(SBI)

11-95 FORM HCFA-339 1102.3 (Cont.)

EXHIBIT 1FORM 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 HCFA-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.

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE
(You MUST USE Instructions For Completing This Form Located In PRM-II, §§1100ff.)

Provider Name: QualiCare, Inc

Provider Number(s): 37-7259

Filed with Form HCFA-

/ / 287 / ~~1728~~ / / 2552 / / 2088 / /2540 / / 2540S

/ / _____ (Other Specify)

Period: From 1/1/95 To 12/31/95

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 QualiCare Inc 377259 (Provider name(s) and number(s)) for the cost report period beginning _____ and ending 123195, 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) Tracy L Kludring
Officer or Administrator of Provider(s)

Date

President
Title

Tracy L. Kludring RN (405)632-7094
Name and Telephone Number of Person to Contact for More Information

Kirk Rutzkowski (405) 495-5626

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4-3 1996
MEDICARE AUDIT & REIMBURSEMENT

Rev. 4

11-19

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE

	Yes	No	N/A
b. Management personnel of major suppliers of the provider (drug, medical supply companies, etc.). If "yes" to question 4a and/or 4b, attach a list of the individuals, the organizations involved, and description of the transactions.		X	
5. The provider's Articles of Incorporation and/or Corporate By-Laws or partnership agreement have changed. If "yes", submit copy and date of change as well as a summary of expenses incurred (e.g., Legal and Accounting).		X	
Financial Data and Reports			
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.	X 8 Doc attached		
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.			
2. Cost report total expenses and total revenues differ from those on the filed financial statement. If "yes", submit reconciliation.		X	
3. The cost report was prepared by the provider's independent accountant or consultant. If "yes", list the preparers: Name Patzkowski & Associates PC Address 1330 N Classen Blvd Suite 208 City OKC State OK Zip 73106	X 8 Doc attached		

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