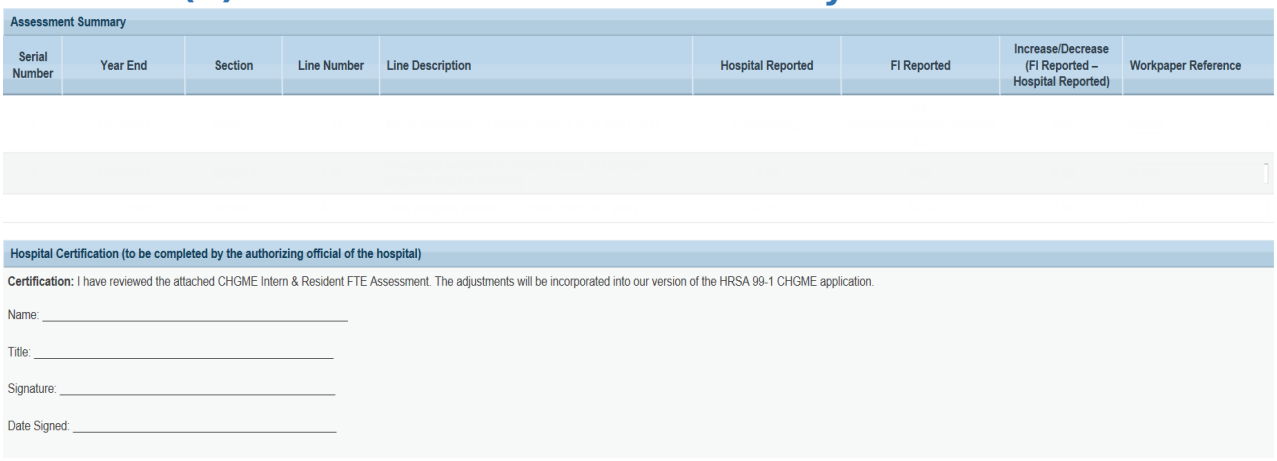
Exhibit O(1): CHGME Assessment Summary



Assessment Summary

Serial Number	Year End	Section	Line Number	Line Description	Hospital Reported	FI Reported	Increase/Decrease (FI Reported – Hospital Reported)	Workpaper Reference

Hospital Certification (to be completed by the authorizing official of the hospital)

Certification: I have reviewed the attached CHGME Intern & Resident FTE Assessment. The adjustments will be incorporated into our version of the HRSA 99-1 CHGME application.

Name: _____

Title: _____

Signature: _____

Date Signed: _____

Public Burden Statement: The purpose of this information collection is to obtain performance data for the following: HRSA Grantees and cooperative agreement recipients, public health, and applications. In addition, these data will facilitate the ability to demonstrate alignment between BHW programs and CHGME Payment Program's participating children's hospitals. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0247 and it is valid until 12/31/2025. Public reporting burden for this collection of information is estimated to average 3.7 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Information Collection Clearance Officer, 5600 Fishers Lane, Room 14NWH04, Rockville, Maryland, 20857.