APPENDIX 14

Audit Report Input Document #1

Provider Name:_____

Facility Address:_____

_____

_____

_____

Name of Contract Firm:_____

Personnel Assigned:_____

_____

_____

Audit Completion Date:_____

Audit Type: Full Scope or Limited Scope

(Circle the applicable audit type)

Other Comments to be Printed (Place an X next to the Desired Comment)

A._____ B._____ C._____ D._____ E._____ F._____ G._____

H._____ I._____ J._____ K._____ L._____ M._____ N._____

O._____ P._____ Q._____ T._____ **U** [1]._____ V._____ W.____

X._____ Y._____ Z._____ **Special Comments-attached**

If comment*U [1] *selected, then mark (1) or more of the following that apply:

a.____ P/A funds were commingled with the facility's general operating funds

b.____ Negative P/A Balances (Identify the resident & amount)

c.____ Balances over $1,500 (Identify the resident & amount)

d.____ No support for disbursements Identify the resident & total amount

e. ____ Inappropriate use of P/A funds (Identify resident and amount inappropriately spent)