

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. 			

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	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> <ol style="list-style-type: none"> The cost is not listed on Part I of EXHIBIT 6. 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. The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS. 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> 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) *X RCE (Use RCE from Table I) = RCE Base*
 Work Year Hours (2,080)

_____ *X \$ _____ = \$ _____*
2,080

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

RCE Base X 5% = Limit

\$ _____ X .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
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____