

This report is required by law (42 USC 1395mm and 42 USC 1995I).
 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: <div style="background-color: yellow; padding: 2px;">XYZ Health Plan, Inc. 1234 Hospital Drive Anytown, USA 99999</div>		
2 Reporting Period: From: <div style="background-color: yellow; padding: 2px;">01/01/00</div> To: <div style="background-color: yellow; padding: 2px;">12/31/00</div>	Plan Number: <div style="background-color: yellow; padding: 2px;">H-xxxx</div>	
3 a. Type of Report: <input type="checkbox"/> Budget Forecast <input checked="" type="checkbox"/> Interim Reports <input type="checkbox"/> Final Cost Report	b. Bill Processing Option: <div style="background-color: yellow; padding: 2px;">Select Option</div>	c. Reimbursement Under: <div style="background-color: yellow; padding: 2px;">Select Section</div>
<p>MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW</p> <p>CERTIFICATION BY OFFICER OF THE PLAN</p> <p>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 01/01/2000 to 12/31/2000 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.</p>		
<div style="background-color: yellow; width: 100px; height: 15px; margin-bottom: 5px;"></div> SIGNATURE (Officer or Administrator of the Plan)	<div style="background-color: yellow; width: 100px; height: 15px; margin-bottom: 5px;"></div> DATE	
<div style="background-color: yellow; width: 100px; height: 15px; margin-bottom: 5px;"></div> TITLE	<div style="background-color: yellow; width: 100px; height: 15px; margin-bottom: 5px;"></div> PHONE NUMBER	

FORM CMS 276-99 (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.

INTERIM REPORT		PLAN NO.:	PERIOD	WORKSHEET
		H-xxxx	FROM: 01/01/00 TO: 12/31/00	1
1	Hospitals			1
2	Skilled Nursing Facilities			2
3	Home Health Agencies			3
4	Other Providers			4
5	Non-Providers			5
6	Plan Administration			6
7	Special Administrative Costs			7
8	Administrative and General			8
9	Total Costs (Sum of lines 1 thru 8)		-	9
10	Cost per Member-Month (Line 9 divided by Part II, Line 1)		-	10
11	Appropriate ratio from budget forecast (Worksheet A, Part V)			11
12	Medicare costs (Line 10 times Line 11)		-	12
13	Payment Rate (Line 12 times Line 5 of Part II)		-	13
14	Current Payment Rate			14

PART II - MEMBERSHIP		PART B
		1
1	Total Member Months	1
2	Total Medicare Member-Months	2
3	Medicare Member-Months (Secondary)	3
4	Medicare Member-Months (Primary)	-
5	Ratio (Line 4 divided by Line 2)	0.0000

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SECTION 2305 - 2305.3)