ANNUAL REPORT OF PHYSICIAN-OWNED HOSPITAL OWNERSHIP AND/OR INVESTMENT INTEREST

CMS-855POH

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-xxxx

ANNUAL REPORT OF PHYSICIAN-OWNED HOSPITAL OWNERSHIP AND/OR INVESTMENT INTEREST

In accordance with section 1877(i)(1)(C)(i) of the Social Security Act (the Act), physician-owned hospitals that seek to comply with the whole hospital or rural provider exceptions to the physician self-referral law must submit an annual report containing a detailed description of specific ownership and investment information.

Physician-owned hospitals will satisfy the above reporting requirement by completing the relevant fields below on an annual basis.

☐ If the information submitted in this report has not changed since it was last reported to CMS by the hospital, check this box and complete Section 1, Section 4 (if there is a new Contact Person), and Section 5.

SECTION 1: IDENTIFYING INFORMATION OF THE PHYSICIAN-OWNED HOSPITAL

PHYSICIAN-OWNED HOSPITAL IDENTIFICATION INFORMATION

Furnish the Legal Business Name, TIN, NPI and CCN of the Physician-Owned Hospital whose ownership and/or investment interest is being reported.

Legal Business Name as reported to the Internal Revenue Service (not the "Doing Business As" name)		
Tax Identification Number (TIN)	National Provider Number (NPI)	Medicare Identification Number (CCN) *(if issued)*

DEFINITION OF TERMS USED IN THIS REPORT

Ownership or investment interest means an interest in an entity through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in any entity that furnishes designated health services, as defined in 42 C.F.R. § 411.351. It does not include an interest that satisfies the requirements at 42 C.F.R. 411.356(a) or (b).

Physician means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, as defined in section 1861(r) of the Social Security Act. A physician and the professional corporation of which he or she is a sole owner are considered one and the same.

Immediate family member means a husband or wife of a physician; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Physician-owned hospital means any Medicare participating hospital (as defined in 42 C.F.R. § 489.24) in which a physician, or an immediate family member of a physician, has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at 42 C.F.R. § 411.356(a) or (b).

Physician Owner/Investor means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

Important: Pursuant to section 1877(i)(2) of the Act, information collected in this form may be published on the official CMS internet site.

INSTRUCTIONS FOR COMPLETING THIS REPORT

SECTION 2 must be completed for every organization that has any percentage of ownership or investment interest in the physician-owned hospital.

This reporting requirement includes the following types of organizations:

- Organizations that have a physician owner(s), and which have an ownership or investment interest in the physician-owned hospital.

  Example: "Doctors LLC" has an ownership interest in the physician-owned hospital. Doctors LLC is owned by Dr. Johnson and Dr. Smith. Doctors LLC's ownership interest must be reported in Section 2. Dr. Johnson and Dr. Smith's ownership interests must be reported in Section 3.

- Organizations that have no physician owners, but which have an ownership or investment interest in the physician-owned hospital.

  Example: "Real Estate LLC" is not owned by any physicians, but has an investment interest in the physician-owned hospital. Real Estate LLC's investment interest must be reported in Section 2.

SECTION 3 must be completed for every individual who has any percentage of ownership or investment interest in the physician-owned hospital.

This reporting requirement includes the following types of individuals:

- All physicians who have a direct or indirect ownership or investment interest in the physician-owned hospital.

  Example: "Care Facilities, Inc." has a direct ownership interest in the physician-owned hospital. Dr. Johnson has a direct ownership interest in Care Facilities, Inc., and, as a consequence, an indirect ownership interest in the physician-owned hospital. Dr. Johnson's ownership interest must be reported in Section 3. Care Facilities Inc. must be reported in Section 2 as a direct owner and Section 3 as the organization through which Dr. Johnson has an indirect ownership interest.

- A physician's immediate family members who have a direct or indirect ownership or investment interest in a physician-owned hospital.

  Example: Dr. Johnson's wife, who is not a physician, has a direct ownership interest in the physician-owned hospital. Mrs. Johnson's ownership interest must be reported in Section 3.

- All individuals who are not physicians or immediate family members of a physician, but who have a direct or indirect ownership or investment interest in the physician-owned hospital.

  Example: Nancy Jones, a teacher, has a direct ownership interest in the physician-owned hospital. Ms. Jones's ownership interest must be reported in Section 3.

SECTION 5 must be signed by a delegated or authorized official who was previously reported and approved on the CMS-855A Provider Enrollment Application at the time the physician-owned hospital was enrolled or when a CMS-855A was submitted to report a change in the delegated or authorized official.

SECTION 2: OWNERSHIP OR INVESTMENT INTEREST INFORMATION (ORGANIZATIONS)

NOTE: If there is more than one organization, copy and complete this section for each.

A. ORGANIZATION IDENTIFYING INFORMATION

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Tax Identification Number *(Required)*

Medicare Identification Number(s) (PTAN) *(if issued)*	NPI *(if issued)*

B. ORGANIZATION PERCENT OF OWNERSHIP OR INVESTMENT INTEREST

Percentage and effective date of direct ownership/investment interest	Percentage and effective date of direct ownership/investment interest
☐☐.☐☐ % _____ Effective *(mm/dd/yyyy)*	☐☐.☐☐ % _____ Effective *(mm/dd/yyyy)*

SECTION 3: OWNERSHIP OR INVESTMENT INTEREST INFORMATION (INDIVIDUALS)

NOTE: If there is more than one individual, copy and complete this section for each.

A. INDIVIDUAL IDENTIFYING INFORMATION

		Last Name	

☐ Check here if the individual identified above is a physician.

☐ Check here if the individual identified above is an immediate family member of a physician.

B. PERCENT OF OWNERSHIP OR INVESTMENT INTEREST

Percentage and effective date of direct ownership/investment interest	Percentage and effective date of indirect ownership/investment interest
☐☐.☐☐ % _____ Effective *(mm/dd/yyyy)*	☐☐.☐☐ % _____ Effective *(mm/dd/yyyy)*

C. INDIRECT OWNERSHIP/INVESTMENT INTEREST INFORMATION

If the individual above has an indirect ownership or investment interest, provide the name and address of the organization through which the individual has the indirect ownership or investment interest. If the individual has an indirect ownership or investment interest in the hospital through multiple organizations, then copy and complete this section for each organization.

Legal Business Name as Reported to the Internal Revenue Service		
"Doing Business As" Name *(if applicable)*		
Address Line 1 *(Street Name and Number)*		
Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town	State	ZIP Code + 4
Tax Identification Number *(Required)*		
Medicare Identification Number(s) (PTAN) *(if issued)*	NPI *(if issued)*	

SECTION 4: CONTACT PERSON INFORMATION

If questions arise concerning the information submitted in this report, the MAC will contact the individual checked below.

☐ Contact the Authorized Official in Section 5.

☐ Contact person listed below.

			Jr., Sr., M.D., etc.

Contact Person Address Line *1 (Street Name and Num*ber)

Contact Person Address Line 2 *(Suite, Room, Apt. #, etc.)*

NOTE: The Contact Person will be authorized to discuss only issues concerning this report. The MAC will not discuss any other Medicare issues for this provider with the above Contact Person.

SECTION 5: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT AND SIGNATURE

A. CERTIFICATION STATEMENT AND SIGNATURE

This report must be signed by a Delegated or Authorized Official previously reported on a CMS-855A Enrollment Application.

READ, SIGN AND DATE this certification statement before returning this report. In doing so, you are attesting to meeting the Medicare requirements stated below.

Under penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this report, and the information contained herein is true, correct and complete.
2. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this report or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this reporting form, may be punished by criminal, civil, or administrative penalties including, but not limited to, revocation of Medicare billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
3. I agree to abide by the Social Security Act and all applicable Medicare laws, regulations and program instructions that apply to this provider. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Stark law which is set forth at 42 U.S.C. § 1395nn or § 1877 of the Social Security Act). The Medicare laws, regulations and program instructions are available through the MAC.
4. Neither I, nor any physician reported on this form is currently debarred or excluded by the Medicare or State Health Care program, e.g., Medicaid, or other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.

Delegated or Authorized Official Signature and Date

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Telephone Number	E-mail Address *(if applicable)*	Title/Position

Authorized Official Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***	**Date Signed** ***(mm/dd/yyyy)***

All signatures must be original and signed in blue ink. Stamped, faxed or copied signatures will not be accepted. Reports not signed and dated will not be processed and will be returned.

MEDICARE PROVIDER PRIVACY ACT STATEMENT

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f(a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395I(3)), 1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C. 1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 104–134), as amended.

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/ directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners, as well as managing/directing employees. Managing/ directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN, OEID and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **http://www.cms.gov/Regulations-and-Guidance/Guidance/PrivacyActSystemofRecords/Systems-of-Records-Items/CMS023307.html**.

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.