urban hospitals' cost reporting periods that began during FY 1993 (that is, October 1, 1992 through September 30, 1993). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status or to meet the triennial review standards for cost reporting periods beginning on or after October 1, 1995, the number of discharges a hospital must have for its cost reporting period that began during FY 1994 would have to be at least—

- 5,000; or
- Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the June 2, 1995 proposed rule at 60 FR 29222.)

Based on the latest discharge data available, the final median numbers of discharges for urban hospitals by census regions are as follows:

Region	No. of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6815
2. Middle Atlantic (PA, NJ, NY)	8618
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7500
4. East North Central (IL, IN, MI, OH, WI)	7155
5. East South Central (AL, KY, MS, TN)	5582
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5135
7. West South Central (AR, LA, OK, TX)	4464
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8179
9. Pacific (AK, CA, HI, OR, WA)	5594

We reiterate that, to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1995, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1994 would have to be at least 3,000.

3. Retention of Referral Center Status

Section 412.96(f) states the general rule that each hospital receiving the referral center adjustment is reviewed every 3 years to determine if the hospital continues to meet the criteria for referral center status. To retain status as a referral center, a hospital must meet the criteria for classification as a referral center specified in § 412.96 (b)(1) or (b)(2) or (c) for 2 of the last 3 years, or for the current year. A hospital may meet any one of the three sets of criteria for individual years during the 3-year period or the current year. For example, a hospital may meet the two mandatory requirements in § 412.96(c)(1) (case-mix index) and (c)(2) (number of discharges) and the optional criterion in paragraph (c)(3) (medical staff) during the first year. During the second or third year, the hospital may meet the criteria under § 412.96(b)(1) (rural location and appropriate bed size).

A hospital must meet all of the criteria within any one of these three sections of the regulations in order to meet the retention requirement for a given year. That is, it will have to meet all of the criteria of § 412.96(b)(1) or § 412.96(b)(2) or § 412.96(c). For example, if a hospital meets the case-mix index standards in § 412.96(c)(1) in years 1 and 3 and the number of discharge standards in § 412.96(c)(2) in years 2 and 3, it will not meet the retention criteria. All of the standards would have to be met in the same year.

In accordance with § 412.96(f)(2), the review process is limited to the hospital's compliance during the last 3 years. Thus, if a hospital meets the criteria in effect for at least 2 of the last 3 years or if it meets the criteria in effect for the current year (that is, the criteria for FY 1996 outlined above in this section of the preamble), it will retain its status for another 3 years. We have constructed the following chart and example to aid hospitals that qualify as referral centers under the criteria in § 412.96(c) in projecting whether they will retain their status as a referral center.

Under § 412.96(f), to qualify for a 3-year extension effective with cost reporting periods beginning in FY 1996, a hospital must meet the criteria in § 412.96(c) for FY 1996 or it must meet the criteria for 2 of the last 3 years as follows:

For the cost reporting period beginning during FY	Use hospital's case-mix index for FY	Use the discharges for the hospital's cost reporting period beginning during FY	Use numerical standards as published in the **Federal Register** on
1995	1993	1993	September 1, 1994.
1994	1992	1992	September 1, 1993.
1993	1991	1991	September 1, 1992.

Example: A hospital with a cost reporting period beginning July 1 qualified as a referral center effective July 1, 1993. The hospital has fewer than 275 beds. Its 3-year status as a referral center is protected through June 30, 1996 (the end of its cost reporting period beginning July 1, 1995). To determine if the hospital should retain its status as a referral center for an additional 3-year period, we will review its compliance with the applicable criteria for its cost reporting periods beginning July 1, 1993, July 1, 1994, and July 1, 1995. The hospital must meet the criteria in effect either for its cost reporting period beginning July 1, 1996, or for two out of the three past periods. For example, to be found to have met the criteria at § 412.96(c) for its cost reporting period beginning July 1, 1994, the hospital's case-mix index value during FY 1992 must have equaled or exceeded the lower of the national or the appropriate regional standard as published in the September 1, 1993 final rule with comment period. The hospital's total number of discharges during its cost reporting year beginning July 1, 1992, must have equaled or exceeded 5,000 or the regional standard as published in the September 1, 1993 final rule with comment period.

For those hospitals that seek to retain referral center status by meeting the criteria of § 412.96(b)(1)(i) and (ii) (that is, rural location and at least 275 beds), we will look at the number of beds shown for indirect medical education purposes (as defined at § 412.105(b)) on the hospital's cost report for the appropriate year. We will consider only full cost reporting periods when determining a hospital's status under § 412.96(b)(1)(ii). This definition varies from the number of beds criterion used to determine a hospital's initial status as