

Mailing Address  
P.O. Box 6133  
Williamsburg VA 23188



Office Location  
325 McLaws Cr. Suite 2  
Williamsburg VA 23185

Courtesy of:  
Peter Mellette, Esq.  
peter@mellettepc.com

## **Client Advisory**

### **CMS Disclosure of Financial Relationships Report Alert**

#### **By Peter M. Mellette, Esq., Mellette PC**

For certain specialty hospitals and other health care providers, September, not April, will be remembered as the “cruellest month.” The Centers for Medicare and Medicaid Services (CMS) published the third phase of the CMS Stark II final regulations at the beginning of the month and, by the end of the month, was sending out a mandatory “Disclosure of Financial Relationships Report” (DFRR) to 500 general and specialty hospitals. Authorized under the Deficit Reduction Act of 2005, the information collected through the DFRR will allow CMS to scrutinize financial relationships between hospitals and physicians and their immediate family members for compliance with the Stark law and CMS new regulatory authority.

Hospitals that have not reviewed their physician relationships and contracting process recently as part of their compliance programs should do so now. All hospitals should expect similar reporting mandates in the future as CMS plans to use the data collected to propose regular financial disclosure procedures for “all Medicare participating hospitals.”

Of the 500 hospitals selected by CMS, 290 are specialty hospitals and certain general acute care hospitals that did not respond to last year’s “voluntary” hospital survey distributed pursuant to the Deficit Reduction Act of 2005. If your hospital did not respond to the voluntary 2006 survey, expect the DFRR’s arrival this fall. While CMS is currently compiling its list of the other 210 hospitals, it has provided no information about its selection criteria for these hospitals.

Unlike last year’s voluntary hospital survey, this survey is mandatory. Hospitals must complete the DFRR within 45 days of their receipt of CMS’ request. Failure to respond in that time could result in civil penalties of up to \$10,000 for each day beyond the response deadline.

In DFRR, CMS seeks information regarding investment or compensation arrangements with physicians (or their immediate family members), including the name and UPIN of each physician or family member owner or investor and the extent and or value of the ownership or investment interest or compensation arrangement. The DFRR consists of six worksheets in an excel spreadsheet format collecting information regarding:

- The hospital’s characteristics

- The hospital's financial relationships including owners and ownership interests (both physician and non-physician)
- Direct ownership and investment interests reported by individual physicians (including loans or loan guarantees)
- Calculations of ownership percentages
- Leases or "under arrangements" relationships with physicians or their family members
- All other compensation arrangements between physicians and the hospital, including leases, medical director agreements, on-call stipends, and even charitable donations and non-monetary compensation arrangements, such as birthday presents and tickets to sporting events

Hospitals must complete and return the DFRR by mail, with the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other senior officer of the hospital certifying its accuracy.

The information that CMS collects through the DFRR will be used to analyze investment, ownership, and compensation relationships between hospitals and their physicians. CMS requests the inclusion of supporting documentation, such as copies of written agreements between a hospital and its physicians. CMS estimates that it will take at least four hours to prepare the report. However, this estimate seems grossly unrealistic based on the scope of financial information and supporting documentation requested in the DFRR.

CMS is prohibited from releasing confidential business or personal information reported in the DFRR to the public pursuant to the Federal Trade Secrets Act, 18 U.S.C. § 1905, and Exemption 6 to the Federal Freedom of Information Act, 5 U.S.C. § 552(b)(6), except to the extent permitted by law. However, CMS has authority to share the DFRR results with other Federal agencies and Congressional committees. Even if the DFRR information on physician ownership and relationships remains safe from public disclosure, hospitals can expect to see more enforcement of Stark resulting from this survey.

DFRR is one part of CMS' approach to hospital transparency. Eventually, CMS seeks to establish requirements that all hospitals "disclose to patients whether they are physician owned, and if so the names of such physician owners." For example, on August 2, 2007, CMS inserted new disclosure requirements for specialty hospitals into its final rule and comments regarding the acute care hospital inpatient prospective payment system. The inserted disclosure requirements call for physician-owned specialty hospitals to disclose such ownership to patients and provide the names of the physician owners upon request. They also ask that these hospitals require their physician owners on the medical staff disclose their ownership and investment interests to all patients they refer to the hospitals. Currently, CMS has the authority to terminate a provider agreement for noncompliance with these disclosure requirements upon their adoption.

In a similar vein, Representative Fortney “Pete” Stark has introduced amendments to the Children's Health and Medical Protection Act of 2007, which the House passed on August 1, 2007 and which would eliminate the whole hospital exception to the Stark law “so that physicians cannot self refer to hospitals in which they have ownership.” The amendment would apply to all hospitals and not just specialty hospitals. Rep. Stark’s amendment grandfathers hospitals with Medicare provider agreements as of July 24, 2007. However, the grandfathered hospitals have 18 months following enactment to meet new standards: requiring disclosure of ownership, limiting physician ownership to an aggregate of no more than 40% of the facility and no more than 2% individually, and disclosing to patients if they fail to have 24-hour physician coverage. The legislation is still pending in the senate.

If enacted into law, the Stark law amendments would significantly restrict physician ownership of hospitals and require the restructuring of many existing relationships involving specialty hospitals and ambulatory surgery centers. Expect the information CMS collects through the DFRR to be used in implementation of the Stark law.

The recent Stark II phase III regulations will be covered elsewhere in more detail, but will affect certain recruitment and joint venture relationships. The new “stand in the shoes” regulatory change will allow CMS to look through certain indirect relationships between a designated health service and a physician organization to find a direct compensation arrangement with the referring physician barred by the Stark law. Other changes affect the geographic area definition and relocation allowable for recruitment payments or guarantees and better define the allowable terms and parties to such agreements. There are also CMS comments which suggest a different direction in the treatment of leased physicians and leased space to qualify as a group practice or for the in-office ancillary service exception to the Stark law prohibition.

Should your hospital receive the mandatory DFRR this fall, complete the report promptly but after careful research by compliance professionals. If you have any questions regarding DFRR or your hospital’s financial relationships with its physicians or their immediate family members, please contact your attorney for more information.

### **About the Author**

Peter M. Mellette is an attorney and principal of the Virginia based firm of Mellette PC, where he represents physicians, hospitals, and other health care providers on regulatory compliance issues, in the Certificate of Public Need process and in licensing and payment disputes. He may be contacted at [peter@mellettepc.com](mailto:peter@mellettepc.com) or (877) 635-5388.

**Peer Reviewed By: Robert Harrison Gibbs, Esquire, Williamsburg, Virginia,**  
[harrison@mellettepc.com](mailto:harrison@mellettepc.com).

**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 CFR § 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 each hospital provide information concerning their ownership, investment and compensation arrangements by completing the Disclosure of Financial Relationships Report ("DFRR" or "Report"). Each hospital must complete all worksheets within 45 days from the date of the cover letter and accompanying instructions. 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.

Please send the completed original DFRR and a copy along with all accompanying documentation, with a signed and certified copy of the responses to: Physician Self-Referral, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mailstop C4-25-02, Baltimore, Maryland 21244-1850. Questions concerning the mandatory disclosure of financial relationships may be directed to Jacqueline Proctor at (410) 786-8852 or Joanne Sinsheimer at (410) 786-4620. Questions regarding the Excel formatting should be directed to John Davis at (410) 786-0008.

**CERTIFICATION STATEMENT**

I do 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 belief and knowledge.

\_\_\_\_\_  
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 4 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(s) 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.

NOTE: An entity that furnishes 20 or fewer Part A and Part B services during a calendar year is excepted from this reporting requirement pursuant to 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 CMS 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 directed to Jacqueline Proctor at (410) 786-8852 or Joanne Sinsheimer at (410) 786-4620. Questions regarding the Excel formatting should be directed to John Davis at (410) 786-0008.

**CERTIFICATION STATEMENT**

I do 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 using the exception found at 411.362(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 4 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(s) 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

HOSPITAL CHARACTERISTICS  
Worksheet 1

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) \_\_\_\_\_  
7 City \_\_\_\_\_ 8 State \_\_\_\_\_ 9 Zip \_\_\_\_\_

10 Cost Reporting Period \_\_\_\_\_ - \_\_\_\_\_  
(Begin) (End)

11 Ownership type  
a  Corp d  LLP  
b  LLC e  Not for Profit  
c  LP f  Other: \_\_\_\_\_

12 Number of Licensed Beds \_\_\_\_\_  
13 Is hospital an academic medical center?  YES  NO

14 Did the hospital formerly operate as another type of hospital or provider (e.g., ambulatory surgical center) ?  
 YES (complete lines 15 & 16) Date \_\_\_\_\_  
 NO (skip to line 17)  
15 Legal Name, City, State of former hospital or provider \_\_\_\_\_  
16 Type of hospital or provider \_\_\_\_\_

17 Is the hospital partnered with another hospital or provider? (e.g., joint venture or financial arrangements)  
 YES (complete Items 18 -24 for each partner)  
 NO (skip to 25)  
18 Legal Name of Partner: \_\_\_\_\_  
19 Address (1) \_\_\_\_\_  
20 Address (2) \_\_\_\_\_  
21 City \_\_\_\_\_ 22 State \_\_\_\_\_ 23 Zip \_\_\_\_\_  
24 Type of arrangement or partnership (describe) \_\_\_\_\_

25 Classes of Stock (Describe each class of stock). (Provide a copy of 1 blank subscription agreement for each class).  
a \_\_\_\_\_  
b \_\_\_\_\_  
c \_\_\_\_\_  
d \_\_\_\_\_

26 When was the hospital stock value determined?  
a  No Stock  
b  Value determined within last two years d Date \_\_\_\_\_  
c  Value not determined in last two years. e Date when last determined \_\_\_\_\_

27 Within the past 3 years, were there physician or other immediate family owners/investors?  
 YES (Complete all worksheets)  
 NO (Complete worksheets 5 & 6)

28 Provide the hospital's separate independently audited financial statements with footnotes and supplementary information.  
If not available, submit either a financial statement that has been reviewed, compiled, or internally prepared, and so indicate. The financial statement must be for the period **ending in 2006**.

29 Is there any type of limitation of liability (regardless of source) on any physician's investment (e.g., a stop loss agreement)?  
 YES (Submit a written description in detail on a separate sheet. Include Physician's Name & NPI.)  
 NO

30 With regard to the hospital's overall ownership, provide the percentages of physician ownership and non physician ownership.  
a Physician Ownership = \_\_\_\_\_ b. Non-Physician Ownership \_\_\_\_\_ Total \_\_\_\_\_  
(Must = 100%)

**Overview of Hospital Ownership  
Worksheet 2**

**Part I -- Cost of Investment -- Comprehensive -- All Physicians**

A	B	C	D	E	F
Dollar Investment (for each Class of Stock) Description of Stock/Equity or Secured Debt	Total of All Physician Investment	Total of All Non-Physician Individual Investment	Total of All Group Practice Investment	Total of All Other Corporate Investment	Total (sum Column A-E)
1					
2					
3					
4					
5					
6					
7 Total Investment (Sum of lines 1-6)					
8 Percent Ownership (Category Total/Line 7, Col F)					

**PART II -- Physician Percent Direct Ownership -- Report by Individual Physicians**

	A	B	C	D	E	F
9 Class of Stock/Equity or Secured Debt: PHYSICIAN NAME (Identify all Ownership) Example -- John M. Doe 123-34-5678						
10	2.50%	0.00%	10.00%			
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						

99 Total  
(Insert additional lines to accommodate additional owners - Totals Should be 100%)



**Financial Disclosure Report  
Direct Ownership  
Worksheet 3**

**PART I -- Investment Reconciliation -- Report by Individual Physicians**

1 Name \_\_\_\_\_ Last \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ MI \_\_\_\_\_  
 (use - dashes)  
 4 Social Security No. \_\_\_\_\_  
 5 NPI # \_\_\_\_\_  
 11 Owner: a  Individual Physician  
 b  Immediate Family  
 (Phys. Name \_\_\_\_\_)  
 c  Non-Physician-Owner (Individuals)  
 d  Group Practice  
 e  Other corporate owners  
 Specify: \_\_\_\_\_

6 Address (1) \_\_\_\_\_  
 7 Address (2) \_\_\_\_\_  
 8 City \_\_\_\_\_ 9 State \_\_\_\_\_ 10 Zip \_\_\_\_\_

**12 Class of Stock/Equity or Secured Debt**

A Begin Date (mm/dd/yy)	B Dollar Amt	C # of Shares	D Price per Share
13 _____	Initial or Starting Investment \$ _____	_____	_____
14 _____	Additional purchases _____	+	_____
15 _____	Dividends _____	+	_____
16 _____	Stock Splits _____	+	_____
17 _____	Relinquished or Sale _____	-	_____
18 _____	Return of Capital _____	-	_____
19 _____	other assessments _____	+	_____
20 _____	Capital Calls _____	-	_____
21 _____	OTHER _____	+/-	_____
22 _____	Investment at Year End = \$ _____	=	_____

23 Explain how the return on invested capital is calculated:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

24 Specify whether it is 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).  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Financial Disclosure Report  
 Direct Ownership  
 Worksheet 3

Part II -- Loans/Loan Guarantees by Hospital on Behalf of Physician-Owners or Investors - Report by Individual Physicians

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

	A	B
	Loan #1	Loan #2
25 Date of Loan	_____ (mm/dd/yy)	_____ (mm/dd/yy)
26 Name of Lender	_____	_____
27 Purpose of Loan	_____	_____
28 Amount of Principal	_____	_____
29 Interest Rate	_____ (expressed as a percent)	_____ (expressed as a percent)
30 Term	_____ (months)	_____ (months)
31 Payoff Date	_____ (mm/dd/yy)	_____ (mm/dd/yy)
32 Current Payment Status	_____	_____
33 Describe Change in Terms: (if any)	_____	_____

34 Is the physician-owner/investor'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 corporate investor).

YES  NO (If yes, complete line 35.)

35 If Line 34 is yes, describe in detail here:

---



---



---



---

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET

**OWNERSHIP PERCENTAGE CALCULATION**  
 (Complete for Each Owner)  
 Worksheet 4

**DIRECT OWNERSHIP**

1 Name of Owner _____  2 What is the name of the First Stock/Equity or Secured Debt? 3 What is the name of the Second Stock/Equity or Secured Debt? 4 What is the name of the Third Stock/Equity or Secured Debt? 5 What is the name of the Fourth Stock/Equity or Secured Debt? 6 What is the name of the Fifth Stock/Equity or Secured Debt? 7 What is the name of the Sixth Stock/Equity or Secured Debt?	<b>A</b>  Name of Stock _____ _____ _____ _____ _____ _____ <b>TOTAL INVESTMENT</b>	<b>B</b>  Direct Ownership % _____ _____ _____ _____ _____ _____ <b>TOTAL INVESTMENT</b>	<b>C</b>  Direct Ownership \$ _____ _____ _____ _____ _____ _____ <b>TOTAL INVESTMENT</b>	<b>D</b>  Total Investment for all Owners _____ _____ _____ _____ _____ _____ <b>(sum lines 2-7)</b>
---	--	--	---	---

**NOTES:**

Column B should agree with Worksheet 2, Part II, for the particular Stock/Equity or Secured Debt.  
 Column C should agree with Worksheet 3, line 22, Column B.  
 Column D should agree with Worksheet 2, Part I, Column F.

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET

Lease or Under Arrangements  
Worksheet 5

1 Hospital Name: \_\_\_\_\_ 2 Medicare Provider Number \_\_\_\_\_

**LAND**

3 Is the Hospital the sole owner of the land on which the hospital operations are conducted?

(If the answer is yes, skip to line 8.)

(If the answer is no, complete the following AND submit copy of Leasing Agreement or Contract in effect during the cost reporting period ending in 2006.)

YES  NO

A	B	C	D	E	F	G
Name of Owner	Address	Type of DHS Entity	Common ownership or control w/hospital	Beginning Date	Ending Date	Type of Security Interest
4	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
5	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
6	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
7	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____

8 How was the Fair Market Value (FMV) determined for each purchase, arrangement, or lease?  
(Please attach and submit copies of supporting documentation.) \_\_\_\_\_

**BUILDINGS and STRUCTURES**

9 Is the Hospital the sole owner of the buildings and structures in which the hospital operations are conducted?

(If the answer is yes, skip to line 14.)

(If the answer is no, complete the following AND submit copy of Leasing Agreement or Contract in effect during the cost reporting period ending in 2006.)

YES  NO

A	B	C	D	E	F	G	H
Name of Owner	Address	Type of DHS Entity	Type of Building or Structure	Common ownership or control w/hospital	Beginning Date	Ending Date	Type of Security Interest
10	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
11	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
12	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
13	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____

14 How was the Fair Market Value determined for each purchase, arrangement, or sale? \_\_\_\_\_

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET

**Lease or Under Arrangements  
Worksheet 5**

(Please attach and submit copies of supporting documentation.)

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET

Lease or Under Arrangements  
Worksheet 5

**CAPITAL EQUIPMENT**

15 Is the Hospital the sole owner of the capital equipment that the hospital uses? YES  NO   
 (If the answer is yes, how was the Fair Market Value determined for each Purchase, Arrangement or sale?)

16 (If the answer is no, complete the following AND submit copy of Leasing Agreement or Contract in effect during the cost reporting period ending in 2006.)

A	B	C	D	E	F	G
Name of Owner	Address	Type of DHS Entity	Type of Equipment	Common ownership or control w/hospital	Beginning Date	Ending Date
				Yes <input type="checkbox"/> No <input type="checkbox"/>		
				Yes <input type="checkbox"/> No <input type="checkbox"/>		
				Yes <input type="checkbox"/> No <input type="checkbox"/>		
				Yes <input type="checkbox"/> No <input type="checkbox"/>		

H	I	J
Type of Security Interest	Describe Terms of any Lease	Describe How FMV Was Determined (Attach documentation)

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET

Compensation Arrangements with Physicians (Refer to 42 CFR 411.357).  
Worksheet 6

Part II -- Other Types of Compensation Arrangements

- 1 Were there any isolated transactions with a physician, such as a one-time sale of property or sale of a practice (42 CFR 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 NPI/UPIN Number.
- 2 Was there any remuneration paid to a physician that did not relate to a designated health service (42 CFR 411.357(g))?  
 YES  NO  
If YES, attach an explanation. The explanation should include the Physician's Name and NPI/UPIN Number.
- 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 CFR 411.357(i))?  
 YES  NO  
If YES, attach an explanation. The explanation should include the Physician's Name and NPI/UPIN Number.
- 4 Were there any charitable donations made by a physician to the hospital (42 CFR 411.357(j))?  
 YES  NO  
If YES, attach an explanation. The explanation should include the Physician's Name and NPI/UPIN Number.
- 5 Were there any non-monetary compensation and/or medical staff incidental benefits granted to a physician that exceeded published limits (42 CFR 411.357 (k) & (m))?  
 YES  NO  
If YES, attach an explanation. The explanation should include the Physician's Name and NPI/UPIN Number.

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET

Compensation Arrangements with Physicians (Refer to 42 CFR 411.357).  
Worksheet 6

Part I -- Compensation Arrangements (Rentals, Personal Service Arrangements, and Recruitment).

	Physician Name	Physician NPI/UPIN	Owner/Investor? Yes/No	A Rental of Office Space §411.357(a)	B Rental of Equipment §411.357(b)	C Personal Service Arrangement §411.357(d)	D Physician Recruitment §411.357(e)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							

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