This report is required by law (42 USC 1395mm and 42 USC 1995l).
Failure to report can result in all interim payments made since
the beginning of the cost reporting period being deemed overpayments.

FORM APPROVED
OMB NO. 0938-0165

PREPAID HEALTH PLAN COST REPORT
GENERAL INFORMATION

WORKSHEET S

1 Name and Address of Plan:

2 Reporting Period:
From:
To:

Plan Number:
H-xxxx

3 a. Type of Report:
[X] Budget Forecast
[ ] Interim Reports
[ ] Final Cost Report

b. Bill Processing Option:
Select Option

c. Reimbursement Under:
Select Section

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OF THE PLAN

I HEREBY CERTIFY that I have examined the accompanying Statement of Reimbursable Cost, the allocation of expenses and services, and the attached Worksheets for the period from 01/00/1900 to 01/00/1900 and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the Plan in accordance with applicable instructions, except as noted.

SIGNATURE (Officer or Administrator of the Plan)

DATE

TITLE

PHONE NUMBER

FORM CMS 276-08 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2302)

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 0938-0165. The time required to complete this information is estimated to average as follows: (1) for HMOs/CMPs, 24 hours to complete the budget forecast, 80 hours to complete the fourth quarter and final cost reports, and 12 hours to complete the first, second, and third quarterly reports; and (2)for HCPPs, 16 hours to complete the budget forecast, 60 hours to complete the final cost report, and 8 hours to complete the mid-year report. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

BUDGET FORECAST

WORKSHEET A
PARTS I & II

Name of Plan: 0 Budget Period From: 1/0/1900
Plan Number: H-xxxx To: 01/00/00

	PART I - PRIOR YEAR COST & STATISTICAL DATA Period From: To:	TRIAL BALANCE PER BOOKS	PMPM COSTS	TOTAL MEDICARE PMPM COSTS	MEDICARE PART A PMPM COSTS	MEDICARE PART B PMPM COSTS	MEDICARE RATIO (COL 3 / COL 2)	MEDICARE PART A RATIO (COL 4 / COL 3)	
		1	2	3	4	5	6	7	
0	Total Member Months	XXXXXXXXXX		XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXXX	0
1	Hospital Costs.....................		0.0000	0.0000			0.0000	0.0000	1
2	Skilled Nursing Facilities......		0.0000	0.0000			0.0000	0.0000	2
3	Home Health Agencies........		0.0000	0.0000			0.0000	0.0000	3
4	Other Providers...................		0.0000	0.0000			0.0000	0.0000	4
5	Non-Providers.....................		0.0000	0.0000			0.0000		5
6	Plan Administration...........		0.0000	0.0000			0.0000	0.0000	6
7	Special Admin. Costs:.........								7
7a	Accretion/Deletion............		0.0000	0.0000			1.0000		7a
7b	Cost Report Certification.....		0.0000	0.0000			1.0000		7b
7c	Other:		0.0000	0.0000			1.0000		7c
8	Administration & General.....		0.0000						8
9	Total Costs (Sums Ln 1-8)....	0	0.0000	0.0000	0.0000	0.0000			9

		TOTAL PROJECTED COSTS	PROJECTED PMPM COSTS (COL 1 / COL 2, LN 0)	MEDICARE PROJECTED PMPM COSTS (COL 2 * COL 6, Pt. I)	PMPM ADJUSTMENT (FROM ATTACHED WORKSHEET)	ADJUSTED MEDICARE PMPM COSTS (COL3+ COL4)	MEDICARE PART A PMPM COSTS (COL 5 * COL 7, PT. I)	MEDICARE PART B PMPM COSTS (COL 5 - COL 6)	
		1	2	3	4	5	6	7	
		XXXXXXXXXX		XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXXX	0
1	Hospital Costs.....................		0.0000	0.0000		0.0000	0.0000	0.0000	1
2	Skilled Nursing Facilities......		0.0000	0.0000		0.0000	0.0000	0.0000	2
3	Home Health Agencies........		0.0000	0.0000		0.0000	0.0000	0.0000	3
4	Other Providers...................		0.0000	0.0000		0.0000	0.0000	0.0000	4
5	Non-Providers.....................		0.0000	0.0000		0.0000		0.0000	5
6	Plan Administration............		0.0000	0.0000		0.0000	0.0000	0.0000	6
7	Special Admin. Costs:.........								7
7a	Accretion/Deletion............		0.0000	0.0000		0.0000		0.0000	7a
7b	Cost Report Certification.....		0.0000	0.0000		0.0000		0.0000	7b
7c	Other:		0.0000	0.0000		0.0000		0.0000	7c
8	Administrative & General.....		0.0000						8
9	3rd Party Insurer Revenue....					0.0000		0.0000	9
10	Total Costs (Sum Lns 1-9)....	0	0	0	0.0000	0.0000	0.0000	0.0000	10
11	Est. Deductible & Coinsurance					0.0000	0.0000	0.0000	11
12	Medicare Costs (Ln 10 - 11)					0.0000	0.0000	0.0000	12
13	Pay% (Ln12*Pt.IV,Col2,Ln4)					0.0000			13

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Exhibit 1

BUDGET FORECAST

WORKSHEET A
PARTS III, IV & V

Name of Plan: 0 — Budget Period From: 01/00/00
Plan Number: H-xxxx — To: 01/00/00

	PART III - DEDUCTIBLE AND COINSURANCE	TOTAL	MEDICARE PART A	MEDICARE PART B	
		1	2	3	
1	Total Estimated Part A deductible and coinsurance (Attach Worksheet)...................................	XXXXXXXXX		XXXXXXXXXX	1
2	Part A Member Months (Part IV, Col 1, Line 3)...	XXXXXXXXX	-	XXXXXXXXXX	2
3	Line 1 divided by Line 2..	0.0000	0.0000	XXXXXXXXXX	3
4	Total Part B Costs (Part II, Col 7, Line 10)...	0.0000	XXXXXXXXX	0.0000	4
5	Less Special Administrative Costs (Part II, Col 7, Line 7)..	0.0000	XXXXXXXXX	0.0000	5
6	Part B Costs not Subject to Coinsurance (Describe amount on attached worksheet)..	0.0000	XXXXXXXXX		6
			XXXXXXXXX		
7	Net Part B Costs (Line 4 minus Lines 5 and 6)...	0.0000	XXXXXXXXX	0.0000	7
8	Part B Standard Deductible...	0.0000	XXXXXXXXX		8
9	Part B Blood Deductible PMPM (Attach Worksheet)..	0.0000	XXXXXXXXX		9
10	Mental Health Copayment PMPM (Attach Worksheet)..	0.0000	XXXXXXXXX		10
			XXXXXXXXX		
11	Part B Costs less Deductibles (Line 7 minus sum of Lines 8 thru 10)..	0.0000	XXXXXXXXX	0.0000	11
12	Part B Coinsurance (Line 11 times 20%)...	0.0000	XXXXXXXXX	0.0000	12
13	Part B Coinsurance on Carrier Paid Bills PMPM (Attach Worksheet)..	0.0000	XXXXXXXXX		13
14	Part B Coinsurance on Intermediary Paid Bills PMPM (Attach Worksheet)..................................	0.0000	XXXXXXXXX		14
15	Total Deductible and Coinsurance (Sum of Lines 3, 8, 9, 10, 12, 13 and 14)............................	0.0000	0.0000	0.0000	15

	PART IV - MEMBERSHIP	MEDICARE PART A	MEDICARE PART B	
		1	2	
1	Total Medicare Member Months...			1
2	Medicare Secondary Liable (Employer Groups) Member Months...			2
3	Medicare Primary Member Months (Line 1 less Line 2)...	-	-	3
4	Ratio (Line 3 / Line 1)..	0.0000	0.0000	4

		PMPM	Fluctuation Ratio	
		1	2	
1	Total Medicare Cost Per Capita Rate (Part II, Col 5, Line 12)...	0.0000	XXXXXXXXXX	1
2	Total Costs Per Member Per Month (Part II, Col 2, Line 10)..	0.0000	0.0000	2
3	Cumulative Estimate of Total Costs PMPM for First Two Quarters..		0.0000	3

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BUDGET FORECAST

WORKSHEET B
PARTS I & II

Name of Plan: 0
Plan Number: H-xxxx

Period From: 01/00/00
To: 01/00/00

	PART I - UNDER AND OVER COLLECTION OF PREMIUMS PREMIUM DETERMINATIONS COVERED BY THIS PART Period From: 1/0/1900 To: 1/0/1900	TOTALS	MEMBER MONTHS	COST PER MEMB MONTH	
		1	2	3	
0	Total Medicare Member Months..	XXXXXXXXX		XXXXXXXXXX	0
1	Total Premiums/Dues Collected during the period...		XXXXXXXXX	0.0000	1
2	Total Copayments Collected during the period...		XXXXXXXXX	0.0000	2
			XXXXXXXXX		
3	Total Collections (Line 1 plus Line 2)...	-	XXXXXXXXX	0.0000	3
			XXXXXXXXX		
4	Less: Accounts Receivable for premiums/dues and copayments (beg of period).................		XXXXXXXXX	0.0000	4
			XXXXXXXXX		
5	Net collections for period (Line 3 minus Line 4)...	-	XXXXXXXXX	0.0000	5
6	Add: Accounts Receivable for premiums/dues and copayments (end of period)..................		XXXXXXXXX	0.0000	6
			XXXXXXXXX		
7	Net collections and amounts to be collected (Line 5 plus Line 6)..	-	XXXXXXXXX	0.0000	7
8	Total Medicare deductible and coinsurance PMPM from cost report:	XXXXXXXXX	XXXXXXXXX	XXXXXXXXXX	8
	a. Deductible and copayments (Worksheet M, Col 2+3, Sum lines 8 thru 11).......................	XXXXXXXXX	XXXXXXXXX		a.
	b. Part B coinsurance (Worksheet M, Col 3, Line 13)...	XXXXXXXXX	XXXXXXXXX		b.
	c. Part B coinsurance on services paid by CMS (Worksheet G, Col 2, Lines 23 +24)...........	XXXXXXXXX	XXXXXXXXX		c.
		XXXXXXXXX	XXXXXXXXX		
	d. Total (Sum of Lines 8a thru 8c)...	XXXXXXXXX	XXXXXXXXX	0.0000	d.
		XXXXXXXXX	XXXXXXXXX		
9	Voluntary under collection for the period (Prior Worksheet B, Part, II, Line 7)........................	XXXXXXXXX	XXXXXXXXX		9
10	Under (over) collection from immediate prior period (Prior Worksheet B, Part I, Line 12)........	XXXXXXXXX	XXXXXXXXX		10
		XXXXXXXXX	XXXXXXXXX		
11	Total amount allowed to be charged (Line 8d minus line 9 plus line 10)................................	XXXXXXXXX	XXXXXXXXX	0.0000	11
		XXXXXXXXX	XXXXXXXXX		
12	Under (over) collection for the period (Line 11 minus line 7)..	XXXXXXXXX	XXXXXXXXX	0.0000	12

	PART II -UNDER/OVER COLLECTION FOR BUDGET PERIOD	TOTALS	AMOUNT PER MEMBER MONTH	
		1	2	
1	Total deductible and coinsurance (Worksheet A, Part III, Col 1, Line 15)...	XXXXXXXXX	0.0000	1
2	Under (over) collection from prior period (Part I, Col 3, Line 12)...	0.0000	XXXXXXXXXX	2
3	Ratio of (Line 0 of W/S B, Part I, Col 2) to (Line 1, W/S A, Part IV, Col 2)..	0.0000	XXXXXXXXXX	3
4	Line 2 times Line 3..	XXXXXXXXX	0.0000	4
5	Total allowed to be collected during the period (Line 1 plus Line 4)...	XXXXXXXXX	0.0000	5
6	Total amounts to be charged including Medicare enrollee copayments (Attach Worksheet)..........................	XXXXXXXXX		6
		XXXXXXXXX		
7	Voluntary under or (Over) (Line 5 minus Line 6)	XXXXXXXXX	0.0000	7

FORM CMS 276-08

INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 2304.1 - 2304.2

SUPPORTING WORKSHEET FOR
WORKSHEET A, PART II
CURRENT YEAR PMPM ADJUSTMENTS

Wkst A Line Ref.	DESCRIPTION					PMPM Adj to Wkst A, Part II