

Line 44.--If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.

Line 45, columns 1, 2 and 3.--Enter the name of the home office in column 1, and enter the name of the contractor of the home office in column 2. Enter the contractor number in column 3.

Line 46, columns 1 and 2.--Enter the street address in column 1, or the post office box number in column 2.

Line 47, columns 1, 2 and 3.--Enter the city, State and zip code in columns 1, 2, and 3.

4104.1 Part II - Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Reimbursement Questionnaire.-- The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all providers 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 the cost report. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost report 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.

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.

Line Descriptions

Lines 1 through 18 are required to be completed by all Skilled Nursing Facilities.

Line 1.--Indicate whether the provider has changed ownership. 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 provider 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 provider 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 in column 1. If column 1 is "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 do not engage public accountants to prepare your financial statements, 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 in column 1. If you answer "Y" in column 1, submit 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 in column 1. If you answer "Y" in column 1, 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 in column 1. If you answer "Y" in column 1, submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9.--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 413.89 and CMS Pub. 15-1, §§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 1 or internal schedules duplicating the documentation requested on Exhibit 1 to support the bad debts claimed. If you are claiming bad debts for inpatient and Part B SNF services, complete a separate Exhibit 1 or internal schedule for each category. Also, complete a separate Exhibit 1, as applicable, for bad debts of each sub provider.

Exhibit 1 displayed at the end of this section requires the following documentation:

Columns 1, 2, 3 - Patient Names, Health Insurance Claim (HIC) Number, 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, §314 and 42 CFR 413.89)

Column 4--Indigency/Medicaid Beneficiary--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 CMS Pub. 15-1, §§312 and 322 and 42 CFR §413.89 for guidance on the billing requirements for indigent and Medicaid beneficiaries.

Columns 5 & 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, §§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 & 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.

NOTE: The information in Exhibit 1 is not captured in the ECR file. Therefore, this exhibit must be completed and submitted either manually (hard copy), or in electronic media format (e.g. diskette, or CD).

Line 10--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 11--Indicate whether patient deductibles and/or coinsurance 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 1 or your internal schedules) submitted with the cost report.

Line 12--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 a copy of the approval from the Regional Office for a change in bed size required under CMS Pub. 15-1, §2337.2.

NOTE: For purposes of line 12, available beds are provider beds that are permanently maintained for lodging inpatients. They must be available for use and be housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). (See 42 CFR §412.105(b) and CMS Pub. 15-1, §2200.2.C.)

Line 13--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 14--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 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 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.

Line 15--If you entered "Y" on either line 13 or 14, 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 16--If you entered "Y" on either line 13 or 14, 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 17--If you entered "Y" on either line 13 or 14, 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 18--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 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 consistent manner 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.

Cost Report Preparer Contact Information:

Line 19--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 20--Enter the employer/company name of the cost report preparer.

Line 21--Enter the telephone number in column 1 and email address of the cost report preparer in column 2.

