Questionnaire for Owner receiving compensation

For the period (cost report period)

Owner's Name:

Owner's Job Title:

Annual Salary:

Annual Draw Amount or additional benefits not offered to non-owner related employees, i.e. life insurance, auto allowance, etc., include description and dollar amount:

Percentage of time spent at the facility:

Owner's Duties:

Other employment (specify dates and weekly average of hours at other employment):

Hours per week spent doing clinical work at the facility:

Hours per week spent doing administrative work at the facility:

Does any other employee perform any of the same job duties?

Do you own or work at other entities that receive Medicaid funding?

Signature: _____

Print Name: _____

Date: _____