

Centers for Medicare & Medicaid Services

Disclosure of Financial Relationships Report ("DFRR")

Section 1877(f) of the Social Security Act authorizes the Secretary to collect, in such form, manner, and at such times as the Secretary shall specify, "information concerning [an] entity's ownership, investment and compensation arrangements, including" (1) the covered items and services furnished by the provider or supplier; and (2) the names and unique physician identification numbers (UPINs) of all physicians (or their immediate family members) with an ownership or investment interest, or compensation arrangement. The implementing regulation, 42 C.F.R. § 411.361, states that CMS and OIG may require entities to submit information concerning their reportable financial relationships (any ownership or investment interest, or compensation arrangement) with a physician (or his or her immediate family member).

In accordance with its authority under the statute and regulations, CMS is requiring that certain hospitals provide information concerning their ownership, investment, and compensation arrangements by completing the Disclosure of Financial Relationships Report ("DFRR" or "Report").

Please send, in paper format, the original and one copy of the complete DFRR (which consists of the signed certification statement, all applicable worksheets, and all accompanying documentation) to: Physician Self-Referral, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mailstop C4-25-02, Baltimore, Maryland 21244-1850. (We also ask, but do not require, that you send an electronic version of the completed worksheets to HOSPITALDISCLOSURE@cms.hhs.gov). The complete DFRR (hard copy) must be received by us no later than 60 days from the date that appears on the cover letter or e-mail transmission to you. Section 1877(g) of the Social Security Act provides that failure to disclose timely the information sought can result in civil monetary penalties of up to \$10,000 for each day beyond the deadline established for disclosure. Questions concerning the mandatory Disclosure of Financial Relationships Report may be sent to: DFRR-Questions@cms.hhs.gov

Certification Statement

I hereby certify that the attached responses to this Section 1877(f) Disclosure of Financial Relationships Report, filed on behalf of (insert Medicare Provider name) _____ (insert Medicare Provider Number) _____ are true and correct to the best of my knowledge and belief.

Signature

Printed name

Date

Title *

* The certification must be signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or comparable officer of the hospital.

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-XXXX**. The time required to complete this information collection is estimated to average 6 hours 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 or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Exception from Reporting Requirement

An entity that furnishes a total (Part A and Part B combined) of 20 or fewer Medicare services during a calendar year is exempted from this reporting requirement pursuant to 42 C.F.R. § 411.361(b). If you believe that you are exempted from this requirement, please have the CEO, CFO, or a comparable officer of the Hospital, certify in writing that your hospital furnishes 20 or fewer Part A and Part B services during a calendar year in the certification statement below.

Please send the completed and signed certification to: Physician Self-Referral, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mailstop C4-25-02, Baltimore, Maryland 21244-1850. In addition, please email an electronic copy of the certification to HOSPITALDISCLOSURE@cms.hhs.gov. In the subject matter line please insert the title, "Exception to Disclosure Report." Questions concerning the mandatory disclosure of financial relationships may be sent to: DFRR-Questions@cms.hhs.gov

Certification Statement

I hereby certify that, to the best of my knowledge and belief (insert Hospital name), _____, (insert Provider Number), _____ furnishes 20 or fewer Part A and Part B services during a calendar year. Thus, we are invoking the exception at 42 C.F.R. § 411.361 (b) and will not be reporting financial relationship data concerning our facility.

Signature

Printed name

Date

Title *

* The certification must be signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or comparable officer of the hospital.

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-XXXX. The time required to complete this information collection is estimated to average 6 hours 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 or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Worksheet 1

Hospital Characteristics

- 1 Hospital Legal Name _____ 2 Medicare Provider Number _____
- 3 Hospital d/b/a Name _____ 4 Medicare Participation Date _____
(mm/dd/yy)
- 5 Address (1) _____
- 6 Address (2) _____ 8 State _____ 9 Zip _____
- 7 City _____
- 10 Cost Reporting Period(s) (Ending in 2006) _____ (Begin) _____ (End) _____
- 11 Ownership type Corp LP Not for Profit
 LLC LLP Other (Specify): _____
- 12 Within the cost reporting period(s) ending in 2006, were there one or more individual physicians (including immediate family members) who had (1) a direct ownership or investment interest in the hospital (e.g., through stock issued in the physician's or immediate family member's name), and/or (2) an indirect ownership or investment interest in the hospital (e.g., through stock issued in the name of an entity such as a group practice or LLC or corporation in which the physician or immediate family member had an ownership interest)?
 YES (Complete all worksheets)
 NO (Complete worksheets 7 and 8)
- 13 Number of Licensed Beds _____
- 14 Provide the hospital's separate independently audited financial statements with footnotes and supplementary information. If not available, submit the financial statements that have been reviewed, but if not available, submit financial statements that have been compiled, but if not available, submit the financial statements that have been internally prepared. Indicate whether the submitted financial statements have been independently audited, reviewed, compiled, or internally prepared. The statements must be for the cost reporting period(s) ending in 2006.
- 15 Is there any type of limitation of liability (regardless of source) on any physician's (or immediate family member's) investment (e.g., a stop loss agreement)?
 YES (Submit documentation and include the physician's name and NPI (or LPIN, if the physician has no NPI). If immediate family member, submit name and SSN. If no documentation exists, submit written description of arrangement and indicate that no documentation exists.
 NO

Indirect Ownership in Hospital

A	B	C	D	E	F	G	H
Name of Entity	Type of Entity	Entity's Direct Ownership %	Composition of Entity	% Ownership of Entity	Number of Shares Owned	Class of Stock/Share	Percent of Indirect Ownership
Ex: 1 Group Practice A	Group Practice	50%	John Doe (physician) Bob Brown (physician) Susan Brown (Wife) Bob Brown	50% 30% 20%	2000 1200 800	Class A Class A Class A	25.00% 15.00% 10.00%
1							
2							
3							
4							
5							

Worksheet 4

Payments Made to Hospital by Direct Owners

List all payments made by physician-owners to the hospital based on or related to their direct investment interest, including, but not limited to, initial investments, assessments, capital calls, and loan guarantees:

	A	B	C	D	E	F
	Name of Physician	Self / Relationship (if Immediate Family Member)	NPI	Date	Type of Payment	Amount
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Worksheet 5

Payments Made to Hospital by Indirect Owners

List all payments made by physician-owners to the hospital based on or related to their indirect investment interest, including, but not limited to, initial investments, assessments, capital calls, and loan guarantees:

	A	B	C	D	E	F	G
	Name of Entity:	Composition of Entity and Classification	Self / Relationship (if Immediate Family Member)	NPI	Date	Type of Payment	Amount
1	Example -- Group Practice 1	John Doe (Physician)	Self				
2		Bob Brown (Physician)	Self				
3		Susan Brown (IFM)	Wife, Bob Brown				
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Worksheet 6

Investment Reconciliation

1 Name _____ 2 Owner: Individual Physician Immediate Family (Phys. Name _____) 3 Identification #
 4 Address (1) _____ NPI: _____
 5 Address (2) _____ SSN: _____
 6 City _____ 7 State _____ 8 Zip _____

9 Class of Stock/Equity: _____

A Begin Date (mm/dd/yy)	B Dollar Amt	C # of Shares	D Cost per Share
10 Initial or Starting Investment \$			
11 Additional Purchases	+	+	+
12 Stock Dividends		+	+
13 Stock Splits		+	+
14 Relinquishments or Sales	-	-	-
15 Return of Capital Dividends	-	-	-
16 Capital Calls	+	+	+
17 Other Capital Assessments (not fees) Explain: _____	+	+	+
18 Investment at Cost Report Period Ending in 2006 \$ (mm/dd/06)		=	=

19 Is the physician-owner's risk of loss or liability limited or eliminated by agreement or understanding with any other party? (e.g., a stop-loss agreement, back-up guarantee, or disproportionate guarantee by physician investor).

YES NO (If yes, complete line 20)

20 If Line 19 is yes, describe in detail here:

Worksheet 8

Other Types of Compensation Arrangements (See 42 C.F.R. § 411.357)

1 Were there any isolated transactions with a physician, such as a one-time sale of property or sale of a practice (42 C.F.R. § 411.357(f))?

YES NO

If yes, was the transaction consistent with fair market value?

YES NO

If NO, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

2 Was there any remuneration paid to a physician that did not relate to a designated health service (42 C.F.R. § 411.357(g))?

YES NO

If YES, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

3 Were there any payments made by a physician to the hospital as compensation for any item or service not previously covered in this Report (42 C.F.R. § 411.357(i))?

YES NO

If YES, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

4 Were there any charitable donations made by a physician to the hospital (42 C.F.R. § 411.357(j))?

YES NO

If YES, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

5 Were there any non-monetary compensation and/or medical staff incidental benefits granted to a physician that exceeded published limits (42 C.F.R. § 411.357 (k) & (m))?

YES NO

If YES, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

6 Is it possible for a physician to make a capital investment of a certain percentage and receive a return on invested capital as if he/she made a higher capital investment (e.g., physician invests 2% of total capital and receives a return of 5% of the total capital distribution)?

YES NO

If YES, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

7 Were any loans or loan guarantees made either by the hospital on behalf of any physician or by any physician on behalf of the hospital?

YES NO

If YES, attach an explanation, which includes the physician's name, his or her National Provider Identifier, the date of the loan, name of lender, purpose of loan, amount of principal (expressed as a percent), term of the loan, payoff date, current payment status, and change in terms (if any).

8 Were there any initial investments, assessments, capital calls, or other types of payments made by the hospital on behalf of any physician?

YES NO

If YES, attach an explanation. The explanation should include the physician's name and National Provider Identifier.