4004.2 Part II - Hospital and Hospital Health Care Complex Reimbursement Questionnaire.--The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all hospitals submitting cost reports to the Medicare contractor under title XVIII of the Act. Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of cost reports. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor immediately after submission of the ECR. The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation required to complete the desk review.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

Line Descriptions

NOTE: The responses on all lines are Yes or No unless otherwise indicated. If, in accordance with the following instructions, you are requested to submit documentation, indicate the line number for each set of documents you submit.

Lines 1 through 21 are required to be completed by all hospitals.

Line 1--Indicate whether the hospital has changed ownership immediately prior to the beginning of the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2--Indicate whether the hospital has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3--Indicate whether the hospital is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for no. If "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

Note: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, chapter 10, and 42 CFR 413.17.)

Line 4--Indicate whether the financial statements were prepared by a certified public accountant. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If you answer no in column 1, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for no. If "Y", submit a reconciliation with the cost report.

Line 6--Indicate whether costs were claimed for a nursing program. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "Y" for yes or "N" for no in column 2 to indicate whether the provider is the legal operator of the program.

Line 7--Indicate whether costs were claimed for allied health programs. Enter "Y" for yes or "N" for no. If "Y", submit a list of the program(s) with the cost report and annotate for each whether the provider is the legal operator of the program.

Note: For purposes of lines 6 and 7, the provider is the legal operator of a nursing program and/or allied health program if it meets the criteria in 42 CFR 413.85(f)(1) or (f)(2).

Line 8--Indicate whether approvals and/or renewals were obtained during the cost reporting period for nursing programs and/or allied health programs. Enter "Y" for yes or "N" for no. If "Y", submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9--Indicate whether costs for interns and residents in approved GME programs were claimed on the current cost report. Enter "Y" for yes or "N" for no. If "Y", submit the current year Intern-Resident Information System (IRIS) with the cost report in a password-encrypted file on a CD or flash drive, or by a contractor-approved means such as electronic mail or a secure website.

Line 10--Indicate whether intern and resident approved GME program(s) have been initiated or renewed during the cost reporting period. Enter "Y" for yes or "N" for no. If "Y", submit copies of the certification(s)/program approval(s) with the cost report. (See 42 CFR 413.79(l) for the definition of a new program.)

Line 11--Indicate whether GME costs were directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program on Worksheet A. Enter "Y" for yes or "N" for no. If "Y", submit a listing of the cost centers and amounts with the cost report.

Line 12--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89 for the criteria for an allowable Medicare bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit listings supporting the bad debts claimed in the cost report. Effective for cost reporting periods beginning on or after October 1, 2018, a cost report will be rejected when submitted without listings that correspond to the amount of bad debt claimed (42 CFR 413.24(f)(5)). Exhibit 2 (for cost reporting periods beginning prior to October 1, 2022) and Exhibit 2A (for cost reporting periods beginning on or after October 1, 2022) present the information required to support the bad debt claimed. (See exhibits and instructions presented at the end of §4004.2.) If applicable, submit separate exhibits for each provider number in a hospital health care complex.

[Exhibit 2 and instructions moved to the end of §4004.2 with Exhibit 2A and instructions.]

Line 13--Indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the policy with the cost report.

Line 14--Indicate whether patient deductibles and/or coinsurance amounts were waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, do not include the deductibles and/or coinsurance amounts that were waived on the bad debt listing (i.e., Exhibit 2 or Exhibit 2A).

Line 15--Indicate whether total available beds have changed from the prior cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, provide an analysis of available beds and explain any changes that occurred during the cost reporting period.

NOTE FOR LINE 15: For purposes of line 15, available beds are provider beds that are permanently maintained for lodging inpatients. They must be available for use and housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). (See CMS Pub. 15-1, chapter 22, §2200.2.C., CMS Pub. 15-2, chapter 40, §4005.1, and 42 CFR 412.105(b).)

Line 16--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement Report (PS&R) only. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y" enter the paid-through date of the PS&R in columns 2 and/or 4. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 17--Indicate whether the cost report was prepared using the PS&R for totals and provider records for allocation. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in columns 2 and/or 4. Also, submit a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must show dollars by cost center and include which revenue codes were allocated to each cost center. The total revenue on the cost report must match the total charges on the PS&R (as appropriately adjusted for unpaid claims, etc.,) to use this method. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. If the contractor does not find the documentation sufficient, the PS&R will be used in its entirety.

Line 18--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 19--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 20--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 21--Indicate whether the cost report was prepared using provider records only. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

- Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components, capital PPS rate components and other PRICER information covering the cost reporting period.

- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a manner consistent with the PS&R.

- Reconciliation of remittance totals to the provider's internal records.

- Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

NOTE FOR LINE 21: Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material to further describe and validate the reliability of your system.

Lines 22 through 40 are required to be completed by cost-reimbursed and TEFRA hospitals only.

Line 22--Indicate whether assets have been re-lifed for Medicare purposes. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed listing of these specific assets, by class, as shown in the Fixed Asset Register with the cost report.

NOTE FOR LINE 22: "Class" means those depreciable asset groupings you use (e.g., land improvements, moveable equipment, buildings, fixed equipment).

Line 23--Indicate whether changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy of the Appraisal Report and Appraisal Summary by class of asset with the cost report.

Line 24--Indicate whether new leases and/or amendments to existing leases were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a listing of the new leases and/or amendments to existing leases if the annual rental cost of each of these leases is $50,000 or greater with the cost report. The listing should include the following information:

- Identify if the lease is new or a renewal.
- Parties to the lease.
- Period covered by the lease.
- Description of the asset being leased.
- Annual charge by the lessor.

NOTE FOR LINE 24: Providers are required to submit copies of the lease, or significant extracts, upon request from the contractor.

Line 25--Indicate whether new capitalized leases were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individual assets by class, the department assigned to, and respective dollar amounts if the annual rental cost of these leases is $50,000 or greater with the cost report.

Line 26--Indicate whether assets subject to §2314 of DEFRA were acquired during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a computation of the basis with the cost report.

Line 27--Indicate whether your capitalization policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy with the cost report.

Line 28--Indicate whether new loans, mortgage agreements, or letters of credit were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the debt documents and amortization schedules with the cost report. Also, state the purpose of the borrowing.

Line 29--Indicate whether you have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed analysis of the funded depreciation account for the cost reporting period with the cost report. (See CMS Pub. 15-1, chapter 2, §226, and 42 CFR 413.153.)

Line 30--Indicate whether existing debt has been replaced prior to its scheduled maturity with new debt. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy of the new debt document and a schedule calculating the allowable cost. (See CMS Pub. 15-1, chapter 2, §233.3, for description of allowable cost.)

Line 31--Indicate whether debt has been recalled before its scheduled maturity without the issuance of new debt. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed analysis supporting the debt cancellation costs and treatment of these expenses on the cost report. (See CMS Pub. 15-1, chapter 2, §215, for description and treatment of debt cancellation costs.)

Line 32--Indicate whether you have entered into new agreements or if changes occurred in patient care services furnished through contractual arrangements with suppliers of service. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the contracts in those instances where the cost of the individual's services exceeds $25,000 per year with the cost report.

Where you do not have written agreements for purchased services, submit a description listing the following information:

- Duration of the arrangement.
- Description of services.
- Financial arrangement.
- Name(s) of parties to the agreement furnishing the services.

Line 33--If you answered "Y" on line 32, were the requirements of CMS Pub. 15-1, chapter 21, §2135.2, pertaining to competitive bidding applied? Enter "Y" for yes or "N" for no in column 1. If column 1 is "N", submit an explanation with the cost report.

Line 34--Indicate whether services were furnished at your facility under an arrangement with provider-based physicians. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit Exhibit 1 (exhibit and instructions presented at the end of §4004.2), where applicable.

You may submit computer generated substitutes for these schedules provided they contain, at a minimum, the same information as in Exhibit 1. (This includes the signature on a substitute Exhibit 1.)

Allocation agreements (Exhibit 1) are required if physician compensation is attributable to both direct patient care and provider services. Allocation agreements are also required if all of the provider-based physician's compensation is attributable to provider services (i.e., departmental supervision and administration, quality control activities, teaching and supervision of Interns-Residents and/or Allied Health Students, and in the case of teaching hospitals electing cost reimbursement for teaching physicians' services, for compensation attributable to direct medical and surgical services furnished to individual patients, and the supervision of intern and residents furnishing direct medical and surgical services to individual patients). However, Exhibit 1 is not required if all of the provider-based physician's compensation is attributable to direct medical and surgical services to individual patients.

Physicians' compensation information is considered to be confidential, and therefore, qualifies for exemption from disclosure under the Freedom of Information Act, and specifically under 5 U.S.C. 552(b)(4). The compensation information also qualifies for exemption from disclosure under 5 U.S.C. 552(b)(6) which covers "personnel and medical files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." An individual's compensation is a personal matter and its release would be an invasion of privacy. Accordingly, CMS will not release, or make available to the public, compensation information collected.

[Instructions for Exhibit 1 and sample form moved to the end of §4004.2.]

Line 35--If you answered "Y" on line 34, indicate whether new agreements or amendments to existing agreements were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the new agreements or the amendments to existing agreements with the cost report.

Line 36--Indicate whether home office costs are claimed on the cost report. Enter "Y" for yes or "N" for no in column 1.

Line 37--If you answered "Y" on line 36, indicate whether a home office cost statement was prepared by the home office. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule displaying the entire chain's direct, functional, and pooled costs as provided to the designated home office contractor as part of the home office cost statement.

Line 38--If you answered "Y" on line 36, indicate whether the fiscal year end of the home office is different from that of the provider. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the fiscal year end of the home office in column 2.

Line 39--If you answered "Y" on line 36, indicate whether the provider renders services to other components of the chain. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule listing the names of the entities, the services provided, and cost incurred to provide these services with the cost report.

Line 40--If you answered "Y" on line 36, indicate whether the provider renders services to the home office. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule listing the services provided, and cost incurred to provide these services with the cost report.

Line 41--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 42--Enter the employer/company name of the cost report preparer.

Line 43--Enter the telephone number and email address of the cost report preparer.

NOTE: Exhibits 1 and 2 must be completed either manually (in hard copy) or via separate electronic/digital media as this information is not captured in the ECR file.

Exhibit 1 - Allocation of Physician Compensation Hours Instructions and Form

Complete this exhibit in accordance with CMS Pub. 15-1, chapter 21, §2182.3. The data elements shown are physicians' hours of service providing a breakdown between the professional and provider component.

Prepare a physician time allocation for each physician by department, who receives payment directly from you or a related organization for services rendered. This includes physicians paid through affiliated agreements. A weighted average for the entire department may be used where all physicians in the department are in the same specialty. Where a weighted average is submitted, individual time allocations need not be submitted. The physician or department head supplying this information must sign the schedule.

EXHIBIT 1

Allocation of Physician Compensation: Hours

Provider Name: _____
CCN: _____
Department: _____
Physician Name: _____

Cost Reporting Year: Beginning: _____ Ending: _____

Basis of Allocation: Time Study __/__/__ Other __/__/__ Describe: _____

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	
1A. Provider Services - Teaching and Supervision of Allied Health Students	
1B. Provider Services - Non Teaching Reimbursable Activities such as Departmental Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	
1D. Subtotal - Provider Administrative Services (Lines 1, 1A, 1B, 1C).	
2. Physician Services: Medical and Surgical Services to Individual Patients	
3. Nonreimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	
4. Total Hours: (Lines 1D, 2, and 3)	
5. Professional Component Percentage (Line 2 / Line 4)	
6. Provider Component Percentage - (Line 1D / Line 4)	

_____ _____
Signature: Physician or Physician Department Head Date

This page is reserved for future use.

NOTE: Exhibits 1 and 2 must be completed either manually (in hard copy) or via separate electronic/digital media as this information is not captured in the ECR file.

Exhibit 2 - Listing of Medicare Bad Debts and Appropriate Supporting Data Instructions and Form

If seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from Medicare beneficiaries (Worksheet S-2, Part II, line 12, is Y), for a cost reporting period beginning prior to October 1, 2022, complete Exhibit 2, or internal schedules that provide the same level of information as is requested on the exhibit, to support the bad debts claimed. If claiming bad debts for inpatient and outpatient services, complete a separate exhibit or internal schedule for each (one schedule for inpatient and one schedule for outpatient).

Exhibit 2 requires the following information:

Columns 1, 2, and 3 - Patient Names, Health Insurance Claim Number, and Dates of Service (From - To)--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number (HICN) or Medicare Beneficiary Identifier (MBI), and dates of service that correlate to the filed bad debt. (See 42 CFR 413.89.)

Column 4--Indigency/Medicaid Beneficiary--If the patient included in column 1 has been deemed indigent (either by virtue of being dual eligible for Medicare and Medicaid, or otherwise), place a check in the "yes" section of this column. If the patient included in this column has a valid Medicaid number, also include this number in the "Medicaid Number" section of this column. See the criteria in 42 CFR 413.89 for guidance on the billing requirements for indigent and Medicaid beneficiaries.

Columns 5 and 6--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased--This information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, and 3 of this exhibit. The date in column 6 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(f).)

Column 7--Remittance Advice Dates--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC No., and dates of service shown in columns 1, 2, and 3 of this exhibit.

Columns 8 and 9--Deductibles & Coinsurance--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services.

Column 10--Total Medicare Bad Debts--Enter on each line of this column, the sum of the amounts in columns 8 and 9. Calculate the total bad debts by summing up the amounts on all lines of column 10. This total must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

EXHIBIT 2

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER NAME _____ PREPARED BY _____
CCN _____ DATE PREPARED _____
FYE _____ INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HICN / MBI	(3) DATES OF SERVICE		(4) INDIGENCY & MEDICAID BENEFICIARY (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENE-FICIARY	(6) DATE COLLECTION EFFORTS CEASED	(7) MEDICARE REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT. SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/MEDICAID BENEFICIARY, FOR POSSIBLE EXCEPTION.

Exhibit 2A -- Listing of Medicare Bad Debts Instructions and Form

If seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from Medicare beneficiaries (Worksheet S-2, Part II, line 12, is Y) for a cost reporting period beginning on or after October 1, 2022, complete Exhibit 2A to support the bad debts claimed. Complete separate exhibits for bad debts resulting from inpatient services and outpatient services. A hospital healthcare complex claiming bad debts for multiple components must complete separate exhibits for each CCN. Enter dates in the MM/DD/YYYY format.

Exhibit 2A requires the following information:

Enter the provider name, CCN, subprovider CCN (if applicable), cost reporting period (CRP) beginning and ending dates, whether the listing represents Medicare bad debts for inpatient or outpatient services, the name of the preparer, the date prepared, the total of Medicare allowable bad debts (sum of column 23), and the total of dual-eligible Medicare bad debts (sum of amounts entered in column 23 where column 7 has an entry).

Columns 1, 2, 3, 4, 5, and 6--From the Medicare beneficiary's bill, enter the beneficiary's name, dates of service, patient account or identification number, and MBI or HICN, that correlate to the claimed bad debt. (See 42 CFR 413.89(f).)

Column 7--Enter the Medicare beneficiary's Medicaid number if the beneficiary was dually eligible (eligible for Medicare and some category of Medicaid benefits). If there is an entry in this column, there must be an entry in column 10.

Column 8--Enter "Y" for yes if the Medicare beneficiary was not eligible for Medicaid but the provider deemed them to be indigent; otherwise, enter "N" for no. (See 42 CFR 413.89(e)(2)(ii).)

Column 9--Enter the Medicare remittance advice date for the Medicare beneficiary information in columns 1 through 6.

Column 10--Enter the Medicaid remittance advice date or, when the provider does not receive a Medicaid remittance advice, enter "AD" for alternate documentation used to determine state liability (42 CFR 413.89(e)(2)(iii)(B)), that corresponds to the Medicare beneficiary information in columns 1 through 7.

Column 11--Enter the date a remittance advice was received from a secondary payer, if applicable. When a secondary payer does not accept liability, a denial or notification date may be entered.

Column 12--Enter the amount of coinsurance and deductible for which the Medicare beneficiary is responsible. If the beneficiary is a qualified Medicare beneficiary (QMB), enter "QMB." For a Medicare beneficiary who is dually eligible for Medicaid (not a QMB), enter the amount the beneficiary is required to pay under the state cost sharing agreement (42 CFR 413.89(e)(2)(iii)). For a Medicare beneficiary deemed indigent by the provider (column 8 is "Y"), enter zero.

Column 13--Enter the date that the first bill was sent to the Medicare beneficiary. If the beneficiary is a QMB, enter "QMB."

NOTE FOR COLUMNS 14 THROUGH 17: The dates reported in column 14 (the date that the Medicare beneficiary's liability was written off of the provider's accounts receivable), column 15 (the date that the collection agency ceased collection effort), column 16 (the date that all collection efforts ceased), and column 17 (the date that deductible and coinsurance amounts were written off as a Medicare bad debt), may be the same date.

Column 14--Enter the date the Medicare beneficiary's liability was written off of the accounts receivable (A/R) in the provider's financial accounting system. The date entered in this column may be the same as, or earlier than, the date the account was deemed worthless (written off as a Medicare bad debt).

Columns 15A and 15--In column 15A, enter "Y" for yes if the account was sent to a collection agency; otherwise, enter "N" for no. If column 15A, is "Y", in column 15, enter the date the collection agency returned the account (i.e., the date that the collection agency ceased collection effort on the account).

Column 16--Enter the date all collection efforts ceased, both internal and external, including efforts to collect from Medicaid and/or from a state for its cost sharing liability.

Column 17--Enter the date the deductible and coinsurance amounts were written off as a Medicare bad debt (i.e., the amount must have been written off as a bad debt against the A/R in the provider's financial accounting system); all collection effort, internal and external, against the Medicare beneficiary and/or other third parties ceased; and a Medicaid remittance advice was received from the state for Medicaid patients or alternate documentation exists as permitted under 42 CFR 413.89(e)(2)(iii)(B).

Column 18--Enter the amount of recoveries for amounts previously written off as an allowable Medicare bad debt in this or a prior cost reporting period. The amount reported in this column includes any payments received on an account after the account was written off as a bad debt, including payments received in the same year the account was written off when the payment was received after the date of the write off. (See 42 CFR 413.89(f).)

Column 19--If an amount is reported in column 18, enter the fiscal year end of the cost reporting period in which the Medicare bad debt (to which the recovery applies) was claimed and reimbursed. This column is optional; however, the date assists in identifying recovery amounts that must be offset. The fiscal year end entered in this column is a prior cost reporting period unless the write-off and recovery both occurred during this cost reporting period.

Column 20--Enter the Medicare deductible from the Medicare remittance advice (before any payments received from any party). Report deductible amounts only when the provider billed the patient with the expectation of payment. See 42 CFR 413.89(e)(2) for possible exception.

Column 21--Enter the Medicare coinsurance amount from the Medicare remittance advice (before any payments received from any party). Report coinsurance amounts only when the provider billed the patient with the expectation of payment. See 42 CFR 413.89(e)(2) for possible exception.

Column 22--Enter the amount of any payments received from the Medicare beneficiary, their estate, third party insurance, etc., before the account was written off, for any amounts reported in column 20 and/or column 21. For example, when a beneficiary had a liability from a prior year for a deductible of $2,500 and made payments totaling $1,500 in the prior and current years, the provider determined the remaining balance of $1,000 uncollectible and deemed worthless. The payments of $1,500 are reported in column 22, leaving the remaining $1,000 written off in the current period as an allowable bad debt.

Column 23--Enter the allowable Medicare bad debt amount. This amount must be less than or equal to the sum of the amounts in columns 20 and 21, less any payments in columns 18 and 22. If the fiscal year end in column 19 is prior to this cost reporting period, enter the recovery amount (reported in column 18) as a negative amount in this column. For each CCN, the sum of the amounts entered in this column on each listing, (inpatient and outpatient), as applicable, must equal the bad debts claimed for that CCN on the Medicare cost report. For example, CCN ##-0001, an inpatient acute care hospital, reported bad debts of $24,000 on the Exhibit 2A for inpatient and indicated that $12,000 on the Exhibit 2A for Medicaid eligible. The amount reported on Worksheet E, Part A, line 64, must equal $24,000. The amount reported on Worksheet E, Part A, line 66, must equal $12,000 (dual eligible).

Column 24--This column is for informational purposes. Enter any comments or additional information as needed.

EXHIBIT 2A

TITLE	MEDICARE BAD DEBTS
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDI-CAID NUMBER	PROVIDER DEEMED INDI-GENT	MEDI-CARE REMIT-TANCE ADVICE DATE	MEDI-CAID REMIT-TANCE ADVICE DATE	SEC-ONDARY PAYER RA RE-CEIVED DATE	BENE-FICIARY RESPON-SIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
1	2	3	4	5	6	7	8	9	10	11	12	13

A/R WRITE OFF DATE	SENT TO COLLEC-TION AGENCY (Y/N)	RETURN FROM COLLEC-TION AGENCY DATE	COLLEC-TION EFFORT CEASED DATE	MEDI-CARE WRITE OFF DATE	RECOVER-IES ONLY: AMOUNT RECEIVED	RECOVER-IES ONLY: MCR FYE DATE	MEDI-CARE DE-DUCTIBLE AMOUNT	MEDI-CARE CO-INSUR-ANCE AMOUNT	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOW-ABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24

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