HOSPITAL ABATEMENT DISTRIBUTION REGISTRATION FORM – EXHIBIT A

HOSPITAL ABATEMENT DISTRIBUTION REGISTRATION FORM DEADLINE: September 30, 2022

I. Claimant Information

Please provide the information for the Claimant in Section I if you are submitting a claim on behalf of an Operating Entity.

A. Name of Operating Entity:	
B. Federal Employer Identification Number:	____ – ________

II. Hospital/Facility Information

Please provide the following information for each Acute Care hospital/facility owned and/or operated by the above referenced Claimant in Section I for which a claim is being filed. If there is more than one such Acute Care hospital/facility owned by the Claimant, please complete a separate Exhibit A for EACH Acute Care hospital/facility for which a claim is being filed.

A. Name of Hospital/Facility:			
B. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
C. Duration of Ownership:	Date Acquired/Opened	Date Sold/Closed	
D. Number of Staffed Beds:[1]			

[1] *The number of beds reported from a hospital's most recent Medicare cost report (W/S S-3, Part I, line 7 column 2). Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, post anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion*

I certify that I am authorized to sign this Registration Form Exhibit A and I understand that an authorized signature on this Registration Form Exhibit A serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Your typed signature and submission of this Registration Form Exhibit A will have the same force and effect as if you signed the Registration Form Exhibit A on paper, which you may do alternatively.

Signature: ____

Executed on date: (MM/DD/YYYY) _________________________________

Print the name of the person who is completing and signing this Registration Form Exhibit A.

Name (First, Middle, Last): ____

Title: ____

Hospital: ____

Address: ____

____

Contact phone: (________) – ________ – _____________

Email: ____

of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes."