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 4 hours and 22 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/ /2088/ /*222* / From _____

/*216*/ /*1984*/ _____ (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 REIMBURSMENT QUESTIONAIRE			
	YES	NO	N/A
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 *MAC* 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 included in the filed cost report. Failure to have such records available for review by *MACs* 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. A. <u>Provider Organization and Operation</u> 1. The provider has: 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). 2. *The provider is involved in business transactions, including management contracts and services under arrangements, with individuals or entities (e.g., chain home offices, drug or medical supply companies, etc.) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships.* If "yes" attach a list of the individuals, the organizations involved, and description of the transactions. B. <u>Financial Data and Reports</u> 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: a. Audited; b. Compiled; and c. Reviewed. NOTE: Where there is no affirmative response to the above described financial statements, attach a copy of the financial statements prepared *by you* and a description of the changes in accounting policies and practices if not mentioned in those			

PROVIDER COST REPORT REIMBURSMENT QUESTIONAIRE			
	YES	NO	N/A
statements. 2. Cost report total expenses and total revenues differ from those on the filed financial statement. If "yes", submit reconciliation. *C*. Approved Educational Activities 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. Costs were claimed for Interns and Residents in Approved Programs on the current cost report.* *If "yes" attach a list of the programs and the approval for each program.* *D.* Bad Debts *Do not complete for HHAs and Hospices.* 1. The provider seeks Medicare reimbursement for bad debts. If "yes", complete Exhibit 2 or submit internal schedules duplicating documentation required on Exhibit 2 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 *2*. *E*. PS&R Data 1. The cost report was prepared using the PS&R only? If "yes", attach, *where applicable*, 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. 2. The cost report was prepared using the PS&R for totals and the provider records for allocation.			

PROVIDER COST REPORT REIMBURSMENT QUESTIONAIRE			
	YES	NO	N/A
If yes, include, *where applicable*, 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 working papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. Include working papers supporting the allocation of charges, *patient days, visits, etc.* into the various cost centers. If internal records are used for *these allocations*, the source of this information must be included in the documentation. 3. Provider records only were used to complete the cost report? 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> The minimum requirements are: - Copies of input tables, calculations, or charts supporting data elements 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. Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material. 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. 4. If yes to questions 1 or 2 above, were any of the following adjustments made to the Part A PS&R data? 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.			

PROVIDER COST REPORT REIMBURSMENT QUESTIONAIRE			
	YES	NO	N/A
b) Correction of other PS&R information? c) Late charges? d) Other (describe)? 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.			

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____ PREPARED BY _____

NUMBER _____ DATE PREPARED _____

FYE _____ INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) *DATE COLLECTION EFFORT CEASED*	(7) *MEDICARE* REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT. SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION