(g) of this section for the applicable fiscal year may also qualify to receive a supplemental payment.

(2) Indian Health Service and Tribal Hospitals and Puerto Rico hospitals that do not have a Factor 3 amount for fiscal year 2022 determined under paragraph (g)(1)(iii)(C)(*9*) of this section are not eligible to receive a supplemental payment under this paragraph (h).

(3) The amount of the supplemental payment for a fiscal year is determined as the difference between the following:

(i) A base year amount defined as the FY 2022 uncompensated care payment determined for the hospital, in accordance with paragraph (g)(1) of this section, adjusted by 1 plus the percent change in the aggregate amount of uncompensated care payments as estimated by CMS in accordance with paragraphs (g)(1)(i) and (ii) of this section between fiscal year 2022 and the applicable fiscal year. If the hospital did not qualify for an additional payment for uncompensated care under paragraph (g) of this section for fiscal year 2022, CMS uses the Factor 3 determined for the hospital under paragraph (g)(1)(iii)(C)(*9*) of this section to estimate the amount of the additional payment for uncompensated care that the hospital would have received in fiscal year 2022 if the hospital had qualified for an additional payment for uncompensated care under paragraph (g)(1) of this section for that fiscal year.

(ii) The additional payment for uncompensated care determined for the hospital for the applicable fiscal year, in accordance with paragraph (g)(1) of this section.

(4) If the base year amount under paragraph (h)(3)(i) of this section is equal to or lower than the additional payment for uncompensated care determined for the hospital for the applicable fiscal year in accordance with paragraph (g)(1) of this section, the hospital will not receive a supplemental payment under paragraph (h) of this section for that fiscal year.

(i) *Manner and timing of payments.* (1) Interim payments are made during the payment year to each hospital that is estimated to be eligible for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, subject to the final determination of eligibility at the time of cost report settlement for each hospital.

(2) Final payment determinations are made at the time of cost report settlement, based on the final determination of each hospital's eligibility for payment under this section.

[54 FR 36494, Sept. 1, 1989]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.106, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§412.107 Special treatment: Hospitals that receive an additional update for FYs 1998 and 1999.

(a) *Additional payment update.* A hospital that meets the criteria set forth in paragraph (b) of this section receives the following increase to its applicable percentage amount set forth in §412.63 (p) and (q):

(1) For FY 1998, 0.5 percent.

(2) For FY 1999, 0.3 percent.

(b) *Criteria for classification.* A hospital is eligible for the additional payment update set forth in paragraph (a) of this section if it meets all of the following criteria:

(1) *Definition.* The hospital is not a Medicare-dependent, small rural hospital as defined in §412.108(a) and does not receive any additional payment under the following provisions:

(i) The indirect medical education adjustment made under §412.105.

(ii) The disproportionate share adjustment made under §412.106.

(2) *State criteria.* The hospital is located in a State in which the aggregate payment made under §412.112 (a) and (c) for hospitals described in paragraph (b)(1) of this section for their cost reporting periods beginning in FY 1995 is less than the allowable operating costs described in §412.2(c) for those hospitals.

(3) *Hospital criteria.* The aggregate payment made to the hospital under §412.112 (a) and (c) for the hospital's cost reporting period beginning in the fiscal year in which the additional payment update described in paragraph (a) of this section is made is less than the

allowable operating cost described in § 412.2(c) for that hospital.

[62 FR 46030, Aug. 29, 1997]

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(a) *Criteria for classification as a Medicare-dependent, small rural hospital—*

(1) *General considerations.* For cost reporting periods beginning on or after April 1, 1990, and ending before October 1, 1994, or for discharges occurring on or after October 1, 1997, and before October 1, 2024, a hospital is classified as a Medicare-dependent, small rural hospital if it meets all of the following conditions:

(i) It is located in a rural area (as defined in subpart D of this part) or it is located in a State with no rural area and satisfies any of the criteria under § 412.103(a)(1) or (3) or under § 412.103(a)(2) as of January 1, 2018.

(ii) The hospital has 100 or fewer beds as defined in § 412.105(b) during the cost reporting period.

(iii) The hospital is not also classified as a sole community hospital under § 412.92.

(iv) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the hospital's cost reporting period or periods as follows, subject to the provisions of paragraph (a)(1)(v) of this section:

(A) The hospital's cost reporting period ending on or after September 30, 1987 and before September 30, 1988.

(B) If the hospital does not have a cost reporting period that meets the criterion set forth in paragraph (a)(1)(iv)(A) of this section, the hospital's cost reporting period beginning on or after October 1, 1986, and before October 1, 1987.

(C) At least two of the last three most recent audited cost reporting periods for which the Secretary has a settled cost report.

(v) If the cost reporting period determined under paragraph (a)(1)(iv) of this section is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(2) *Counting days and discharges.* In counting inpatient days and discharges for purposes of meeting the criteria in paragraph (a)(1)(iii) of this section, only days and discharges from acute care inpatient hospital stays are counted (including days and discharges from swing beds when used for acute care inpatient hospital services), but not including days and discharges from units excluded from the prospective payment system under §§ 412.25 through 412.30 or from newborn nursery units. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(3) *Criteria for hospitals that have remote location(s).* For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, combined data from the main campus and its remote location (s) are required to demonstrate that the criteria in paragraphs (a)(1) and (2) of this section are met. For the location requirement specified in paragraph (a)(1)(i) of this section, the hospital must demonstrate that the main campus and its remote locations each independently satisfy this requirement.

(b) *Classification procedures.* (1) The MAC determines whether a hospital meets the criteria specified in paragraph (a) of this section.

(2) A hospital must submit a written request along with qualifying documentation to its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section.

(3) The MAC will make its determination and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation.

(4) For applications received on or before September 30, 2018, a determination of MDH status made by the MAC is effective 30 days after the date the MAC provides written notification to the hospital. For applications received on or after October 1, 2018, a determination of MDH status made by the MAC is effective as of the date the