under §9-206, to be excluded from workers' compensation coverage;
- (g) the business is an employer of only "casual employees" as provided under LE §9-205 and defined in Maryland Law; or
- (h) the business is an owner operator of a Class F (Tractor) vehicle who meets the requirements of exclusion as defined under LE §9-218.

Mail Application to: The Workers' Compensation Commission  
Attention: Certificate of Compliance Officer  
10 East Baltimore Street  
Baltimore, MD 21202-1641

**Facsimile Applications Will Not Be Accepted. Do not photocopy or electronically reproduce.**

Licensing Agency's  
Stamp

# APPLICATION FOR CERTIFICATE OF COMPLIANCE

(Please type or print legibly. Review instructions on reverse side prior to completing application.)

1. \_\_\_\_\_  
Name of Business (If trading as self, leave blank)

2. \_\_\_\_\_  
Name of Owner(s) If a partnership, print each partner's name (attach separate sheet if necessary)

3. \_\_\_\_\_  
Business Address (P. O. Box Not Acceptable)      City      State      Zip Code

4. \_\_\_\_\_  
Mailing Address      City      State      Zip Code

5. (\_\_\_\_\_) \_\_\_\_\_  
Phone Number (Pager Number Not Acceptable)      FEIN or Social Security Number(s)

6. The above named business would qualify for a Certificate of Compliance for the following reason: (Check the appropriate box and do not modify or qualify the stated reasons in any way.)

- a.  Sole Proprietor: The business is a sole proprietorship with no employees.
- b.  Partnership: The business is a partnership with no employees other than the individual partners.
- c.  A Maryland Close Corporation (attach Exclusion Form C-16R): The business is a Maryland Close Corporation with no employees other than corporate officers.
- d.  Farm Corporation (attach Exclusion Form C-16R): The business is a farm corporation with no employees other than corporate officers.
- e.  Professional Corporation (attach Exclusion Form C-16R): The business is a professional corporation with no employees other than corporate officers.
- f.  Limited Liability (attach Exclusion Form C-16R): The business is a limited liability company with no employees other than limited liability company members.
- g.  Casual Employees: The business only employs casual workers as provided in LE §9-205 and defined under Maryland Laws.
- h.  Owner/Operator of Class F Vehicle: The business is that of an owner operator of a Class F (Tractor) vehicle and meets the requirements of exclusion as defined under LE §9-218.

I AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

7. \_\_\_\_\_  
Signature(s) If a partnership, all partners must sign      Date  
(Use separate sheet if necessary)

After careful review of this application and based solely on the information contained in or attached to this application, the application is  APPROVED  DISAPPROVED.

\_\_\_\_\_  
Authorized Signature      Date

An applicant who receives notice of disapproval may: (1) reapply for a certificate of compliance or (2) appeal the rejection in accordance with §§ 10-222 and 10-223 of the State Government Article.

EXHIBIT 286

(Rev. 44, 05-08-09)

HOSPITAL/CAH MEDICARE DATABASE WORKSHEET

CMS Certification Number (CCN): \_\_\_\_\_ Date of Worksheet Update: \_\_\_\_\_  
Medicaid Provider Number: \_\_\_\_\_ (MMDDYYYY) (M1)

National Provider Identification Number(s) (NPI): \_\_\_\_\_

Fiscal Year Ending Date (MMDD): \_\_\_\_\_

Name and Address of Facility (Include City, State):  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number (M2): \_\_\_\_\_ Zip Code: \_\_\_\_\_

CEO Telephone Number: \_\_\_\_\_ Fax Number (M3): \_\_\_\_\_

Email Address: \_\_\_\_\_

Website Address: \_\_\_\_\_

Accreditation Status: \_\_\_\_\_

Select one

0 Not Accredited

1 JC

2 AOA

3 DNV

Effective Date of Accreditation: \_\_\_\_\_

(MMDDYYYY) (M4)

Renewal Date of Accreditation: \_\_\_\_\_

(MMDDYYYY) (M5)

Multiple Accreditation Status: Yes \_\_\_\_\_ No \_\_\_\_\_

(Select all others that apply; do not include the primary accreditation organization):

JC \_\_\_\_\_

AOA \_\_\_\_\_

DNV \_\_\_\_\_

State/County Code (M6): 21

State Region Code (M7): ex3

Type of Program Participation (M8): \_\_\_\_\_

CLIA ID Numbers (M9):

Select one

1 Medicare

2 Medicaid

3 Medicare & Medicaid

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicare CAH Status or Type of Medicare Hospital (select 1) (M10): \_\_\_\_\_

01 Short-term \_\_\_\_\_

02 Long-term \_\_\_\_\_

03 Religious Nonmedical Health Care Institution \_\_\_\_\_

04 Psychiatric \_\_\_\_\_

05 Rehabilitation \_\_\_\_\_

06 Childrens \_\_\_\_\_

07 Distinct Part Psychiatric  
Hospital \_\_\_\_\_

08 Cancer Hospital \_\_\_\_\_

11 Critical Access Hospital (CAH) \_\_\_\_\_

Affiliation with a Medical School (M11): \_\_\_\_\_

01 Major

02 Limited

03 Graduate School

04 No Affiliation

Resident Programs (M12) (select all that apply): \_\_\_\_\_

01 Allopathic

02 Dental

03 Osteopathic

04 Other

06 Podiatric

Ownership Type (select 1) (M13): \_\_\_\_\_

01 Church

02 Private (Not for Profit)

03 Other (specify: \_\_\_\_\_)

04 Private (For Profit)

05 Federal

06 State

07 Local

08 Hospital District or Authority

09 Physician Ownership

10 Tribal

Average Daily Census (M14): \_\_\_\_\_

Number of Staffed Beds (M15): \_\_\_\_\_

Type of Chain/Health System Involvement (M16): \_\_\_\_\_

- 01 None
- 02 System Ownership
- 03 System Management

Name of System (M17): \_\_\_\_\_

Corporate Headquarters City (M18): \_\_\_\_\_ State (M19): \_\_\_\_\_

Number of Employees Salaried by Hospital/CAH (Use Full Time Equivalent FTE)				
M20	Physicians (Salaried only)		M30	Medical Technologists (Lab)
M21	Physicians - Residents		M31	Nuclear Medicine Technicians
M22	Physician Assistants (PA)		M32	Occupational Therapists
M23	Nurses - CRNA		M33	Pharmacists (Registered)
M24	Nurses - Practitioners		M34	Physical Therapists
M25	Nurses - Registered		M35	Psychologists
M26	Nurses - LPN		M36	Radiology Technicians (Diagnostic)
M27	Dieticians		M37	Respiratory Therapists
M28	Medical Social Workers		M38	Speech Therapists
M29	Medical Laboratory Technicians		M39	All Others

Medicare Payment-Related Categories for a Hospital or a CAH (select all that apply) (M40): \_\_\_\_\_

CAH Categories		Hospital Categories	
01	CAH Psychiatric DPU	07	Hospital PPS Excluded Psych Unit
02	CAH Rehabilitation DPU	08	Hospital PPS Excluded Rehab Unit
03	CAH Swing Beds	09	Hospital Swing Beds
		10	Medicare Dependent Hospital
		11	Regional Referral Center

Services Provided by the Facility (M41): \_\_\_\_\_

- 0 Service not provided
- 1 Services provided by facility staff only
- 2 Services provided by arrangement or agreement
- 3 Services provided through a combination of facility staff and through agreement

			34	Operating Rooms	
02	Alcohol and/or Drug Services		35	Ophthalmic Surgery	
03	Anesthesia Service		36	Optometric Services	
04	Audiology				
			38	Organ Transplant Services ( <i>Not Medicare-certified</i> )	
06	Burn Care Unit		39	Orthopedic Surgery	
07	Cardiac Catheterization Laboratory		40	Outpatient Services	
08	Cardiac-Thoracic Surgery		41	Pediatric Services	
09	Chemotherapy Service		42	Pharmacy	
10	Chiropractic Service		43	Physical Therapy Services	
11	CT Scanner		44	Positron Emission Tomography Scan	
12	Dental Service		45	Post-Operative Recovery Rooms	
13	Dietetic Service		46	Psychiatric Services - Emergency	
14	Emergency Department (Dedicated)		47	Psychiatric - Child/Adolescent	
			48	Psychiatric - Forensic	
16	Extracorporeal Shock Wave Lithotripter		49	Psychiatric - Geriatric	
17	Gerontological Specialty Services		50	Psychiatric - Adult Inpatient	
			51	Psychiatric - Outpatient	
			52	Radiology Services - Diagnostic	
20	ICU - Cardiac (non-surgical)		53	Radiology Services - Therapeutic	
21	ICU - Medical/Surgical		54	Reconstructive Surgery	
22	ICU - Neonatal		55	Respiratory Care Services	
23	ICU - Pediatric		56	Rehab Services - Inpatient	
24	ICU - Surgical				
			58	Rehab -Outpatient	
26	Laboratory - Clinical		59	Renal Dialysis (Acute Inpatient)	
			60	Social Services	
28	Magnetic Resonance Imaging (MRI)		61	Speech Pathology Services	
29	Neonatal Nursery		62	Surgical Services - Inpatient	
30	Neurosurgical Services		63	Surgical Services - Outpatient	
31	Nuclear Medicine Services		64	Trauma Center ( <i>Designated</i> )	
32	Obstetric Service		65	<i>Transplant Center (Medicare Certified)</i>	
33	Occupational Therapy Services		66	Urgent Care Center Services	

Sprinkler Status, Main Campus (select 1) (M42): \_\_\_\_\_

- 01 Totally sprinklered: All required areas are sprinklered
- 02 Partially sprinklered: Some but not all required areas are sprinklered

03 Sprinklers: *No required areas are sprinklered*

Total number of *provider-based* off-site locations under the same CCN (M43): \_\_\_\_\_

TYPES OF OFF-SITE LOCATIONS			
01	Inpatient Remote Location		07 Satellite of an <i>IPPS-Excluded Psych Unit</i>
02	Offsite Outpatient Surgery		08 Satellite of a Long Term Care Hospital
03	<i>Offsite</i> Urgent Care Center		09 Satellite of a Cancer Hospital
04	Satellite of a Rehabilitation Hospital		10 Satellite of a Childrens' Hospital
05	Satellite of a Psychiatric Hospital		11 <i>Offsite</i> Emergency Department
06	Satellite of an <i>IPPS-Excluded Rehab Unit</i>		12 Other Provider-Based Offsite Facility/ <i>Department</i>

For each off-site location, complete and attach the Provider-Based Off-Site Locations Continuation Worksheet.

Number of related or affiliated providers or suppliers (M44): \_\_\_\_\_

TYPES OF AFFILIATED PROVIDERS/SUPPLIERS			
01	<i>Ambulance Service</i>		06 Hospice
02	Ambulatory Surgery Center		07 <i>Organ Procurement Organization</i>
03	End Stage Renal Disease		08 Psychiatric Residential Treatment Facility
04	Federally Qualified Health Center		09 Rural Health Clinic
05	Home Health Agency		10 Skilled Nursing Facility (SNF)

For each affiliated provider/supplier, complete and attach the Affiliated Provider/Supplier Continuation Worksheet, indicating the provider/supplier name, CCN, and type.

(M45) *Co-location Status: Is there another hospital, or a satellite location of another hospital, that occupies space in a building used by the hospital described in this worksheet?*

- 01 Yes
- 02 No

If yes, provide the name and CCN number of the co-located hospital:

*Name*

*CCN*

**PROVIDER-BASED OFF-SITE LOCATION CONTINUATION WORKSHEET**  
**PAGE 1 OF \_\_\_\_\_**

**ENTRY#** \_\_\_\_\_  
**Type of Off-site Location (from table M43):** \_\_\_\_\_  
**Name of Off-Site Location:** \_\_\_\_\_  
**Off-Site Street Address:** \_\_\_\_\_  
**County:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Sprinklered Status of Off-site Location (select 1):** \_\_\_\_\_  
01 **Totally sprinklered: All required areas are sprinklered;**  
02 **Partially sprinklered: Some but not all required areas sprinklered;**  
03 **Sprinklers: *No required areas are sprinklered***  
04 **Sprinklers are not required**

**ENTRY#** \_\_\_\_\_  
**Type of Off-site Location (from table M43):** \_\_\_\_\_  
**Name of Off-Site Location:** \_\_\_\_\_  
**Off-Site Street Address:** \_\_\_\_\_  
**County:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Sprinklered Status of Off-site Location (select 1):** \_\_\_\_\_  
01 **Totally sprinklered: All required areas are sprinklered;**  
02 **Partially sprinklered: Some but not all required areas sprinklered;**  
03 **Sprinklers: *No required areas are sprinklered***  
04 **Sprinklers are not required**

**ENTRY#** \_\_\_\_\_  
**Type of Off-site Location (from table M43):** \_\_\_\_\_  
**Name of Off-Site Location:** \_\_\_\_\_  
**Off-Site Street Address:** \_\_\_\_\_  
**County:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Sprinklered Status of Off-site Location (select 1):** \_\_\_\_\_  
01 **Totally sprinklered: All required areas are sprinklered;**  
02 **Partially sprinklered: Some but not all required areas sprinklered;**  
03 **Sprinklers: *No required areas are sprinklered***  
04 **Sprinklers are not required**

**Make additional copies as needed for additional off-site locations.**

**AFFILIATED PROVIDER/SUPPLIER CONTINUATION WORKSHEET PAGE 1 OF \_\_\_\_\_**

**Identify all affiliated Medicare-certified providers/suppliers, indicating for each the name, CCN, and type of provider/supplier, using the codes from M44.**

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

**Make additional copies as needed for additional affiliated providers/suppliers.**