

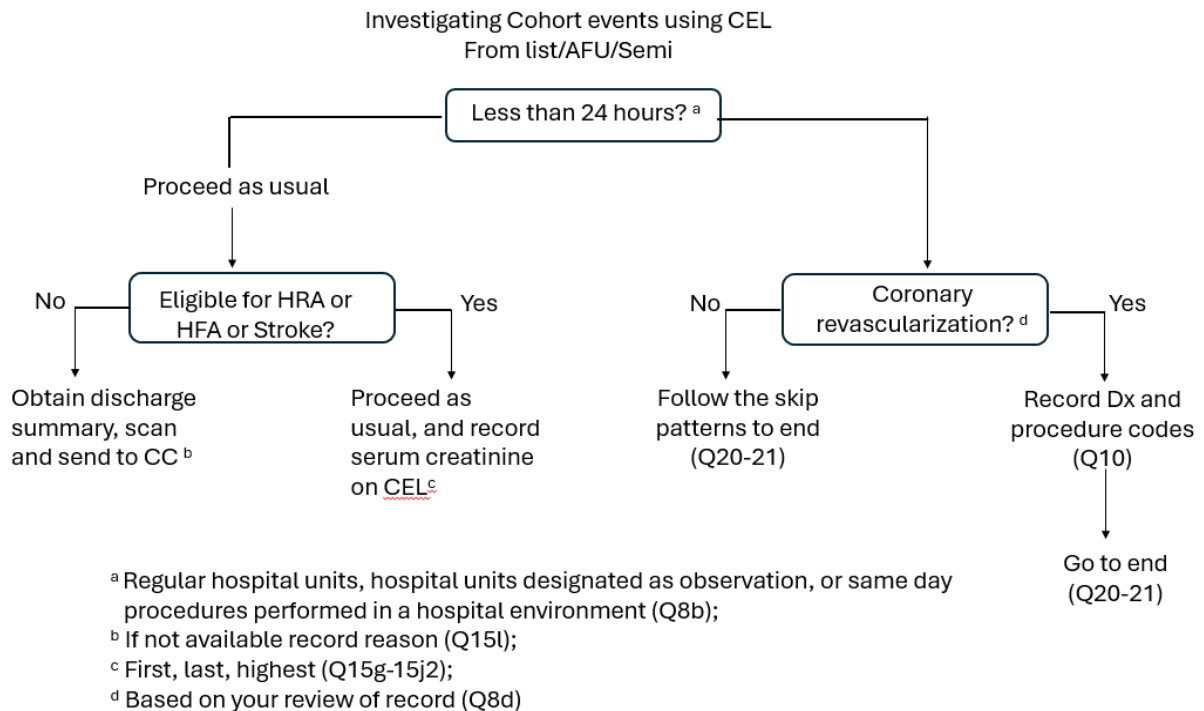
**INSTRUCTIONS FOR COMPLETING
COHORT EVENT ELIGIBILITY FORM
CEL, VERSION I, 05/21/2026
CEL QxQ, 05/21/2026**

I. GENERAL INSTRUCTIONS

The Cohort Event Eligibility (CEL) Form should be the first form to be completed for an identified event in a cohort member. The staff completing the CEL form must be certified and should be familiar with the document titled "General Instructions for Completing Paper Forms" prior to completing this form.

A CEL form should be completed, including establishing an Event ID Number, for all cohort deaths, hospitalizations lasting 24 hours or more, as well as hospital stays identified as observation stays or otherwise lasting less than 24 hours, including same-day procedures performed in the hospital. The protocol to complete a CEL form for observation stays lasting less than 24 hours including same day surgical procedures was implemented in October 2014 (See Figure 1). The purpose of this change is to collect information about coronary revascularization procedures performed for stays in hospital lasting less than 24 hours, or procedures performed in ambulatory surgery centers. See below for situations where stays less than 24 hours do not require a CEL. Another modification is inclusion of data on serum creatinine for hospitalizations lasting 24 hours or more that are not otherwise eligible for abstraction for myocardial infarction, heart failure or stroke using the HRA, HFA, or STR forms, respectively, including obtaining a discharge summary, when available. Effective October 2015, data collection for "date of arrival at the hospital" for events that are ineligible for CHD, Heart Failure, Stroke abstraction, OR if a coronary revascularization procedure was performed for a stay lasting less than 24 hours was added. As of May 2026, the Steering Committee has approved a modification of the creatinine protocol: creatinine will only be collected for events eligible for abstraction as potential myocardial infarction, heart failure, or stroke events.

Figure 1. Non-Fatal Cohort Event Flow Diagram



There are several ways in which one may be led to fill out a Cohort Event Eligibility Form. Three common paths are: (1) an event is identified through Cohort Follow-up (Annual or Semi-annual) procedures, (2) an event is identified through community surveillance procedures, but is discovered to have occurred in a cohort participant, or (3) a hospitalization or observation stay or same-day procedure event is unexpectedly discovered while investigating another hospital admission of a cohort member. In each of these cases, a Cohort Event Eligibility Form is completed for the event. A CEL form should be completed for all hospitalizations (>24 hours) reported by Cohort member (regardless of reason for the hospitalization) and for all reported coronary revascularization procedures occurring in ambulatory surgery center or seen by surgeon.

SPECIAL NOTE ON POSSIBLE DUPLICATION:

- A. Deaths found through Annual or Semi-annual Cohort Follow-up (FU) must be cross-checked with the death certificate list and vice versa to avoid duplicate investigations.
- B. Hospitalizations and hospital observation stays, regardless of duration, and same day procedures in area hospitals found through Cohort FU need to be cross-checked against hospital discharge indices and vice versa.
- C. Hospitalized deaths identified using a hospital discharge index need to be cross-checked versus the death certificate index and vice versa.

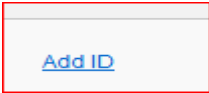
Situations for completing a CEL for less than 24 hour stay with no coronary revascularization

When upon investigating an event reported during cohort follow-up (AFU/SAF), it is determined that the episode was for less than 24 hours AND there was no evidence that a coronary revascularization procedure was done (e.g. no CABG, PTCA, coronary stent placement, coronary atherectomy or other PCI) then a CEL is completed to indicate that the event lasted < 24 hours (Q8c = YES) and no coronary revascularization (Q8d=NO). This will take you to the end of the CEL form.

HOW TO ENTER AN EVENT ID FOR A COHORT NOT ON H-LIST

Before entering an event ID for a cohort member, make sure that the instructions above about Special Note on possible duplication have been followed and crossed-checked by checking the MRN, DOD and Hospital number to see if there is an exact match. If not, then proceed with the following steps.

- A. From the Event ID Numbers that are distributed from the CC to the field centers, choose the next available, unassigned ID to add to the DMS. Once this ID has been selected, make sure that it is destroyed to avoid future use of it. An Event ID Number is added DMS to initiate keying of the CEL Form for cohorts not identified on the H-List.



Step 1. After login to the DMS select: Add ID:

Step 2. Enter the Event ID Number.

Step 3. After entering the Event ID Number ID click on the ID. The next screen should look like this:

Form Group	Form Name
Administrative Forms	↓
Hospitalizations	↓
Deaths	↓

Step 4. Under the Form Group, select the green arrow under Form Name associated with Hospitalizations

Form Group, click on it and the CEL Form, Version F should show.

II. DETAILED INSTRUCTIONS FOR CEL QUESTIONS

Question 1a.- b: Last name, First name, Middle name

Record the individual's last name, first name and middle name, or as much as is available. Print clearly in capital letters.

Question 1c: Deleted

Question 2: Participant ID

Record the individual's 7-digit cohort participant ID number.

Question 3: Deleted.

Question 4: Date of discharge or death

If the source of information is a hospital record, record the date of discharge. It will be found on the face sheet or the ER sheet. If the patient transferred from acute care to rehab or chronic care in the same hospital, count the date of transfer as the discharge date. If a computer listing is used, use the date on that list. If the patient died, or if the source of information is a death certificate, record the date of death. If the source of information is the Cohort FU (Annual or Semi-annual) and the month, day, or year is not available, leave blank and set the field status to "Missing", ignore the skip following this item and continue with Item 5.

Question 4a: Date of Birth

Record participant's date of birth.

Question 5: Source used to identify event

Indicate the first source where the event was identified. The source options are Cohort Follow-up, Surveillance Procedures, or Other.

Question 6: Is this event a death?

If the event is a death, record "Yes." Otherwise, record "No" and go to item 8.

Question 6a: Was an autopsy performed?

Record "Yes" if there was an autopsy. Otherwise, record "No".

Question 7: Is this event an out-of-hospital death, or a death for which hospitalization cannot be located?

If the event is an out-of-hospital death (including case where cohort is dead on arrival or died in the emergency department), or if it is an in-hospital death for which no hospitalization information can be located after exhaustive efforts to obtain documentation, record "Yes" and go to item 14a. Otherwise, record "No" and continue to question 8a.

Question 8a: Hospital Code Number.

Enter the two-digit code assigned to this hospital (See Appendix AA for list of hospital codes). If outside the ARIC communities use the appropriate code (96-99) and write in the hospital name and address. In situations where the event occurred in an ambulatory surgery setting affiliated with ARIC catchment hospitals, use the hospital code as appropriate, otherwise code (96-99)

8a3: Was permission granted to access medical record: Record "Yes" if permission is granted to access medical record. If permission is not granted, record "No" and go to item 19a.

Question 8b: Can information on this hospitalization be located?

This question should be answered "No" (N) if a hospitalization is ascertained by Cohort FU (Annual or Semi-annual) but the hospitalization cannot be verified. Possible scenarios where Question 8.b should be answered "No" are if the reported hospitalization is from a catchment area hospital but the hospitalization is not on the corresponding hospital discharge index or b) because it occurred in an out-of- catchment area hospital and ARIC staff cannot obtain the medical record or any verification from that hospital that the hospitalization took place. If answered No (N), go to item 19a. Question 8b should be answered "Yes" (Y) if a hospitalization is ascertained by Community Surveillance from the list of hospital discharges furnished by catchment area hospitals. If later when attempting to abstract the hospital record the chart cannot be found, that fact is entered STR form.

Question 8c: Is this event a hospital stay lasting less than 24 hours

The purpose of this question is to identify hospital, ER or ambulatory out-patient visits that last less than 24 hours. The question should be answered "Yes" (Y) if the length of stay in the hospital was less than 24 hours which includes stays in regular hospital units, hospital units designated as observation, and same day procedures performed in a hospital environment.

8d: Was a coronary revascularization procedure performed during this event?

Record "Yes" if after reviewing the available information in the medical record you can confirm that either a CABG, PTCA, coronary stent placement, coronary atherectomy or other PCI was performed. If "Yes" questions 9, 10, 19e, 20 and 21 are to be completed

Question 9: Hospital Record Number

Enter the hospital medical record number from the hospital chart. This number will be found stamped or typed on almost every page of the hospital record. The easiest place to find it is both on the medical record folder and in the upper right/left hand corner of the face sheet. List the number from left to right. Enter only digits and letters; omit dashes and spaces. Do not add zeroes to the right of the number. If the number changes with each admission, use the appropriate number for the one (admission) being abstracted.

Question 9a: How was need for abstraction established for this cohort event?

Record the source of data used to evaluate need for abstraction. An example of "other" is the hospital's computer listing or cohort follow-up.

Question 10: Hospital discharge diagnosis and procedure codes (ICD Codes):

The purpose of this section is to capture all ICD codes (discharge diagnosis and procedure codes) exactly as they appear in the medical chart (face sheet or discharge summary). This is important because there are situations where codes in the hospital index list (H-List) do not match the codes in the hospital chart.

If the event (i.e., hospitalization, observation stay (less than 24 hour stays) or same day procedure) is included in the hospital index, then the codes from the index will be prefilled into the DMS. It should be noted that the order of the codes prefilled by the DMS may not match order on the face sheet of the hospital discharge record due to the hospital provided the codes out of order. In this case sites would need to change the order to match the hospital discharge record. If there is a change in the codes and the need for abstraction changes from "N" (screen would show "blank/grayed out", i.e., no value is displayed in the DMS screen) to "Y" in any of CEL15a, 15b, or 15c the abstraction should be done as indicated. Should there be a change in the need for abstraction from "Y" to "N" ("blank/grayed out, i.e., no value is displayed in the DMS screen), and this should be rare, there is no need to delete an abstraction already done. Be sure to include the primary diagnosis as designated by the M.D., as well as all secondary diagnoses. Starting December 18, 2020, ICD-9 diagnosis and procedure codes are considered as invalid in CDART to reduce data entry errors. (If a CEL needs to be entered

for an old event year in which ICD-9 codes were used, the abstractor can override the invalid message so that the ICD-9 code can be entered.)

Description of valid ICD-10 diagnosis codes: CNY.YYYC where C is A-Z, N is 0-9, Y is A-Z except U. Here the decimal portion of the code and the number of characters after the decimal are optional. Examples of valid codes: I21, I21.1, R99.6, U07.0, U07.1, I21., I21.01, I21.A, O9A, C50.919, S06.5X4A, T83.511A

Description of valid ICD-10 procedure codes: XXXXXXX (exactly 7 X's) where X is any numeral 0-9 or any letter A-Z except the letters I and O. Examples of valid codes: 06H93DZ, 5A2204Z, GZFZZZZ, HZ53ZZZ

NOTE: Do not enter ANY codes in the note log field.

Note: Questions 11a, 11a1, 11b, 11b1, 11f 11f1 will be automatically completed by the DMS.

Question 11.a: Are any of the following codes listed?

ICD 9 codes: 402, 410-414, 427, 428 or 518.4

ICD 10 codes: I11.x, I20.x, I21.x, I22.x, I24.x, I25.x, I46.x, I47.x, I48.x, I49.x, I50.x, J81.0, R00.1

If any code is as indicated, regardless of decimal (except for ICD-9 code 518.4 which must include the 4 in first place to the right of the decimal), record "Yes". In the DMS this is automatically determined. If "Yes", then skip to 11b.

Question 11.a.1: Are any of the following codes listed? [Click here to open CEL Paper Form for list of ICD Codes](#)

Due to the large number of ICD 10 codes the CC truncated the codes to the first three characters, as these represent the category of codes that are further subdivided by the use of any or all of the 4th, 5th, 6th or 7th characters. (The codes are not visually on the screen, but are utilized in the background programming). The full list of the truncated codes for items 11a1, 11b1 and 11f1 are as follows:

ICD 9 codes: 00.50-00.54, 00.61-00.66, 35-39, 88.5, 89.49, 99.10, 250, 390-459, 745-747, 794.3, 798, or 799

ICD 10 codes for items

021x	02Sx	03Nx	04Jx	05Hx	06Dx	0GTx
025x	02Tx	03Px	04Lx	05Jx	06Hx	0JH6x
027x	02Ux	03Qx	04Nx	05Lx	06Jx	0JH7x
028x	02Vx	03Rx	04Qx	05Nx	06Lx	0JH8x
02Bx	02Wx	03Sx	04Rx	05Qx	06Nx	0JHDx
02Cx	02Yx	03Ux	04Sx	05Rx	06Qx	0JHFx
02Hx	031x	03Vx	04Ux	05Sx	06Rx	0JHGx
02JA3ZZ	035x	03Wx	04Vx	05Ux	06Sx	0JHHx
02JY3ZZ	037x	041x	051x	05Vx	06Ux	0JHLx
02Kx	039x	045x	055x	061x	06Vx	0JHMx
02Lx	03Bx	047x	057x	065x	06Wx	0JHNx
02Nx	03Cx	049x	059x	067x	06Xx	0JHPx
02Px	03Hx	04Bx	05Bx	069x	06Yx	0JPy
02Qx	03Jx	04Cx	05Cx	06Bx	06Zx	0JQx
02Rx	03Lx	04Hx	05Dx	06Cx	06Ax	0JRx

0W9x	B54x	I11.x	I36.x	I62.x	I82.x	Q27.x
0WCx	B33.x	I12.x	I37.x	I63.x	I83.x	Q28.x
0WJx	B34.x	I13.x	I38	I65.x	I85.x	R00.x
0X3x	B97.x	I15.x	I39	I66.x	I86.x	R09.x
0Y3x	E10.x	I20.x	I40.x	I67.x	I87.x	R41.x
3E0x	E11.x	I21.x	I41	I68.x	I89.x	R45.x
4A0x	E12.x	I22.x	I42.x	I69.x	I95.x	R53.81
4B02XTZ	E13.x	I23.x	I43	I70.x	I97.x	R58
5A0x	E14.x	I24.x	I44.x	I71.x	I99.x	R64
5A1x	G45.x	I25.x	I45.x	I72.x	K64.x	R68.82
8E023DZ	I00	I26.x	I46.x	I73.x	M30.x	R69
B20x	I01.x	I27.x	I47.x	I74.x	M31.x	R94.x
B21x	I02.x	I28.x	I48.x	I75.x	Q20.x	R96.x
B24x	I05.x	I30.x	I49.x	I76	Q21.x	R98
B32x	I06.x	I31.x	I50.x	I77.x	Q22.x	R99
B42x	I07.x	I32	I51.x	I78.x	Q23.x	
B50x	I08.x	I33.x	I52	I79.x	Q24.x	
B51x	I09.x	I34.x	I60.x	I80.x	Q25.x	
B52x	I10	I35.x	I61.x	I81	Q26.x	

If any code is as indicated, regardless of decimal, record "Yes." If not, record "No". If "No", then skip to 11b. In DMS this is automatically determined

Question 11.a.2: Are any of the following mentioned or suggested in the discharge summary?

Review the discharge summary for any of the CHD-related terms listed. Note that the first list of terms must be considered "acute," and the second list must pertain to this admission. If any one of the terms is found, record "Yes." If in doubt about a term, ask the surveillance MD at your field center.

Question 11.b: Are any of the following codes listed?

ICD 9 codes: 430-436

ICD 10 codes: G45.x, I60.x, I61.x, I62.x, I63.x

If any code is as indicated, regardless of decimal record, "Yes." In DMS this is automatically determined. (Note the changed range from Version C of CEL.). If "Yes", then skip to 11.f

Question 11b1: Are any of the following codes listed? [Click here to open CEL Paper Form for list of ICD Codes](#)

Due to the large number of ICD 10 codes the CC truncated the codes to the first three characters, as these represent the category of codes that are further subdivided by the use of any or all of the 4th, 5th, 6th or 7th characters. (The codes are not visually on the screen, but are utilized in the background programming). See Item 11a1 for list of codes.

Note, if any code is as indicated, regardless of decimal, record "Yes." If not, record "No". If "No", then skip to 11.f. In DMS this is automatically determined.

Question 11b2: Are any of the following mentioned or suggested in the discharge summary?

Review the discharge summary for any of the stroke-related terms listed. Note that the first list of terms must be considered "acute and the second list must pertain to this admission. If any one of the terms is found, record "Yes." If in doubt about a term, ask the surveillance MD at your field center.

Question 11f: Are any of the following codes listed?

ICD 9 codes: 398.91, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 415.0, 416.9, 425.4, 428, 518.4, 786.0

ICD 10 codes: I09.81, I11.0, I13.0, I13.2, I26.0x, I27.81, I27.9, I42.0, I42.5, I42.8, I42.9, I50.x, J81.0, R06.x

If the code is as indicated, record "Yes." In DMS this is automatically determined. If "Yes", and neither of 11a nor 11a2 is "Yes" then skip to 12. If "Yes" and either of 11a or 11a2 is "Yes", then skip to 15a.

Question 11f1 . Are any of the following codes listed? [Click here to open CEL Paper Form for list of ICD Codes](#)

Due to the large number of ICD-10 codes the CC truncated the codes to the first three characters, as these represent the category of codes that are further subdivided by the use of any or all of the 4th, 5th, 6th or 7th characters. (The codes are not visually on the screen, but are utilized in the background programming). See Item 11a1 for list of codes.

Note, if any code is as indicated, regardless of decimal record "Yes." If not, record "No." In DMS this is automatically determined. If "No", and neither of 11a nor 11a2 is "Yes", then skip to 12. If "No", and either of 11a or 11a2 is "Yes", then skip to 15a.

Question11f2: Are any of the following mentioned or suggested in the discharge summary?

Review the discharge summary for any of the heart failure-related terms listed. Note that the first list of terms must be considered "acute and the second list must pertain to this admission. If any one of the terms is found, record "Yes." If in doubt about a term, ask the surveillance MD at your field center.

If either of the items 11a or 11a2 is "Yes", then follow the applicable skip instruction in the box following this item.

Question12: Is this event an in-hospital death?

If the event is an in-hospital death, record "Yes" and continue with item 14. Otherwise, record "No" and skip to item 15a.

Question 13: Deleted

Question 13a: Deleted.

Question 14.a: ICD-10 Code for underlying cause of death.

Record the underlying cause of death by listing the ICD-10 Code as they appear on the death certificate for deaths occurring in 1999 and afterward. If it is not available, record the immediate cause. Here is a description of valid ICD-10 diagnosis code: CNY.YYYC where C is A-Z, N is 0-9, Y is A-Z except U. The decimal portion of the code and the number of characters after the decimal are optional. Examples of valid codes: I21, I21.1, R99.6, U07.0, U07.1, I21., I21.01, I21.A, O9A, C50.919, S06.5X4A, T83.511A

Question 14b: Is the code E-10-E14, I10, I11, 120-I25, I46-I51, I70, I97 (exclude I97.2), J81, J96, R96, R98, or R99?

If the ICD-10 code is as indicated, regardless of decimal, record "Yes". If not, record "No". In DMS this is automatically determined.

Question 15a-f: Determination of additional abstraction forms to complete

The purpose of this section is to determine the need for hospitalized MI, HF, or stroke abstraction or out-of-hospital death abstraction. These are filled automatically by the DMS. Otherwise the rules given on the form

determine the responses. If changes in these fields occur and the need for abstraction changes from "N" (screen would show "blank/grayed out" , i.e., no value is displayed in the C-DART screen) to "Y" in any of CEL15a, 15b, 15c, 15d, or 15e then the needed abstraction should be done. Should there be a change in the need for abstraction from Y to N, and this should be rare, there is no need to delete an abstraction already done. Q15e is determined from Q6. Q15f is determined by Q6a and Q15a-d.

Note: In DMS the response "N" will no longer be inserted into 11a, 11a1, 11b, 11b1, 11f, 11f1, 14b, 15a-f. Instead, the field will appear 'grayed out' and skipped unless the answer is "Y". The response "Y" is still inserted in these fields when it is appropriate. This is in order to increase the efficiency of the form.

Question 15g-15l are skipped when this event is an out of hospital death or a death for which information cannot be found (item 7=Yes), or where permission is not granted to access the medical record (item 8a.3=No), or where information on this hospitalization cannot be located (item 8b=No) or if the hospitalization is < 24 hours (item 8c=Yes).

If the event is not eligible for CHD, HFA or Stroke abstraction (15a≠Yes and 15b≠Yes and 15c≠Yes), items 15g through 15l are skipped.

Question 15g: Serum creatinine values

In-lab creatinine values are preferred. Take Point of Care blood creatinine only if in-lab creatinine is not available. Record the value of the first, last and highest measurements of serum creatinine. If there is only one serum creatinine value, then "last" and "highest" values and dates are left blank. Likewise, if there are only two values, 'highest' is left blank.

Question 15h1: First serum creatinine

Record the initial serum creatinine measurement if one is present in the chart in 15h1. Record the date of the first serum creatinine in 15h2. If there is only one serum creatinine value, then "last" and "highest" values and dates are left blank. Likewise, if there are only two values, 'highest' is left blank.

Question 15i2: Last serum creatinine

Then record the last recorded measurement available in the medical record in 15i1. Record the date of the last serum creatinine in 15i2.

Question 15j1: Highest remaining values (if more than two) serum creatinine

In addition to recording the first and the last measured serum creatinine in the two preceding questions, the first highest of any remaining measurements is to be recorded in Question 15j1. Record the date of this measurement in Question 15j2. If there are no serum creatinine measurements other than those recorded in Questions 15h1 (first), and 15i2 then leave blank in 15j1 and 15j2. If there is more than one date that has the same 'highest' result, use the first date associated with the duplicate reporting of the remaining highest reporting.

Question 15k: Was the discharge summary for this event available?

The purpose of this question is to allow for the identification and collection of a discharge summary for a hospitalization lasting 24 hours or more that is not eligible for CHD, HF, or stroke abstraction. Record "Y" if a discharge summary is available and you are able to obtain a copy, then go to item 19a. Record "N" if the discharge summary is not available. If a discharge summary is not available, specify in 15l the reason by selecting one of the items indicated. The options are that the discharge summary is missing (M), or you are not permitted access to the summary (P), or other (O).

NOTE: Discharge summaries identified in Question 15k are those for hospitalizations for reasons other than CHD, HF, or stroke. However, abstractors should investigate these events and attempt to obtain the discharge

summary, including those events occurring in hospitals outside the catchment area. Please scan and blind discharge summary for ALL events with a >24hr hospitalization, regardless of whether the events are eligible for abstraction, (per protocol, see Manual 3, Section 11.9) and send to the coordinating center, using the appropriate naming convention as described in Manual 3 (Appendix X).

Question 16, 17, 18: Deleted.

Questions 19a: Was this event reported on the corresponding Annual or Semi-annual Cohort Follow-up for this participant?

To assure that all deaths and hospitalizations discovered through Follow-Up (FU) are investigated, the CEL and Follow-Up forms must be cross-referenced. For each cohort event, determine whether the death or hospitalization was reported on the participant's latest Follow-Up form, i.e., AFU, sAF, or DEC. To do this for deaths, double check that each cohort death is indicated on the latest DEC or latest AFU form. If the death is recorded on a DEC form or AFU form, enter Y on the CEL for item 19.a and proceed to enter the CFU contact year in 19.b. It is important to note that Surveillance does not distinguish between Annual and semi Annual cohort follow-up (CFU) for the source of identifying a cohort event (see question CEL5)

19b: Record the contact year of corresponding cohort follow-up for this event.

For hospitalizations and observation stays, including those less than 24 hour and same day procedures precautions have to be taken because participants' reports of dates and reasons for hospitalization on Follow-Up may be inaccurate. Compare the name of the hospital, date of hospitalization, and discharge diagnoses as listed on the CEL Form with those on the Follow-Up forms (AFU or sAF). If the information matches exactly, answer 19.a. "Yes".

If these values do not match exactly, judgments have to be made about whether the hospitalizations are the same based on the following priorities: 1) hospital name, 2) date of hospitalization within plus or minus six months, and 3) the reason for hospitalization. The hospital name and date should match within reason. If the name of the hospital does not match, the participant should be recontacted to check this. If the hospitalization can be confirmed within reason, answer 19.a. "Yes." If not, answer "No" and skip to item 20.

Question 19e: Arrival date at this hospital.

Enter the date of arrival at the hospital. In some instances, the arrival date may be different from the admit date indicated on the chart. Note: This question is completed for cohort events that are ineligible for HRA, HF, STR abstraction (in other words, a CHI form will not be completed). Follow the skip pattern on the form.

Question 20: Date of data collection.

Record the date on which the form was completed.

Question 21: Code number of person completing this form.

The field center staff member who has performed the abstraction and completed the form must enter his/her valid ARIC code number in the boxes provided.

**Appendix AA
HOSPITAL CODES**

List of Active Catchment Area Hospitals as of 09/28/2015

Site	Name	Hospital Type	Notes
Forsyth County			
11	Wake Forest Baptist Med Center(used to be North Carolina Baptist)	Teaching	
12	Novant Health Forsyth Medical Center (used to be Forsyth County Memorial)	Nonteaching	
14	Novant Health Kernersville Medical Center (used to be Kernersville Medical Center)	Nonteaching	Added in 2013
15	Novant Health Clemmons Medical Center (used to be Clemmons Medical Center)	Nonteaching	Added in 2014
96	Hospital outside study area	--	
Jackson			
21	University of Mississippi Med Center	Teaching	
23	St. Dominic's Hospital	Nonteaching	
24	Merit Health Central Med Center	Nonteaching	Name change 2015
25	Mississippi Baptist Hospital	Nonteaching	
27	Merit Health Madison Hospital	Nonteaching	JHS only (name change in 2015)
28	Merit Health Rankin Hospital	Nonteaching	JHS only (name change in 2015)
97	Hospital out of study area	--	
Minnesota Townships			
30	Abbott-Northwestern Hospital – Allina Health	Teaching	Name change 2015
36	Park Nicollet Medical Center	Teaching	Name change 2015
40	North Memorial Medical Center	Teaching	
98	Hospital out of study area	--	
Washington County			
51	Meritus Medical Center	Nonteaching -	Name change in 2013
99	Hospital out of study area	--	

Inactive Hospitals

13	Medical Park (Novant Health Medical Park Hospital)		
22	Veterans Administration Hospital	Teaching	
24	Hennepin County Medical Center	Teaching	
26	Merit Health Hospital	Nonteaching	Name change 2015
31	Riverside Medical Center	Teaching	Closed
32	Fairview Southdale Hospital – Fairview Health Services	Nonteaching	Name change 2015
33	Fairview- Ridges	Non-teaching	Closed
34	Hennepin County Medical Center	Teaching	
35	Mercy Hospital – Allina Health	Nonteaching	Name change 2015
37	Metropolitan	Non teaching	Closed
38	Midway	Non teaching	Closed
39	Mt. Sinai	Non teaching	Closed
41	St. Paul Ramsey	Non teaching	Closed
42	St. John's Northeast	Non teaching	Closed
43	St. Mary's	Non teaching	Closed
44	Unity Hospital – Allina Health	Nonteaching	Name change 2015
45	University of Minnesota Medical Center, Fairview	Teaching	
46	VA Medical Center	Teaching	
47	Fairview	Non teaching	
48	Phillips Eye Institute	Non Teaching	
52	Western Maryland Center	Nonteaching	
53	VA Medical Center, WV	Nonteaching	
54	University of Maryland	Teaching	
55	Frederick Memorial	Nonteaching	
56	Johns Hopkins Hospital	Teaching	
57	Washington Hospital Center	Nonteaching	
58	George Washington University	Teaching	
59	Georgetown University	Teaching	
60	Saint Joseph Medical Center	Nonteaching	
61	Washington Adventist	Nonteaching	

62
63

Sinai Hospital
Union Memorial

Nonteaching
Nonteaching

APPENDIX BB

ADDITIONAL FORMS REQUIRED BASED UPON RESPONSES

FORM	CRITERIA BASED ON THIS FORM
AFU, SAF, DEC	Item 6 = Y
HRA, CHI	Item 15a = Y
STR, CHI	Item 15b = Y
HFA, CHI	Item 15c = Y
IFI(s), PHQ, DTH	Item 15d = Y
PHQ(s)	Item 15d = Y
DTH	Item 15e = Y
COR	Item 15f = Y