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 excepted from this reporting requirement pursuant to 42 C.F.R. § 411.361(b). If you believe that you are excepted 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.

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 1

Hospital Characteristics

1 Hospital Legal Name _____ # Medicare Provider Number _____

3 Hospital d/b/a Name _____ # Medicare Participation Date _____ (mm/dd/yy)

5 Address (1) _____

6 Address (2) _____

7 City _____ # State _____ 9 Zip _____

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 UPIN, 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

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Worksheet 2

Direct Ownership in Hospital

A	B	C	D
Identify all Owners by Class of Stock	**Self / Relationship (if Immediate Family Member)**	**Basis of Stock/Shares (in Dollars)**	**Percent Ownership in Hospital**
Example--Class A Stock			
John M. Doe 123-34-5678	Self	$25,000	25.00%
Alice Doe	Wife, John M. Doe	$25,000	25.00% #
Group Practice #1	N/A	$50,000	50.00%
Total		$100,000	100.00%

Class _____:

Total			100.00%

Class _____:

Total			100.00%

Class _____:

Total		100.00%

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Worksheet 3

Indirect Ownership in Hospital

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

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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**
	Example -- Group Practice 1	John Doe (Physician)	Self				
		Bob Brown (Physician)	Self				
		Susan Brown (IFM)	Wife, Bob Brown				
1							
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3							
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Worksheet 6

Investment Reconciliation

1 Name _____ # Owner: 3 Identification #

4 Address (1) _____ ☐ Individual Physician NPI: _____

5 Address (2) _____ ☐ Immediate Family SSN: _____

6 City _____ 7 State _____ 8 Zip _____ (Phys. Name _____)

9 **Class of Stock/Equity:** _____

	A Begin Date			B Dollar Amt	C # of Shares	D Cost per Share
10	_____ (mm/dd/yy)	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	_____ (mm/dd/06)	Investment at Cost Report Period Ending in 2006	$	_____	= _____	= _____

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:

_____

_____

_____

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Worksheet 7

Compensation Arrangements -- Rentals, Personal Service Arrangements, and Recruitment (See 42 C.F.R. § 411.357)

			A	B	C			D
Physician Name	Physician NPI	Owner/Investor? Yes/No	Rental of Office Space § 411.357(a)	Rental of Equipment § 411.357(b)	Personal Service Arrangement* § 411.357(d)			Physician Recruitment § 411.357(e)
					# of PSAs	Uniform Y/N	Signed Y/N	

For each box completed with a number above, include a copy of the written agreement between the physician(s) and the hospital in force during the period ending in 2006.

***See full instructions for the PSA exception.**

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

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.