

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 Social Security Act (hereafter referred to as "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 nursing school. 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 school 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 school 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 which are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89ff and CMS Pub. 15-1, chapter 3, §§306-324, for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 2 or internal schedules duplicating the documentation requested on Exhibit 2 to support the bad debts claimed. If you are claiming bad debts for inpatient and outpatient services, complete a separate Exhibit 2 or internal schedule for each category.

Exhibit 2 requires the following documentation:

Columns 1, 2, and 3 - Patient Names, Health Insurance Claim (HIC) 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 and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, chapter 3, §314, and 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 CMS Pub. 15-1, chapter 3, §§312 and 322, and 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 dates 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), and CMS Pub. 15-1, chapter 3, §§308, 310 and 314.)

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.

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 are waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 2 or your internal schedules) submitted with the cost report.

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 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: 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: "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: 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 are 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, 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 completing Exhibit 1:

Exhibit 1, Allocation of Physician Compensation Hours:

- 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.

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.

Cost Report Preparer Contact Information:

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

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. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C).	_____
2. Physician Services: Medical and Surgical Services to Individual Patients	_____
3. Non-Reimbursable 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

EXHIBIT 2
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER NAME _____
CCN _____
FYE _____

PREPARED BY _____
DATE PREPARED _____
INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & MEDICAID BENEFICIARY (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(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.

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