
Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 11, Form CMS-339

Department of Health &
Human Services (DHHS)
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<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
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Sections 1100-1102.3 (cont.)	11-3 - 11-14 (12 p.)	11-3 - 11-18 (16 p.)
Exhibits 1-6	11-15 - 11-39 (25 p.)	11-19 - 11-49 (31 p.)

This transmittal corrects Worksheet references on EXHIBIT 1, page 11-27, paragraphs 1 and 3d. All other material remains the same.

REVISED MATERIAL--EFFECTIVE DATE: *Cost Reporting Periods Ending on or After March 31, 2006*

Sections 1100-1102.3 are being revised to change the Agency name from "HCFA" to "CMS".

Section 1100 is being revised to delete the requirement that home offices complete Form CMS-339.

Section 1102 is expanded to provide instructions detailing how the modifications/deletions of certain sections of Exhibit 1 affect various types of providers.

Section 1102.3 is being revised to implement the instructions communicated in Program Memorandum-Intermediaries, Transmittal A-01-137 (CR 1865) which addresses "Modifications to Form CMS-339 Requirements, Provider Cost Report Reimbursement Questionnaire". These modifications include deletion of the following sections/subsections of Exhibit 1 and the related instructions.

Section A (Provider Organization and Operation) - deleted A.2 and A.3.

Section B (Financial Data and Reports) - deleted B.3.

Section C (Capital Related Cost) - deleted C.8.

Section E (Insurance) - deleted entirely.

Section F (Deferred Compensation and Pension) - deleted entirely.

Section H (Nonpaid Workers) - deleted entirely.

Section I (Purchased Services) - deleted I.1.

Section O (Owners/Management Personnel Compensation) and Exhibit 6 - deleted entirely.

Also, portions of Section 1102.3 which contain quoted or paraphrased Medicare reimbursement principles are being deleted so that this section contains only instructions germane to the completion of Exhibits 1-6.

DISCLAIMER: The revision date and transmittal number only apply to material in red italics. All other material was previously published in the manual and is only being reprinted.

CHAPTER 11
 PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE
 FORM *CMS-339*

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1100. GENERAL

Form *CMS*-339 must be completed by all providers submitting cost reports to the Medicare intermediary 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 and to minimize the need for direct contact between you and your intermediary. 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.

To the degree that the information in the *CMS*-339 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 intermediary should consult with the *CMS* Regional Office.

1100.1 Filing Requirements of Provider Cost Report Reimbursement Questionnaire.--Providers receiving payments and filing a cost report are required to maintain sufficient financial records and statistical data for the intermediary to use for the proper determination of costs payable under the Medicare program. The Provider Reimbursement Manual (PRM) and the applicable regulations issued by *CMS* (42 CFR 413.20) set forth the criteria for fulfilling these requirements. The questionnaire is designed to facilitate this process and must be completed and submitted with each full cost report. Submit the questionnaire as required by §§1815(a) and 1833(e) of the Act to assure proper payments by Medicare. Failure to submit this questionnaire and the supporting documents will result in suspension of payments to you and may result in a determination that all interim payments made since the beginning of the cost reporting period are overpayments.

Instructions

1102. INSTRUCTIONS FOR FORM *CMS*-339 (PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE)

These instructions are furnished to assist you in determining the type of information required by the questionnaire. *Because different Medicare payment methodologies that require specific type of information apply to various types of providers, all the sections/subsections in Exhibit 1 of the questionnaire do not need to be completed by all providers. Accordingly, a "NOTE" at the beginning of each section of Exhibit 1 specifies which providers are to complete the section. Where mention of "PPS hospitals" or "hospitals/units excluded from PPS" is made in any of those notes, "PPS" refers to all the prospective payment systems (e.g., Inpatient PPS (IPPS), Long Term Care Hospital PPS (LTCH PPS), Inpatient Rehabilitation Facilities PP (IRF PPS), Inpatient Psychiatric Facility PPS (IPF PPS)). Mark the statements in the sections you are not required to complete as "N/A". Also mark as "N/A" those statements in sections you are required to complete that are not applicable to your situation or circumstances.* Mark as either "YES" or "NO" those statements which reflect situations or circumstances applicable to you and submit the necessary information referred to after each question.

The intermediary establishes the type and volume of information required. For example, it is very unlikely and possibly not feasible for the intermediary to establish the need for a complete and current plant ledger. Segments of this ledger or examples of format and related accounting practices are normally sufficient to form opinions on its adequacy and the propriety of reimbursement.

The questionnaire requests providers to submit various listing and summary schedules in lieu of detailed, and potentially voluminous, supporting documentation. This is done to ease the providers' filing burden. However, the intermediary maintains the right to request, and the provider must submit, additional detailed supporting documentation as deemed necessary. Requests for additional information are not intended to be routine. The intermediary should request this information only if necessary to perform a complete review of the provider filing.

1102.1 Exhibit 1 - General Provider Information.--This information identifies the provider and the cost report with which the questionnaire is to be associated.

Enter your name and provider identification number. Information on individual providers in a chain organization or complex reporting to the same intermediary and common to all providers can be handled through one submittal. Indicate those areas of information that are common to all providers and handled under a single submission.

The reporting period covered by the information furnished through the questionnaire must be consistent with the period covered by the cost report.

1102.2 Certification by Officer or Administrator of Provider.--Sign this certification after the questionnaire is completed.

Show the person's name and telephone number your intermediary should contact for more information in the appropriate space provided on the *CMS*-339 questionnaire.

1102.3 Reimbursement Information.--Furnish the information in this section as a means of expediting review and settlement of cost reports. *CMS* has established a process whereby cost report review efforts are to be directed towards desk review at the intermediary's facilities rather than field audits at your site. The information required by the questionnaire is readily available since it is the basic type of documentation necessary to fulfill program recordkeeping requirements. Furnish the information in a single submission with the cost report rather than sporadically throughout the desk review and field audit process. Complete the questionnaire annually.

A. Provider Organization and Operation.--The information gathered through these questions is designed to alert the intermediary of pertinent organizational and/or personnel changes. It will be used to assess potential effects upon the cost report. The information pertaining to you and your personnel relationships within your organization and with outside organizations is essential to the intermediary's evaluation of information obtained through other sections of the questionnaire. The following instructions will assist you in determining the type of information being solicited.

- o When a change of ownership occurs, the information requested in question 1.a enables the intermediary to determine the *party responsible for the cost report*.
- o Describe the information on *relationships with outside entities* requested in question 2 to enable the intermediary to assess whether associated costs are properly handled in the cost report. This information should generally be available from employment disclosure statements.
- o A related organization transaction described in question 2.a occurs when services, facilities or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See PRM-1, Chapter 10 and, 42 CFR 413.17.)

Management contracts and services under arrangements with the provider described in question 2.a pertain to those business transactions where services are performed by the owner or corporation (shareholders) who has common ownership or control over the provider.

B. Financial Data and Reports.--The recordkeeping capabilities and system of internal control is most appropriately expressed through the financial statements. The financial statements, when prepared in accordance with the standards promulgated by the American Institute of Certified Public Accountants, can establish your ability to meet the general requirements for proper cost reporting.

The reliability of the information contained in the cost report can be established, in part, through financial statement disclosures and the opinion expressed by the independent public accountant.

Submit copies of financial statements that are compiled, reviewed or audited by the independent public accountant. Where you do not engage public accountants for this type of service, submit a copy of the financial statements prepared by you and written statements of significant accounting policy and procedure changes affecting reimbursement which occurred during the cost reporting period. This may be accomplished by submitting changes to your accounting or administrative procedures manual. If the audited financial statements are not available for submission with this questionnaire, indicate when the intermediary can expect to receive them.

Where financial statements are available, include the independent public accountant's opinion, the statements themselves, and the footnotes. Only consolidated statements and not financial statements may be available for individual providers in a chain organization or complex. In these circumstances, only the home office will be required to submit a copy of the consolidated financial statements to the designated home office intermediary and to maintain the currency of the procedures on file at the designated home office intermediary for consolidation of the financial statements.

Where the provider's cost report year end and the year end of the audited financial statements differ, submit the following:

- o The audited financial statements; and
- o Working trial balance and financial statements that were used to prepare the cost report.

Submit revenue and expense reconciliations to expedite completion of the intermediary's desk review process.

C. Capital-Related Cost.--The information requested in this section is that which normally cannot be obtained from the cost report, working trial balance or financial statements. This information and that available from the cost report and financial statements should be sufficient to enable the intermediary to formulate an opinion on capital-related cost and whether an audit is necessary.

- o References in questions 1, 2 and 4 to "classes" mean those depreciable asset groupings you use (e.g., land improvements, moveable equipment, buildings, fixed equipment). This assists intermediary evaluation of variances noted from the desk review.
- o *If the answer to Question 3 is "Yes"*, submit a listing of new leases and/or amendments to existing leases if the annual rental costs of each of these leases are:

<u>Type Of Facility</u>	<u>Threshold</u>
Hospital	\$50,000 or greater
SNF	All Leases
HHA	All Leases
All other	All Leases

NOTE: Providers are required to submit copies of the lease, or significant extracts, upon request from the intermediary.

- o Question 5 applies to a provider that acquires health care assets from another owner and is subject to §2314 of the Deficit Reduction Act (DEFRA) regulations if such assets were acquired on or after July 18, 1984.

D. Interest Expense.--Furnish copies of new loans, mortgage agreements, or letters-of-credit occurring during the cost reporting period to the intermediary. This applies to both long-term and current financing.

Provide a detailed analysis of the funded depreciation account for the cost reporting period. (See PRM-1, §226 and 42 CFR 413.153.)

Question 3 pertains to a provider that utilized advance refunding of debt as a method to replace existing debt prior to its scheduled maturity with new debt. For a provider that adopts this refinancing technique, the income and expenses associated with the advance refunding must be treated in accordance with PRM-1, §§233ff and 42 CFR 413.153. Submit an analysis to support the new debt and the calculation of allowable cost for intermediary's review.

If you recalled debt before scheduled maturity without issuing new debt (see PRM-1, §215 and 42 CFR 413.153), submit detailed analysis supporting the debt cancellation costs and treatment of these expenses on the cost report as directed in Question 4.

E. Approved Educational Activities.--Disclose information, *as directed, pertaining to nursing school and allied health/paramedical education programs as well as graduate medical education programs you offered for which you are claiming reimbursement*. Disclose the title and nature of each educational activity, *and where applicable*, the costs involved. The listings of *educational programs* may be maintained by deleting discontinued activities and adding new ones. Furnish copies of approvals and renewals for activities requiring certification.

For the purpose of Question 1, the provider is the legal operator of a nursing school or allied health program if it meets the criteria in 42 CFR 413.85(f)(1) or (f)(2).

F. Purchased Services.--The services referred to in this section are those services furnished through contractual arrangements other than those *pertaining* to nonpaid workers, provider-based physicians (section G), and management *personnel performing functions other than those of the Chief Executive Officer/Administrator, Chief Operating Officer, Chief Financial Officer, or Nursing Administrator*. The services can be administrative in nature or direct patient care. The following instructions assist you in submitting the information.

- o Where you do not have written agreements for purchased services, *include the following in the attached description required in Question 1*:
 - Duration of the arrangement;
 - Description of services;
 - Financial arrangements; and
 - Name(s) of parties to the agreement furnishing the services.

If the answer to question 3 is yes, then the provider must submit to the intermediary the wages and hours associated with each service provided by contract for patient care-related services (i.e.,

nursing, therapeutic, rehabilitative or diagnostic service). In addition, the total wages and hours for all management contracts must also be submitted. Contract management for purposes of the wage index is limited to the personnel cost for those individuals who are actually working at the hospital facility in the capacity of the Chief Executive Officer/Administrator, Chief Operating Officer, Chief Financial Officer, or Nursing Administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions. *Do not include* other management or administrative services, consultant services, physician services, clinical personnel, housekeeping or security services, planning contracts, independent financial audits, or any other service not related to the overall management and operation of the facility. *Also, do not include expenses associated with supplies, travel and other miscellaneous items.* (See *PRM-II, Section 3605.2.*)

G. Provider-Based Physicians— The information requested in this section is essential in order for the intermediary to evaluate the reasonableness of physician compensation included in the cost report and the propriety of the amounts reimbursed under the provisions of the Medicare statute.

The purpose of these schedules is to gather information from you in support of reimbursement for services furnished *in a provider setting* by provider-based physicians *who have financial arrangements under which they are compensated by, or through, the provider.* (See *PRM-1, §§2182ff. and 2109ff.*). Complete all applicable schedules accurately. Submit them with the Provider Cost Report Reimbursement Questionnaire. You may submit computer generated substitutes for these schedules provided they contain, at a minimum, the same information as in Exhibits 2 through 4A. (This includes the signature on a substitute for Exhibit 2.)

Allocation Agreements (Exhibit 2) are required if physician compensation is attributable to both direct patient care services and provider services. Allocation agreements are also required if all of the provider-based physician's compensation is attributable to provider services: e.g., (a) for departmental supervision and administration, quality control activities, or graduate medical education, 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 interns and residents furnishing direct medical and surgical services to individual patients. *However*, Allocation Agreements (Exhibit 2) are not required if all of the provider-based physician's compensation is attributable to direct medical and surgical services to individual patients.

CMS considers the compensation information to be confidential, and therefore, qualifying 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 THE QUESTIONNAIRE ON
PROVIDER-BASED PHYSICIANS
EXHIBITS 2 THROUGH 4A**

Exhibit 2 - Allocation of Physician Compensation Hours

The objective of this exhibit is to furnish a reasonably accurate delineation of activities on the basis of an average workweek. Complete this exhibit in accordance with *PRM-1, §2182.3*. The data elements shown are physicians' hours of service providing a breakdown between the professional and the provider component for intermediary and carrier use.

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. However, Exhibit 2 does not have to be completed for physicians whose services are exclusively direct patient care and whose total compensation has been eliminated from the cost report. 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.

Exhibits 3 and 3A- Hospital Emergency Department Provider-Based Physician Allowable Availability Service Costs Under Hourly Rate or Salary Arrangements: Data Elements - Computation

Complete Exhibit 3 in accordance with PRM-1, §2109. Completion of Exhibit 3 (Data Elements) and a copy of the approved allocation agreement, together with the instructions and illustration in §2109.4B, enables you to complete Exhibit 3A (Computation Worksheet).

Exhibits 4 and 4A- Hospital Emergency Department Provider-Based Physician Allowable Unmet Guarantee Amounts Under Minimum Guarantee Arrangements: Data Elements - Computation

Complete Exhibit 4 in accordance with *PRM-I*, §2109. Completion of Exhibit 4 (Data Elements) and a copy of the approved allocation agreement, together with the instruction and illustration in §2109.4C, enables you to complete Exhibit 4A (Computation Worksheet).

H. Home Office Costs.--Ensure that each intermediary servicing a provider in a chain is furnished with a detailed summary of the entire chain's direct, functional and pooled home office costs. Where an intermediary serves more than one provider in a chain it is only necessary to submit one summary to that intermediary. (*See PRM-I, §2153.*)

If the answer to question 7 is yes, *you* must submit details for the total wages and wage-related cost, and hours associated with all home office or related organization personnel who perform services for the provider. The costs shown must be the costs to the home office or related organization.

I. Bad Debts.--A provider's bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries are considered in the program's calculation of reimbursement to the provider *if they meet the criteria specified in 42 CFR 413.80ff and PRM-I, §§ 306-324.*

A provider whose Medicare bad debts meet the above criteria should complete Exhibit 5 or submit internal schedules duplicating the documentation requested on Exhibit 5 to support bad debts claimed. If the provider claims bad debts for inpatient and outpatient services, complete a separate Exhibit 5 or internal schedules for each category.

Exhibit 5 of Form *CMS*-339 which can be used to list the bad debts claimed contains much of the information the intermediary will need in order to determine the allowability of the bad debts. In

accordance with OBRA 1987, intermediaries may not require hospitals to submit such a list if it was not the intermediary's practice to require such data from the hospital as of August 1, 1987. However, voluntary submission of this exhibit would greatly assist the intermediary in verifying the allowability of the bad debts claimed. The submission of this listing may possibly provide the intermediary with sufficient information upon which to base its acceptance of the bad debts claimed on the hospital's cost report, without the necessity of an on-site visit.

Exhibit 5 requires the following documentation:

Columns 1,2,3 - Patient Names, HIC NO., Dates of Service (From - To).--The documentation requested for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number (social security number) and dates of service that correlate to the filed bad debt. (See *PRM-I*, §314 and 42 CFR 413.80.)

Column 4 - Indigency/Welfare Recipient.--If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column 1 has a valid Medicaid number, also include this number in this column. See the criteria in Provider Reimbursement Manual – I, §§312 and 322 and 42 CFR 413.80 for guidance on the billing requirements for indigent and welfare recipients.

Columns 5 & 6 - Date First Bill Sent to Beneficiary - Write-Off Date.--This information should be obtained from the provider's files *and should correlate with the beneficiary name and date of service shown in columns 1, 2, and 3 of this exhibit.* (See *PRM-I*, §310.)

Column 7 - Remittance Advice Dates.--Enter in this column the remittance advice dates that correlate with the beneficiary name and date of service shown in columns 1, 2, and 3 of this exhibit. This will enable the intermediary to verify the authenticity of the Medicare patient and the related *deductible and coinsurance amounts.*

Columns 8 & 9 - Deductible - Coinsurance.--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services *as instructed in this exhibit.*

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” should agree with the bad debts claimed in the cost report.* Attach additional supporting schedules, if necessary, for bad debt recoveries.

J. Bed Complement. -- Available beds, for *the purpose of this section, 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 *PRM-I, Section 2200.2.C and PRM-II, Section 3605.*)

The beds which can be used to determine the “available bed days” for the purpose of computing the Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) adjustments are defined in 42 CFR 412.105(b).

K. Medicare Settlement Data (PS&R DATA).--The PS&R system generates several reports which provide apportionment, statistical, settlement and reimbursement data that can be used

in filing the cost report. Although the primary input into the PS&R system is the Form CMS -1450 claims data, a significant amount of information is calculated and assembled through the PS&R. This includes outpatient prevailing charges, PPS capital elements, MSP data, and SCH data. This data is produced exclusively for the settlement of the Medicare cost report and as such is not reflected on the Medicare remittance advice.

In some cases, the provider may have independent record keeping capabilities which provide them with the capacity to generate the appropriate cost report data consistent with that contained in the PS&R. This could include outpatient pricing and claims splitting modules such as ASC, radiology, and other diagnostic, as well as various other programs used to calculate the required data. The provider's record keeping capability, relative to cost report preparation, will vary by provider type and the scope of the services rendered. A provider's system, in order to be effective, requires all necessary updating of PRICER information, fees, prevailing charges, and other regulatory changes impacting the resultant PS&R, as well as adjustment claims. This is an ongoing process that does not end with the filing of the cost report, but continues through final settlement.

The revenue codes on the Form *CMS* -1450 have been standardized for Medicare billing purposes without regard to providers' actual revenue and expense accounting process. In many cases, therefore, there will be differences between the classifications of revenues in the PS&R and the general ledger classifications that can affect Medicare reimbursement. Providers must evaluate the impact of these classification differences and maintain accurate Medicare logs which collect charge data consistent with the general ledger classifications of revenues and expenses, if they are not using the PS&R in its entirety.

Several actions are required for providers in filing the cost report, whether they use the PS&R for the source document or internal log records. In each of the following examples, providers must include the summary of their "unpaid" log as support for any claims not included on the PS&R. The summary should include totals consistent with the breakdowns on the PS&R. This report should be generated to reflect claims paid that are unprocessed or unpaid as of the cut off date of the PS&R.

The cut off date equates to the paid date reflected on the PS&R. These required actions vary slightly for Part A and Part B data and are summarized below:

Part A, using PS&R only - Providers are required to develop a table for inclusion with the filed cost report which provides a crosswalk between the revenue codes and charges found on the PS&R to the cost center groupings found on the cost report. This crosswalk reflects a one-on-one match, cost center to revenue code. No overlap is permitted in this example. Unpaid claims will be added to the PS&R totals, following the same revenue crosswalk. For crosswalk, see example 1.

Part A, using PS&R for totals, provider records for allocation - Providers are required to develop a table for inclusion with the cost report which provides a detailed crosswalk between the revenue codes, departments, and charges found on the PS&R to the cost center groupings found on the cost report. In this instance, there is not a requirement for a one on one match, but providers must show total dollars by cost center and the range of revenue codes within each cost center. The total revenue must match that found on the PS&R, plus any claims reflected on the unpaid log. Supporting workpapers must be maintained by the provider to identify the source of their data in order to attest to its accuracy.

If the intermediary does not find that the workpapers provide sufficient documentation and validation of the provider's records, the PS&R would be used in its entirety. It is the responsibility of the provider to maintain, furnish, and reasonably demonstrate that its internal records provide a more accurate allocation for cost report settlement purposes than the PS&R. For crosswalk, (see example 2).

Part A, using provider records only - Providers who use their internal records for filing the cost report, without reference or cross-reference to the PS&R, are required to provide the intermediary audit staff with detailed documentation of their system flow in order to validate their data. Documentation of systems flow, at a minimum, should include:

- o 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;
- o Log summaries and log detail supporting program utilization statistics, charges, and payment information broken into each Medicare bill type in a manner consistent with the PS&R; and
- o Reconciliation of remittance totals to the provider consolidated log totals.

The provider may supplement this information with a narrative, internal flow charts, or outside vendor informational material to further describe and validate the reliability of their system. It is the responsibility of the provider to furnish and maintain reasonable documentation supporting the accuracy of their data in lieu of the PS&R. In the event the intermediary determines that supporting documentation is insufficient, the intermediary must furnish written discussion detailing weaknesses in the provider's documented system flow prior to either a partial or complete disallowance of the provider's records. It is not necessary for the provider to develop a reconciliation to the PS&R if the work flow demonstrates that the provider has consistently reconciled their logs to the remittance advices received from the intermediary, either claim by claim or in total. No crosswalk is required for this example, merely documentation of system flow. Providers will include an unpaid log summary for review by the intermediary, using the date of the last remittance advice posted to the provider log as the cut off date.

Part B (inpatient and outpatient) using PS&R only - Providers are required to develop a table for inclusion with the filed cost report which provides a crosswalk between the revenue codes and charges found on the PS&R to the cost center groupings found on the cost report. This crosswalk will reflect a one on one match, cost center to revenue code. No overlap is permitted in this example. Allocations for ASC, radiology, and other diagnostic services, *if applicable*, must follow the PS&R. Unpaid claims will be added to the PS&R totals, following the same revenue crosswalk. For crosswalk, (see example 1).

Part B (inpatient and outpatient) using PS&R for totals, provider records for allocation - Providers are required to develop a table for inclusion with the cost report which provides a detailed crosswalk between the revenue codes, departments, and charges found on the PS&R to the cost center groupings found on the cost report. In this instance, there is not a requirement for a one on one match, but providers must show total dollars by cost center and the range of revenue codes within each cost center. The total revenue must match that

found on the PS&R unless the provider has a reduced charge for outpatient services, in which case a detail of the gross used must be provided. Additionally, claims reflected on the unpaid log must be added to the PS&R totals. *If applicable*, allocations for ASC, Radiology, and Other Diagnostic services may follow either the PS&R or the internal hospital log. If the PS&R is used for the allocation, the provider must show how the total charges are detailed to the various PS&R Medicare outpatient types (i.e., ASC, radiology, other diagnostic, and all other Part B). In addition to the type of service breakdown, detailed workpapers supporting the allocation of charges into the various cost centers must be furnished. If the provider uses internal records for either the type of service breakdown or the charge allocation, or both, the source of this information must be included in the documentation provided. If the intermediary does not find the underlying workpapers to provide sufficient documentation and validation of the provider's records, the PS&R will be used in its entirety. It is the responsibility of the provider to maintain, furnish, and reasonably demonstrate that its internal records provide a more accurate allocation for cost report settlement purposes than the PS&R. For crosswalk, see Example 2.

Part B (inpatient and outpatient) using provider records only - Providers who use their internal records for filing the cost report, without reference or cross-reference to the PS&R, are required to provide the intermediary audit staff with detailed documentation of their system flow in order to validate their data. Documentation of system flow, at a minimum, should include:

- o Copies of input tables, calculations, or charts supporting data elements for radiology and other diagnostic prevailing rates, ASC payment group rates, *if applicable*, and other PRICER information covering the cost reporting period;
- o Log summaries and log detail supporting charges, prevailing rates, and payment information broken into each Medicare bill type in a manner consistent with the PS&R; and
- o Reconciliation of remittance totals to the provider consolidated log totals.

The provider may supplement this information with narrative, internal flow charts, or outside vendor informational material to further describe and validate the reliability of their systems. It is the responsibility of the provider to furnish and maintain reasonable documentation supporting the accuracy of their data in lieu of the PS&R. In the event the intermediary determines that supporting documentation is insufficient, the intermediary must furnish written discussion detailing weaknesses in the provider's documented system flow prior to either a partial or complete disallowance of the provider's records. It is not necessary for the provider to develop a reconciliation to the PS&R if the work flow demonstrates that the provider has consistently reconciled their logs to the remittance advices received either claim by claim or in total. No crosswalk is required for this example from the intermediary, merely documentation of system flow. Providers should include an unpaid log summary for review by the intermediary, using the date of the last remittance advice posted to the provider log as the cut off date.

In order to complete the crosswalk for the above examples, the following formats should be used:

Example 1

<u>Revenue Code</u>	<u>Cost Center Name /</u>	<u>Number</u>
250	Drugs Charged to Patients	(56)
270	Med. Supplies Charged to Patients	(55)
360	Operating Room	(37)

Example 2

Per PS&R -

<u>Revenue Code</u>	<u>Amount</u>
25x	\$ 675
27x	\$ 575
30x	\$ 500
36x	\$ 400
32x	\$ 750
41x	\$ 300
45x	\$1000
49x	\$ 700
	<u>\$4900</u>

As filed -

<u>Cost Center Name/Number</u>	<u>Amount</u>	<u>Revenue Codes</u>
Drugs Chg. to P. (56)	\$ 300	25x,27x
Radiology (43)	\$ 900	25x,27x,32x
IV Therapy (48)	\$ 200	25x
Med. Sup. Chg. to P. (55)	\$ 150	27x
Operating Room (37)	\$ 435	27x,36x
Respiratory Therapy (49)	\$ 275	25x,27x,41x
ASC (61.01)	\$ 900	27x,41x,49x
Laboratory (44)	\$ 540	27x, 30x
Emergency (61)	<u>\$1200</u>	25X,27X,45X
	<u>\$4900</u>	

L. Wage Related Costs.--The hospital must provide the intermediary with a complete list of all *core* wage related costs shown in Part I of Exhibit 6 *as directed in L.1.*

To respond to Question 2, determine whether each wage related cost "other than core" exceeds one (1) percent of the total adjusted salaries net of excludable salaries.

Respond to Questions 3.a through 3.e for each "other than core" wage related cost that meets the threshold in Question 2 and report it in Part II of Exhibit 6 only if the answers to all these questions are "Yes" and the cost can be recognized as a wage related cost in conformity with published criteria.

Do not complete Part II of Exhibit 6 if none of the "other than core" wage related costs meet the threshold in Question 2 and/or contain a "No" response to any of Questions 3.a through 3.e.

Wage related costs may be different from fringe benefits allowed under Medicare *because the*

Generally Accepted Accounting Principles (GAAP) are used in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost on Exhibit 6, are not considered fringe benefits. Therefore, Part III of Exhibit 6 must be used to reconcile any fringe benefit costs reported on Worksheet A, column 2 *based on* Medicare principles to the wage related costs reported on Exhibit 6, Parts I or II *based on* GAAP.

EXHIBIT 1
FORM APPROVED
OMB NO. 0938-0301

This questionnaire is required under the authority of sections 1815(a) and 1833(e) of the Social Security Act. Failure to submit this questionnaire will result in suspension of Medicare payments.

To the degree that the information in CMS-339: 1) constitutes commercial or financial information which is confidential, and/or 2) is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0301. The time required to complete this information collection is estimated to average 17 hours and 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE
(You MUST USE Instructions For Completing This Form
Located In PRM-II, §§1100ff.)

Provider Name: _____

Provider Number(s): _____

Filed with Form CMS- _____

Period: _____

// 1728 / /2552 / /2088 / /2540 / / 2540S

From _____

// _____ (Other - Specify)

To _____

**INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION
CONTAINED IN THIS QUESTIONNAIRE MAY BE PUNISHABLE BY FINE AND/OR
IMPRISONMENT UNDER FEDERAL LAW**

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying information prepared by _____
(Provider name(s) and number(s)) for the cost report period beginning _____
and ending _____, and that to the best of my knowledge and belief, it is a true, correct
and complete statement prepared from the books and records of the provider(s) in accordance with
applicable instructions, except as noted.

(Signed)

Officer or Administrator of Provider(s)

Date

Title

Name and Telephone Number of Person to Contact for More Information

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>NOTE: 42 CFR 413.20 and instructions contained in the PRM-1 require that the provider maintain adequate financial and statistical data necessary for the intermediary to use for a proper determination of costs payable under the program. Providers are, therefore, required to maintain and have available for audit all records necessary to verify the amounts and allowability of costs and equity capital included in the filed cost report. Failure to have such records available for review by fiscal intermediaries acting under the authority of the Secretary of the Department of Health and Human Services will render the amount claimed in the cost report unallowable.</p> <p>A. <u>Provider Organization and Operation</u></p> <p><i>NOTE: Section A to be completed by all providers.</i></p> <p>1. The provider has:</p> <ul style="list-style-type: none"> a. Changed ownership. If "yes", submit name and address of new owner, date of change, copy of sales agreement, or any similar agreement affecting change of ownership. b. Terminated participation. If "yes", list date of termination, and reason (Voluntary/Involuntary). <p>2. The provider, members of the board of directors, officers, medical staff or management personnel are associated with or involved in business transactions with the following:</p> <ul style="list-style-type: none"> a. Related organizations, management contracts and services under arrangements as owners (stockholders), management, by family relationship, or any other similar type relationship. b. Management personnel of major suppliers of the provider (drug, medical supply companies, etc.). If "yes" to question 2a and/or 2b, attach a list of the individuals, the organizations involved, and description of the transactions. 			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>B. <u>Financial Data and Reports</u></p> <p><i>NOTE: Section B to be completed by all providers.</i></p> <p>1. During this cost reporting period, the financial statements are prepared by Certified Public Accountants or Public Accountants (submit complete copy or indicate available date) and are:</p> <ul style="list-style-type: none"> a. Audited; b. Compiled; and c. Reviewed. <p>NOTE: Where there is no affirmative response to the above described financial statements, attach a copy of the financial statements prepared and a description of the changes in accounting policies and practices if not mentioned in those statements.</p> <p>2. Cost report total expenses and total revenues differ from those on the filed financial statement. If "yes", submit reconciliation.</p> <p>C. <u>Capital Related Cost</u></p> <p><i>NOTE: Section C to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.</i></p> <p>1. Assets have been relifed for Medicare purposes. If "yes", attach detailed listing of these specific assets, by classes, as shown in the Fixed Asset Register.</p> <p>NOTE: For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, under the capital - PPS consistency rule (42 CFR 412.302 (d)), PPS hospitals are precluded from relifing old capital.</p> <p>2. Due to appraisals made during this cost reporting period, changes have occurred to Medicare depreciation expense. If "yes", attach copy of Appraisal Report and Appraisal Summary by class of asset.</p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>3. New leases and/or amendments to existing leases for land, equipment, or facilities with annual rental payment in excess of the amounts listed in the instructions, have been entered into during this cost reporting period. If "yes", submit a listing of these new leases and/or amendments to existing leases that have the following information:</p> <ul style="list-style-type: none"> o A new lease or lease renewal; o Parties to the lease; o Period covered by the lease; o Description of the asset being leased; and o Annual charge by the lessor. <p>NOTE: Providers are required to submit copies of the lease, or significant extracts, upon request from the intermediary.</p> <p>4. There have been new capitalized leases entered into during the current cost reporting period. If "yes", attach a list of the individual assets by class, the department assigned to, and respective dollar amounts for all capitalized leases in accordance with the thresholds discussed in the instructions.</p> <p>5. Assets which were subject to §2314 of DEFRA were acquired during the period. If "yes", supply a computation of the basis.</p> <p>6. Provider's capitalization policy changed during cost reporting period. If "yes", submit copy.</p> <p>7. Obligated capital has been placed into use during the cost reporting period. If "yes", attach schedule listing each project, the cost of these projects and the date placed into service for patient care.</p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>D. <u>Interest Expense</u></p> <p><i>NOTE: Section D to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.</i></p> <ol style="list-style-type: none"> 1. New loan, mortgage agreements or letters of credit were entered into during the cost reporting period. If "yes", state the purpose and submit copies of debt documents and amortization schedules. 2. The provider has a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. If "yes", submit a detailed analysis of the funded depreciation account for the cost reporting period. (See PRM-1, §226.4.) 3. Provider replaced existing debt prior to its scheduled maturity with new debt. If "yes", submit support for new debt and calculation of allowable cost. (See §233.3 for description of allowable cost.) 4. Provider recalled debt before scheduled maturity without issuance of new debt. If "yes", submit detail of debt cancellation costs. (See §215 for description and treatment of debt cancellation costs.) <p>E. <u>Approved Educational Activities</u></p> <p><i>NOTE: Section E to be completed by all providers.</i></p> <ol style="list-style-type: none"> 1. Costs were claimed for Nursing School and Allied Health Programs. If "yes", attach list of the programs and annotate for each whether the provider is the legal operator of the program. 2. Approvals and/or renewals were obtained during this cost reporting period for Nursing School and/or Allied Health Programs. If "yes", submit copies. 3. Provider has claimed Intern-Resident costs on the current cost report. If "yes", submit the current year Intern-Resident Information System (IRIS) on diskette. 			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>4. Provider has initiated an Intern-Resident program in the current year or obtained a renewal of an existing program. If "yes", submit certification/program approval.</p> <p>5. Graduate Medical Education costs have been directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program, on Worksheet A, Form CMS-2552. If "yes", submit appropriate workpapers indicating to which cost centers assigned and the amounts.</p> <p>F. Purchased Services</p> <p><i>NOTE: Questions 1 and 2 to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS. Question 3 to be completed only by Inpatient PPS (IPPS) hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.</i></p> <p>1. Changes or new agreements have occurred in patient care services furnished through contractual arrangements with suppliers of services. If "yes", submit copies of changes or contracts, or where there are no written agreements, attach description.</p> <p>NOTE: Hospitals are only required to submit such information where the cost of the individual's services exceeds \$25,000 per year.</p> <p>2. The requirements of §2135.2 were applied pertaining to competitive bidding. If "no", attach explanation.</p> <p>3. Contract services are reported on Worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNFs). If yes, submit a schedule showing the total direct patient care related contract labor, hours and calculated rate for each invoice paid during the year for the direct patient care related contract labor reported on Worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNFs). Contracted labor will include any wage related costs. The contracted amounts for the top four management personnel (CEO, CFO, COO and Nursing Administrator) are not required to be reported by individuals.</p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>The total aggregate wage and hours will be reported for these management contracts. Other contracts or contracts for other management personnel should NOT be reported as they are not allowed in the computation of the wage index.</p> <p>G. <u>Provider-Based Physicians</u></p> <p><i>NOTE: Section G to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.</i></p> <ol style="list-style-type: none"> Services are furnished at the provider facility under an arrangement with provider-based physicians. If "yes", submit completed provider-based physician questionnaire (Exhibits 2 through 4A). The provider has entered into new agreements or amended existing agreements with provider-based physicians during this cost reporting period. If "yes", submit copies of new agreements or amendments to existing agreements and assignment authorizations. <p>H. <u>Home Office Costs</u></p> <p><i>NOTE: Questions 1 through 6 to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS. Question 7 to be completed only by IPPS hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.</i></p> <ol style="list-style-type: none"> The provider is part of a chain organization. If "yes", give full name and address of the home office: Name _____ Address _____ City _____ State _____ Zip _____ Designated Intermediary: _____ A home office cost statement has been prepared by the home office. 			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>If "yes", submit a schedule displaying the entire chain's direct, functional and pooled cost as provided to the designated home office intermediary as part of the home office cost statement.</p> <p>3. The fiscal year end of the home office is different from that of the provider. If "yes", indicate the fiscal year end of the home office. FYE _____.</p> <p>NOTE: Where the year ends of the provider and home office are not the same (nonconcurrent year ends), the summary listing, as described in number 2 above, will be necessary to support the provider's cost report.</p> <p>4. Describe the operation of the intercompany accounts. Include in this description the types of costs included from these intercompany accounts and their location on the cost report. (Provide informative attachments not shown on Worksheet A-8-1).</p> <p>5. Actual expense amounts are transferred by the home office to the provider components on an interim basis. (Provide informative attachments if not shown on Worksheet A-8-1.)</p> <p>6. The provider renders services to:</p> <p style="padding-left: 20px;">a. Other chain components.</p> <p style="padding-left: 20px;">b. The home office.</p> <p>If "yes", to either of the above, provide informative attachments.</p> <p>7. Home Office or Related Organization personnel cost are reported on Worksheet S-3, Part II, Line 11 (hospitals) or line 18 (SNFs). If yes, submit a schedule displaying the wages, wage related costs, and hours allocated to the individual chain components as provided to the designated home office intermediary to support the amount reported on Worksheet S-3, Part II, line 11 (hospitals) or line 18 (SNFs).</p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>I. <u>Bad Debts</u></p> <p><i>NOTE: Section I to be completed by all providers.</i></p> <ol style="list-style-type: none"> 1. The provider seeks Medicare reimbursement for bad debts. If "yes", complete Exhibit 5 or submit internal schedules duplicating documentation required on Exhibit 5 to support bad debts claimed. (see instructions) 2. The provider's bad debt collection policy changed during the cost reporting period. If "yes", submit copy. 3. The provider waives patient deductibles and/or copayments. If yes, insure that they are not included on Exhibit 5. <p>J. <u>Bed Complement</u></p> <p><i>NOTE: Section J to be completed by all providers.</i></p> <p>The provider's total available beds have changed from prior cost reporting period. If "yes", provide an analysis of available beds and explain any changes during the cost reporting period.</p> <p>K. <u>PS&R Data</u></p> <p><i>NOTE 1: Section K to be completed by all providers.</i></p> <p>NOTE 2: Refer to the instructions regarding required documentation and attachments.</p> <ol style="list-style-type: none"> 1. The cost report was prepared using the PS&R only? <ol style="list-style-type: none"> a) Part A (including subproviders, SNF, etc.)? b) Part B (inpatient and outpatient). 			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>If yes, attach 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.</p> <p>2. The cost report was prepared using the PS&R for totals and the provider records for allocation.</p> <p>a) Part A (including subproviders, SNF, etc).</p> <p>b) Part B (inpatient and outpatient).</p> <p>If yes, include 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 include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.</p> <p>If the PS&R is used for the allocation of ASC, Radiology, Other Diagnostic, and All Other Part B, explain how the total charges are detailed to the various PS&R Medicare outpatient types. Include workpapers supporting the allocation of charges into the various cost centers. If internal records are used for either the type of service breakdown or the charge allocation, the source of this information must be included in the documentation.</p> <p>3. Provider records only were used to complete the cost report?</p> <p>a) Part A (including subproviders, SNF, etc.).</p> <p>b) Part B (inpatient and outpatient).</p> <p>If yes, attach detailed documentation of the system used to support the data reported on the cost report. <u>If the detail documentation was previously supplied, submit only necessary updated documentation.</u></p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>The minimum requirements are:</p> <ul style="list-style-type: none"> - Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components, capital PPS rate components, ASC payment group rates, Radiology and Other Diagnostic prevailing rates and other claims PRICING information. - Log summaries and log detail supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R. - Reconciliation of remittance totals to the provider consolidated log totals. <p>Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material.</p> <p>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.</p> <p>4. If yes to questions 1 or 2 above, were any of the following adjustments made to the Part A PS&R data?</p> <p>Part A:</p> <ul style="list-style-type: none"> a) Addition of claims billed but not on PS&R? Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log. b) Correction of other PS&R information? 			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>c) Late charges?</p> <p>d) Other (describe)?</p> <p>Part B (inpatient and outpatient):</p> <p>a) Addition of claims billed but not on PS&R? Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log.</p> <p>b) Correction of other PS&R information?</p> <p>c) Late charges?</p> <p>d) Other (describe)?</p> <p>Attach documentation which provides an audit trail from the PS&R to the cost report. The documentation should include the details of the PS&R, reclassifications, adjustments, and groupings necessary to trace to the cost center totals and in addition, for outpatient services, there should be an audit trail from the PS&R to the amounts shown on the cost report for outpatient charges by ASC, radiology, other diagnostic and all other service categories including standard overhead amounts and prevailing charges.</p> <p>L. <u>Wage Related Costs</u></p> <p>NOTE: Section L to be completed only by IPPS hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.</p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>1. Complete EXHIBIT 6, Part I (Per instructions). Part III must be completed to reconcile any differences between any fringe benefit cost reported on Worksheet A, Column 2, using Medicare principles and the corresponding wage related costs reported under GAAP for purposes of the wage index computation.</p> <p>2. The individual wage related cost exceeds one percent of total adjusted salaries after removing excluded salaries. (Salaries reported on Worksheet S-3, <i>Part III, Column 3, line 3 (CMS-2552-96), or Worksheet S-3, Part II, Column 3, Line 26 (CMS-2540-96).</i>)</p> <p>3. Additional wage related costs were provided that meet ALL of the following tests:</p> <ul style="list-style-type: none"> a. The cost is not listed on Part I of EXHIBIT 6. b. If any of the additional wage related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test in question 2 above. c. The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS. d. The individual wage related cost is not included in salaries reported on <i>Worksheet S-3, Part III, column 3, line 3, (CMS-2552-96) or Worksheet S-3, Part II, Column 3, Line 16 (CMS-2540-96).</i> e. The wage related cost is not being furnished for the convenience of the employer. 			

Allocation of Physician Provider Name: _____

Compensation: Hours

Provider Number: _____

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

Hospital Emergency Department
Provider-Based Physician

Provider Name: _____
Provider Number: _____

Allowable Availability Service Costs

Cost Reporting Year: Beginning _____ Ending _____

Under Hourly Rate or Salary Arrangements

Geographic Location of Provider: _____
(City & State)

Data Elements

Specialty: _____

Name of Physician: _____

Allocation Agreement:

Time - Percentage

Total Hours Worked

Availability Services

_____ %

Supervision & Administrative Services

_____ %

Reasonable Compensation Equivalent (RCE) from Table I, Estimate of FTE

\$ _____

RCE Area: Non-Metropolitan ; Metropolitan, Less Than One Million ;

or Metropolitan, Greater Than One Million

Actual Provider Payments:

Total Charges:

Supervision and Administration

\$ _____

Billed Inpatient Charges

\$ _____

Availability Services

\$ _____

Billed Outpatient Charges

\$ _____

Membership in Professional Associations

\$ _____

Imputed Inpatient Charges

\$ _____

Continuing Medical Education

\$ _____

Imputed Outpatient Charges

\$ _____

Malpractice Insurance Premiums

\$ _____

Imputed Employee Charges

\$ _____

Other : _____

\$ _____

\$ _____

Compensation Based on:

Hourly Rate \$ _____ or Salary Basis \$ _____

Note: Attach copy of Approved Allocation Agreements

Hospital Emergency Department	Provider Name: _____
Provider-Based Physician	Provider Number: _____
Allowable Availability Service Costs	Cost Reporting Year: Beginning _____
Under Hourly Rate or Salary	Ending _____ RCE Year _____
Arrangements: Computation	Name of Physician: _____
	Specialty: _____

The Reasonable Cost of the Supervisory, Administrative and Availability Services Time is Computed as Follows:

- Determine the Applicable RCE Base:

Total Hours (Supervisory, Administrative and Availability Services) Work Year Hours (2,080)	\times RCE (Use RCE from Table I)	$=$ RCE Base	
2,080	\times \$ _____	$=$ \$ _____	

- Determine the Limit on the Allowance for Membership in Professional Associations and Continuing Education.

<i>RCE Base</i>	\times 5%	$=$ Limit	
\$ _____	\times .05	$=$ \$ _____	

- Provider Payments for Membership in Professional Associations and Continuing Medical Education:

Membership in Professional Associations	\$ _____
Continuing Medical Education	\$ _____
Total	\$ _____

- Malpractice Insurance Expense (Provider Services Portion) \$ _____

- Adjusted RCE Base:

(Sum of #1 \$ _____ + the lesser of #2 or #3 \$ _____ + #4 \$ _____)	$=$ \$ _____
---	--------------

Provider Name _____

Provider Number _____

Name of Physician _____

6. Actual Provider Payments

Supervision and Administration	\$ _____
Availability Services	\$ _____
Membership in Professional Associations	\$ _____
Continuing Medical Education	\$ _____
Malpractice (Provider Services Related)	\$ _____
Total	\$ _____

7. Amount Includable in Allowable Costs: (Lesser of #5 or #6) \$ _____

8. Allocation of Allowable Costs:

Billed Outpatient Charges (Emergency Department)	\$ _____
Imputed Outpatient and Employee Charges	\$ _____
Total Outpatient Charges	\$ _____
Imputed Inpatient Charges	\$ _____
Billed Inpatient Charges	\$ _____
Total Inpatient Charges	\$ _____
Total Outpatient and Inpatient Charges	\$ _____

Total Outpatient Charges X Allowable Provider Costs = Allowable Part B Costs
Total Charges

_____ X _____ = \$ _____

Total Inpatient Charges X Allowable Provider Costs = Allowable Part A Costs
Total Charges

_____ X _____ = \$ _____

Hospital Emergency Department
 Provider-Based Physician
 Allowable Unmet Guarantee Amounts
 Under Minimum Guarantee Arrangements:
 Data Elements

Provider Name: _____
 Provider Number: _____
 Cost Reporting Year: Beginning _____ Ending _____
 Geographic Location of Provider: _____
 (City and State)

=
 Specialty: _____

Name of Physician: _____

=
 Allocation Agreement:
 A) Professional Services to Individual
 Patients (includes inpatients and
 employees) and Availability Services
 B) Supervision & Administrative Services
 Total

Time - Percentage
 _____ %
 _____ %
 _____ %

Total Hours Worked

Reasonable Compensation Equivalent (RCE) from Table I, Estimate of FTE

\$ _____

RCE Area: Non-Metropolitan ; Metropolitan, Less Than One Million ;
 or Metropolitan, Greater Than One Million

Actual Provider Payments:
 Supervision and Administration \$ _____
 Unmet Guarantee Amount \$ _____
 Membership in Professional Associations \$ _____
 Continuing Medical Education \$ _____
 Malpractice Insurance Premiums \$ _____
 Other \$ _____

Total Charges:
 Billed Outpatient Charges \$ _____
 Billed Inpatient Charges \$ _____
 Imputed Inpatient Charges \$ _____
 Imputed Outpatient Charges \$ _____
 Imputed Employee Charges \$ _____
 Other: _____ \$ _____
 _____ \$ _____

Actual Minimum Guarantee Amount \$ _____

Total Outpatient Charges \$ _____
 Total Inpatient Charges \$ _____

Note: Attach copy of Approved Allocation Agreement

Provider Name _____ Provider Number _____

Name of Physician _____

4. Determine the Allowance for Malpractice Insurance (Supervision and Administration (S&A)):

$$\frac{\text{Supervisory and Administrative Hours}}{\text{Total Hours Worked}} \times \text{Total Payment for Malpractice Insurance} = \text{Allowance}$$

_____ X \$ _____ = \$ _____

5. Adjusted RCE Base for Supervision and Administrative Services:

(Sum of #1 _____ + the Lesser of #2 or #3 _____ + #4 _____) = \$ _____

6. Determine Provider Payments Attributable to Supervision and Administrative Services:

Supervision and Administration (S&A):

S& A Hours X Rate
 _____ X \$ _____ = \$ _____

Membership in Professional Associations:

$\frac{S\&A \text{ Hours}}{\text{Total Hours}} \times \text{Cost}$
 _____ X \$ _____ = \$ _____

Continuing Medical Education:

$\frac{S\&A \text{ Hours}}{\text{Total Hours}} \times \text{Cost}$
 _____ X \$ _____ = \$ _____

Malpractice Insurance Premiums:

$\frac{S\&A \text{ Hours}}{\text{Total Hours}} \times \text{Cost}$
 _____ X \$ _____ = \$ _____

Total = \$ _____

7. Amount Includable in Allowance Costs (*Lesser* of #5 or #6) = \$ _____

Provider Name _____ Provider Number _____

Name of Physician _____

Computation of Reasonable Allowable Cost for an Unmet Guarantee Amount

8. Determine the Applicable RCE Base:

$$\frac{\text{Total Hours (Professional and Availability Services)}}{\text{Work Year Hours (2,080)}} \times \text{RCE (Use RCE from Table I)} = \text{RCE Base}$$

$$\frac{2,080}{2,080} \times \$ \text{_____} = \$ \text{_____}$$

9. Determine the Limit on the Allowance for Membership in Professional Associations and Continuing Medical Education:

$$\text{RCE Base} \times 5\% = \text{Limit}$$

$$\$ \text{_____} \times .05 = \$ \text{_____}$$

10. Determine Actual Provider Payment for Membership in Professional Associations and Continuing Medical Education Applicable to Professional and Availability Services:

$$\frac{\text{Total Hours (Professional and Availability Services)}}{\text{Total Hours Worked}} \times \text{Total Payments for Membership in Professional Associations and Continuing Medical Education} = \text{Actual Provider Payment}$$

$$\text{_____} \times \$ \text{_____} = \$ \text{_____}$$

11. Determine the Allowance for Malpractice Insurance: (Professional and Availability Services)

$$\frac{\text{Total Hours (Professional and Availability Services)}}{\text{Total Hours Worked}} \times \text{Total Payments for Malpractice Insurance} = \text{Actual Provider Payment}$$

$$\text{_____} \times \$ \text{_____} = \$ \text{_____}$$

Provider Name _____ Provider Number _____

Name of Physician _____

12. Adjusted RCE Base:

(Sum of #8 _____ + the Lesser of #9 or #10 _____ + #11 _____) = \$ _____

13. Actual Minimum Guarantee Amount \$ _____

14. Reasonable Minimum Guarantee Amount
(Lesser of #12 or #13) \$ _____

15. Total Charges:

Billed Inpatient Charges	\$ _____
Billed Outpatient Charges	\$ _____
Imputed Inpatient Charges	\$ _____
Imputed Outpatient Charges	\$ _____
Imputed Employee Charges	\$ _____

Total \$ _____

16. Reasonable Unmet Guarantee Amount
(#14 Less #15) \$ _____

17. Summary of Allowable Provider Costs:

Supervisory and Administrative Services (#7)	\$ _____
Reasonable Unmet Guarantee Amount (#16)	\$ _____

Total \$ _____

PART I - Wage Related Cost (Core List)

RETIREMENT COSTS:

- | | | |
|----|---|-------------|
| 1. | 401K Employer Contributions | 1. \$ _____ |
| 2. | Tax Sheltered Annuity (TSA) Employer Contribution | 2. \$ _____ |
| 3. | Qualified and Non-Qualified Pension Plan Cost | 3. \$ _____ |
| 4. | Prior Year Pension Service Cost | 4. \$ _____ |

PLAN ADMINISTRATIVE COSTS (Paid to External Organization):

- | | | |
|----|---|-------------|
| 5. | 401K/TSA Plan Administration fees | 5. \$ _____ |
| 6. | Legal/Accounting/Management Fees-Pension Plan | 6. \$ _____ |
| 7. | Employee Managed Care Program Administration Fees | 7. \$ _____ |

HEALTH AND INSURANCE COSTS:

- | | | |
|-----|---|--------------|
| 8. | Health Insurance (Purchased or Self-Funded) | 8. \$ _____ |
| 9. | Prescription Drug Plan | 9. \$ _____ |
| 10. | Dental, Hearing & Vision Plans | 10. \$ _____ |
| 11. | Life Insurance (If employee is owner or beneficiary) | 11. \$ _____ |
| 12. | Accident Ins. (If employee is owner or beneficiary) | 12. \$ _____ |
| 13. | Disability Ins. (If employee is owner or beneficiary) | 13. \$ _____ |
| 14. | Long-Term Care Ins. (If employee is owner or beneficiary) | 14. \$ _____ |
| 15. | Workmen's Compensation Ins. | 15. \$ _____ |
| 16. | Retiree Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. This is the non-cumulative portion.) | 16. \$ _____ |

TAXES:

- | | | |
|-----|---|--------------|
| 17. | FICA-Employers Portion Only | 17. \$ _____ |
| 18. | Medicare Taxes - Employers Portion Only | 18. \$ _____ |
| 19. | Unemployment Insurance | 19. \$ _____ |
| 20. | State or Federal Unemployment Taxes | 20. \$ _____ |

OTHER:

- | | | |
|-----|---------------------------------|--------------|
| 21. | Executive Deferred Compensation | 21. \$ _____ |
| 22. | Day Care Cost and Allowances | 22. \$ _____ |
| 23. | Tuition Reimbursement | 23. \$ _____ |
| | TOTAL WAGE RELATED COST (CORE) | \$ _____ |

Part II - Other Wage Related Cost

List below detail for each wage related cost that exceeds the 1% threshold. Each wage related cost listed below must be recognized as a wage related cost in conformity with published criteria and instructions.

_____ \$ _____

_____ \$ _____

TOTAL OTHER WAGE RELATED COST

\$ _____

Part III - WAGE RELATED COST RECONCILIATION TO FRINGE BENEFITS REPORTED IN THE COST REPORT

DESCRIPTION	COST PER MEDICARE	COST PER GAAP
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____