

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

<b>PREPAID HEALTH PLAN COST REPORT</b> GENERAL INFORMATION	<b>WORKSHEET S</b>
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1	Name and Address of Plan:  <div style="background-color: yellow; width: 150px; height: 30px; margin-left: 20px;"></div>
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2 Reporting Period: From: <div style="background-color: yellow; width: 100px; height: 15px; display: inline-block;"></div> To: <div style="background-color: yellow; width: 100px; height: 15px; display: inline-block;"></div>	Plan Number: <div style="background-color: yellow; width: 200px; height: 15px; display: inline-block; margin-left: 20px;">H-xxxx</div>
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3 a. Type of Report: <input type="checkbox"/> Budget Forecast <input type="checkbox"/> Interim Reports <input checked="" type="checkbox"/> Final Cost Report	b. Bill Processing Option: <div style="background-color: yellow; width: 100px; height: 15px; display: inline-block; margin-left: 20px;">Select Option</div>	c. Reimbursement Under: <div style="background-color: yellow; width: 200px; height: 15px; display: inline-block; margin-left: 20px;">1876</div>
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**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 12/30/1899 to 12/30/1899 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: HCFA, 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.

Name of Plan: 0  
 Plan #: H-xxxx

PERIOD FROM: 12/30/99  
 TO: 12/30/99

LIST OF PROVIDERS	PROVIDER NUMBER	RELATION-SHIP (1)	BILLS PROCESSED BY (2)	TOTAL DAYS	TOTAL MEDICARE DAYS*	MEDICARE PRIMARY DAYS	MEDICARE SECONDARY DAYS
	1	2	3	4	5	6	7
A. Hospitals & SNF's:							
1				0	0	0	0
2				0	0	0	0
3				0	0	0	0
4				0	0	0	0
5				0	0	0	0
6				0	0	0	0
7				0	0	0	0
8				0	0	0	0
9				0	0	0	0
10				0	0	0	0
11				0	0	0	0
12				0	0	0	0
13				0	0	0	0
14				0	0	0	0
15				0	0	0	0
16				0	0	0	0
17				0	0	0	0
18				0	0	0	0
19				0	0	0	0
20				0	0	0	0
21				0	0	0	0
22				0	0	0	0
23				0	0	0	0
24				0	0	0	0
25				0	0	0	0
26				0	0	0	0
27				0	0	0	0
28				0	0	0	0
29				0	0	0	0
30				0	0	0	0
31				0	0	0	0
32				0	0	0	0
33				0	0	0	0
34				0	0	0	0
35				0	0	0	0
36				0	0	0	0
37				0	0	0	0
38				0	0	0	0
39				0	0	0	0
40				0	0	0	0
41				0	0	0	0
42				0	0	0	0
43				0	0	0	0
44				0	0	0	0
45				0	0	0	0
46				0	0	0	0
47				0	0	0	0
48				0	0	0	0
49				0	0	0	0
50				0	0	0	0
51				0	0	0	0
52				0	0	0	0

\* Note: Col 5 minus 6 & 7 = Non-covered

(1)  
 O - OWNED OR CONTROLLED  
 P - PURCHASED

(2)  
 H - PROCESSED BY HCFA  
 P - PROCESSED BY PLAN

Name of Plan: 0  
 Plan #: H-xxxx

PERIOD FROM: 12/30/99  
 TO: 12/30/99

LIST OF PROVIDERS	PROVIDER NUMBER	RELATIONSHIP (1)	BILLS PROCESSED BY (2)	TOTAL VISITS	TOTAL MEDICARE VISITS*	MEDICARE PRIMARY VISITS	MEDICARE SECONDARY VISITS
	1	2	3	4	5	6	7
<b>B. HHA's:</b>							
1				0	0	0	0
2				0	0	0	0
3				0	0	0	0
4				0	0	0	0
5				0	0	0	0
6				0	0	0	0
7				0	0	0	0
8				0	0	0	0
9				0	0	0	0
10				0	0	0	0
11				0	0	0	0
12				0	0	0	0
13				0	0	0	0
14				0	0	0	0
15				0	0	0	0
16				0	0	0	0
17				0	0	0	0
18				0	0	0	0
19				0	0	0	0
20				0	0	0	0
21				0	0	0	0
22				0	0	0	0
23				0	0	0	0
24				0	0	0	0
25				0	0	0	0
<b>C. Other (Specify Name &amp; Type):</b>							
1				0	0	0	0
2				0	0	0	0
3				0	0	0	0
4				0	0	0	0
5				0	0	0	0
6				0	0	0	0
7				0	0	0	0
8				0	0	0	0
9				0	0	0	0
10				0	0	0	0
11				0	0	0	0
12				0	0	0	0
13				0	0	0	0
14				0	0	0	0
15				0	0	0	0
16				0	0	0	0
17				0	0	0	0
18				0	0	0	0
19				0	0	0	0
20				0	0	0	0
21				0	0	0	0
22				0	0	0	0
23				0	0	0	0
24				0	0	0	0
25				0	0	0	0

\* Note: Col 5 minus 6 & 7 = Non-covered

(1)  
 O - OWNED OR CONTROLLED  
 P - PURCHASED

(2)  
 H - PROCESSED BY HCFA  
 P - PROCESSED BY PLAN

Name of Plan: 0  
Plan #: H-xxxx

PERIOD FROM: 12/30/99  
TO: 12/30/99

LIST OF SUPPLIERS	TYPE OF GROUP (1) 1	PAYMENT MECHANISM (2) 2	HOW PHYSICIANS PAID (2) (3) 3	STATISTICS			
				TOTAL	TOTAL MEDICARE *	MEDICARE PRIMARY	MEDICARE SECONDARY
				4	5	6	7
A. Physician Services:							
1				0	0	0	0
2				0	0	0	0
3				0	0	0	0
4				0	0	0	0
5				0	0	0	0
6				0	0	0	0
7				0	0	0	0
8				0	0	0	0
9				0	0	0	0
10				0	0	0	0
11				0	0	0	0
12				0	0	0	0
13				0	0	0	0
14				0	0	0	0
15				0	0	0	0
16				0	0	0	0
17				0	0	0	0
18				0	0	0	0
19				0	0	0	0
20				0	0	0	0
21				0	0	0	0
22				0	0	0	0
23				0	0	0	0
24				0	0	0	0
25				0	0	0	0
26				0	0	0	0
27				0	0	0	0
28				0	0	0	0
29				0	0	0	0
30				0	0	0	0
31				0	0	0	0
32				0	0	0	0
33				0	0	0	0
34				0	0	0	0
35				0	0	0	0
36				0	0	0	0
37				0	0	0	0
38				0	0	0	0
39				0	0	0	0
40				0	0	0	0
41				0	0	0	0
42				0	0	0	0
43				0	0	0	0
44				0	0	0	0
45				0	0	0	0
46				0	0	0	0
47				0	0	0	0
48				0	0	0	0

(1)  
A - IPA  
B - GROUP PRACTICE  
C - STAFF  
D - INDIVIDUAL PRACTITIONERS

(2)  
A - FEE-FOR-SERVICE  
B - CAPITATION  
C - OTHER-SPECIFY

\* Note Col 5 minus 6 & 7 = Non-covered

Name of Plan: 0  
Plan #: H-xxxx

PERIOD FROM: 12/30/99  
TO: 12/30/99

LIST OF SUPPLIERS	TYPE OF GROUP (1) 1	PAYMENT MECHANISM (2) 2	HOW PHYSICIANS PAID (2) 3	STATISTICS			
				TOTAL	TOTAL MEDICARE*	MEDICARE PRIMARY	MEDICARE SECONDARY
				4	5	6	7
<b>B. Certified Labs:</b>							
1				0	0	0	0
2				0	0	0	0
3				0	0	0	0
4				0	0	0	0
5				0	0	0	0
6				0	0	0	0
7				0	0	0	0
8				0	0	0	0
9				0	0	0	0
<b>C. X-Ray Units:</b>							
1				0	0	0	0
2				0	0	0	0
3				0	0	0	0
4				0	0	0	0
5				0	0	0	0
6				0	0	0	0
7				0	0	0	0
8				0	0	0	0
9				0	0	0	0
<b>D. Others (Specify):</b>							
1				0	0	0	0
2				0	0	0	0
3				0	0	0	0
4				0	0	0	0
5				0	0	0	0
6				0	0	0	0
7				0	0	0	0
8				0	0	0	0
9				0	0	0	0
10				0	0	0	0
11				0	0	0	0
12				0	0	0	0
13				0	0	0	0
14				0	0	0	0
				* Note: Col 5 minus 6 & 7 = Non-covered			
(1) A - IPA B - GROUP PRACTICE C - STAFF D - INDIVIDUAL PRACTITIONERS				(2) A - FEE-FOR-SERVICE B - CAPITATION C - OTHER-SPECIFY			
<b>E. MEMBERSHIP:</b>						MEDICARE PART A 1	MEDICARE PART B 2
1	Total Medicare Member Months.....						
2	Medicare Secondary Liable (Employer Groups) Member Months.....						
3	Medicare Primary Member Months (Line 1 minus Line 2).....					0	0
4	Ratio (Line 3 & Line 1).....					0.0000	0.0000

(3)  
Part B Member Months = Total Member Months

Name of Plan: 0  
 Plan #: H-xxxx

PERIOD FROM: 12/30/99  
 TO: 12/30/99

COST CENTER	TRIAL	RECLASSIFI-	ADJUSTMENTS	ALLOWABLE	A & G	TOTALS	TRANSFER
	BALANCE	CATIONS	(WKST G)	COST	ALLOCATION	(Col 4 + Col 5)	TO
	1	(WKST F)	3	(Col 1 thru 3)	(WKST I, Part I)	6	WKST, LINE
		2		4	5		7
1 Inpatient Hospitals		0	0	0	0	0	J 2-47
2 Outpatient Hospitals		0	0	0	0	0	J 2-47
3 Skilled Nursing Facilities.....		0	0	0	0	0	J 52-61
4 Home Health Agencies.....		0	0	0	0	0	J 66-74
5 Clinics.....		0	0	0	0	0	K   1
6 Physician Groups.....		0	0	0	0	0	K   2-6
7 Individual Physicians.....		0	0	0	0	0	K   7
8 Certified Labs.....		0	0	0	0	0	K   8-10
9 X-Ray Units.....		0	0	0	0	0	K   11-13
10 ESRD Facilities.....		0	0	0	0	0	K   14-15
11 Durable Medical Equipment.....		0	0	0	0	0	K   16
12 Ambulance.....		0	0	0	0	0	K   17
13 Pharmacy (Outpatient).....		0	0	0	0	0	
13a Pharmacy-Medicare Covered Rx		0	0	0	0	0	
14 Emergency-Urgent Needed Svcs..		0	0	0	0	0	K   18
15 Mental Health Services.....		0	0	0	0	0	K   19&20
16 DED+CO pd by MAC/Carrier/Inter		0	0	0	0	0	L   18
17 Other - Medicare Bad Debts.....		0	0	0	0	0	L   9
18 Other - Blood Deductible.....		0	0	0	0	0	L   12
19 Other - (Specify).....		0	0	0	0	0	J&K
20 Other - (Specify).....		0	0	0	0	0	J&K
21 Other - (Specify).....		0	0	0	0	0	J&K
22 Other - (Specify).....		0	0	0	0	0	J&K
23 Other - (Specify).....		0	0	0	0	0	J&K
24 Subtotal (Sum Lines 1-23).....	0	0	0	0	0	0	
25 Plan Administration.....		0	0	0	0	0	L   3
26 Special Admin Costs.....		0	0	0	0	0	L   6
27 Subtotal: (Sum Lns 25+26).....	0	0	0	0	0	0	
28 Admin & General Costs.....		0	0	0	0	0	
29 Total Program Costs (24+27+28)...	0	0	0	0	0	0	



LINE	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1) 1	COST CENTER (Worksheet E) 2	CC LINE NUMBER (WKST E) 3	AMOUNT		
					INCREASES 4	(DECREASES) 5	
54					0	0	
55					0	0	
56					0	0	
57					0	0	
58					0	0	
59					0	0	
60					0	0	
61					0	0	
62					0	0	
63					0	0	
64					0	0	
65					0	0	
66					0	0	
67					0	0	
68					0	0	
69					0	0	
70					0	0	
71					0	0	
72					0	0	
73					0	0	
74					0	0	
75					0	0	
76					0	0	
77					0	0	
78					0	0	
79					0	0	
80					0	0	
81					0	0	
82					0	0	
83					0	0	
84					0	0	
85					0	0	
86					0	0	
87					0	0	
88					0	0	
89					0	0	
90					0	0	
91					0	0	
92					0	0	
93					0	0	
94					0	0	
95					0	0	
96					0	0	
97					0	0	
98					0	0	
99					0	0	
100					0	0	
101					0	0	
102					0	0	
103					0	0	
104					0	0	
105					0	0	
106					0	0	
107					0	0	
108					0	0	
109					0	0	
110	Total Page 2 (Col 4 must equal Col 5).....					0	0

(1) A Letter (A,B, etc.) Must be Entered on Each Line to Identify Each Reclassification Entry.  
(2) Transfer to Worksheet E, Col. 2, lines as appropriate.

Summarized on Worksheet F, Page 3



LINE	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1) 1	COST CENTER (Worksheet E) 2	CC LINE NUMBER (WKST E) 3	AMOUNT	
					INCREASES 4	(DECREASES) 5
111					0	0
112					0	0
113					0	0
114					0	0
115					0	0
116					0	0
117					0	0
118					0	0
119					0	0
120					0	0
121					0	0
122					0	0
123					0	0
124					0	0
125					0	0
126					0	0
127					0	0
128					0	0
129					0	0
130					0	0
131					0	0
132					0	0
133					0	0
134					0	0
135					0	0
136					0	0
137					0	0
138					0	0
139					0	0
140					0	0
141					0	0
142					0	0
143					0	0
144					0	0
145					0	0
146					0	0
147					0	0
148					0	0
149					0	0
150					0	0
151					0	0
152					0	0
153					0	0
154					0	0
155					0	0
156					0	0
157					0	0
158					0	0
159					0	0
160					0	0
161					0	0
162					0	0
163					0	0
164					0	0
165					0	0
166					0	0
167	Total Page 3 (Col 4 must equal Col 5).....				0	0

(1) A Letter (A,B, etc.) Must be Entered on Each Line to Identify Each Reclassification Entry.  
(2) Transfer to Worksheet E, Col. 2, lines as appropriate.

Summarized on Worksheet F, Page 3

RECLASSIFICATIONS

Name of Plan: 0  
 Plan #: H-xxxx

PERIOD FROM: 12/30/99  
 TO: 12/30/99

LINE	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1) 1	COST CENTER (Worksheet E) 2	CC LINE NUMBER (WKST E) 3	AMOUNT	
					INCREASES 4	(DECREASES) 5
168					0	0
169					0	0
170					0	0
171					0	0
172					0	0
173					0	0
174					0	0
175					0	0
176					0	0
177					0	0
178					0	0
179					0	0
180					0	0
181					0	0
182					0	0
183					0	0
184					0	0
185					0	0
186					0	0
187					0	0
188					0	0
189					0	0
190					0	0
191					0	0
192					0	0
193					0	0
194					0	0
195					0	0
196					0	0
197					0	0
198					0	0
199					0	0
200					0	0
201					0	0
202					0	0
203					0	0
204					0	0
205					0	0
206					0	0
207					0	0
208					0	0
209					0	0
210					0	0
211					0	0
212					0	0
213					0	0
214					0	0
215					0	0
216					0	0
217					0	0
218					0	0
219					0	0
220					0	0
221					0	0
222					0	0
223					0	0
224	Total Page 4 (Col 4 must equal Col 5).....				0	0

(1) A Letter (A,B, etc.) Must be Entered on Each Line to Identify Each Reclassification Entry.  
 (2) Transfer to Worksheet E, Col. 2, lines as appropriate.

Summarized on Worksheet F, Page 3

SUMMARY OF RECLASSIFICATIONS

Name of Plan: 0  
Plan #: H-xxxx

PERIOD FROM: 12/30/99  
TO: 12/30/99

CC LINE COST CENTER DESCRIPTIONS	SUMMARY OF RECLASSIFICATIONS		
	INCREASES (From Worksheet F, Pgs 1 & 2) 4	(DECREASES) 5	NET 6
1 Inpatient Hospitals	0	0	0
2 Outpatient Hospitals	0	0	0
3 Skilled Nursing Facilities	0	0	0
4 Home Health Agencies	0	0	0
5 Clinics	0	0	0
6 Physician Groups	0	0	0
7 Individual Physicians	0	0	0
8 Certified Labs	0	0	0
9 X-Ray Units	0	0	0
10 ESRD Facilities	0	0	0
11 Durable Medical Equipment	0	0	0
12 Ambulances	0	0	0
13 Pharmacy (Outpatient)	0	0	0
13a Pharmacy-Medicare Covered Rx	0	0	0
14 Emergency-Urgently Needed Svcs	0	0	0
15 Mental Health Services	0	0	0
16 DED+CO pd by the MAC/Carriers/Intermediaries	0	0	0
17 Other - Medicare Bad Debts	0	0	0
18 Other - Blood Deductible	0	0	0
19 Other - (Specify)	0	0	0
20 Other - (Specify)	0	0	0
21 Other - (Specify)	0	0	0
22 Other - (Specify)	0	0	0
23 Other - (Specify)	0	0	0
24			
25 Plan Administration	0	0	0
26 Special Admin Costs	0	0	0
27			
28 Admin & General Costs	0	0	0
29 Total Reclassifications (Lines 1 thru 28) (Col 6 must net to zero)	0	0	0
DIFFERENCES from total of pages 1 & 2 on page 1, Line 53	0	0	Must net to zero.
If these differences are not zero there is a problem!!			To Worksheet E Column 2

SUPPLEMENT TO WORKSHEET F - RECLASSIFICATIONS

Name of Plan: 0

Plan #: H-xxxx

Period

From:

12/30/99

To:

12/30/99

AD181...AN240

THIS IS A SUPPLEMENTAL WORKSHEET TO SUM UP RECLASSIFICATIONS BY COST CENTER

CCNO	INCREASES	(DECREASES)
1 IP Hosp	Err:504	0
2 OP Hosp	Err:504	0
3 SNF	Err:504	0
4 HHA	Err:504	0
5 Clinic	Err:504	0
6 Physicians Groups	Err:504	0
7 Ind Phy	Err:504	0
8 Labs	Err:504	0
9 Xray	Err:504	0
10 ESRD	Err:504	0
11 DME	Err:504	0
12 Amb	Err:504	0
13 Phrm	Err:504	0
14 Emerg	Err:504	0
15 Mental	Err:504	0
16 Ded & Coins	Err:504	0
17	Err:504	0
18 Other	Err:504	0
19 Nonallowable	Err:504	0
21 Plan Admin	Err:504	0
22 Spec Admin	Err:504	0
24 A&G	Err:504	0
	-----	-----
	Err:504	0
	=====	=====

ADJUSTMENTS TO EXPENSES

Name of Plan:

0

Plan #: H-xxxx

PERIOD FROM:

12/30/99

TO:

12/30/99

CC LINE	DESCRIPTIONS	BASIS FOR ADJ (1) 1	Amount (2) (To Wkst E as appropriate) 2	COST CENTER (Wkst E) 3	CC LINE NUMBER (Wkst E) 4
1	Investment income on commingled restricted & unrestricted funds.....	-	0		
2	Trade, quantity, time & other discounts on purchases.....	-	0		
3	Rebates & refunds of expenses.....	-	0		
4	Rental of space by suppliers.....	-	0		
5	Telephone service.....	-	0		
6	Television & radio service.....	-	0		
7	Parking lot.....	-	0		
8	Home Office Costs (Attach copy of Home Office Cost Statement).....	-	0		
9	Sale of scrap, waste, etc.....	-	0		
10	Adj. resulting from transactions with related organizations (3).....	-	0		
10a	Adj. resulting from transactions with related organizations (3).....	-	0		
10b	Adj. resulting from transactions with related organizations (3).....	-	0		
10c	Adj. resulting from transactions with related organizations (3).....	-	0		
11	Laundry and linen service.....	-	0		
12	Cafeteria - employees, guests, etc.....	-	0		
13	Rental of living quarters to employees and others.....	-	0		
14	Sale of medical and surgical supplies to other than patients.....	-	0		
15	Sale of drugs to other than patients.....	-	0		
16	Sale of medical records and abstracts.....	-	0		
17	Nursing school (tuition, fees, uniforms, finance charges).....	-	0		
18	Income from vending machines.....	-	0		
19	Income from imposition of interest and finance charges.....	-	0		
20	Payments - Physicians' assumption of operating costs.....	-	0		
21	Undistributed risk pool.....	-	0		
22	Charges in excess of MAC screens.....	-	0		
23	Part B coinsurance on services paid by CMS's MAC/Carriers.....	-	0		
24	Part B coinsurance on services paid by CMS's MAC/Intermediaries.....	-	0		
25	Adjustment for physical therapy costs in excess of limit (4).....	-	0		
26	Reinsurance.....	-	0		
27	Depreciation in excess of limits (Attach worksheet).....	-	0		
28	Noncovered purchased service (Attach worksheet).....	-	0		
29	Medicare Bad Debts	-	0		
30	.....	-	0		
31	.....	-	0		
32	.....	-	0		
33	.....	-	0		
34	.....	-	0		
35	.....	-	0		
36	.....	-	0		
37	.....	-	0		
38	.....	-	0		
39	.....	-	0		
40	.....	-	0		
41	.....	-	0		
42	.....	-	0		
43	.....	-	0		
44	.....	-	0		
45	.....	-	0		
46	.....	-	0		
47	.....	-	0		
48	.....	-	0		
49	.....	-	0		
50	Page total.....		0		
51	a. Subtotal from Page 2.....		0		
	b. Subtotal from Page 3.....		0		
	c. Subtotal from Page 4.....		0		
52	TOTAL ADJUSTMENTS.....		0		

- (1) Basis for Adjustment:
  - A = Cost - including applicable overhead, if determinable.
  - B = Amounts Received - if cost cannot be determined.
- (2) Transfer to Worksheet E lines as appropriate.
- (3) From Worksheet H.
- (4) See Chapter 4 of HCFA Pub 15-II; attach Worksheet A-8-3.

ADJUSTMENTS TO EXPENSES

Name of Plan:

0

Plan #: H-xxxx

PERIOD FROM:

12/30/99

TO:

12/30/99

PART I

PAGE 2

CC LINE	DESCRIPTIONS	BASIS FOR ADJ(1) 1	Amount (To Wkst E as appropriate) 2	COST CENTER (Wkst E) 3	CC LINE NUMBER (Wkst E) 4
53		-	0		-
54		-	0		-
55		-	0		-
56		-	0		-
57		-	0		-
58		-	0		-
59		-	0		-
60		-	0		-
61		-	0		-
62		-	0		-
63		-	0		-
64		-	0		-
65		-	0		-
66		-	0		-
67		-	0		-
68		-	0		-
69		-	0		-
70		-	0		-
71		-	0		-
72		-	0		-
73		-	0		-
74		-	0		-
75		-	0		-
76		-	0		-
77		-	0		-
78		-	0		-
79		-	0		-
80		-	0		-
81		-	0		-
82		-	0		-
83		-	0		-
84		-	0		-
85		-	0		-
86		-	0		-
87		-	0		-
88		-	0		-
89		-	0		-
90		-	0		-
91		-	0		-
92		-	0		-
93		-	0		-
94		-	0		-
95		-	0		-
96		-	0		-
97		-	0		-
98		-	0		-
99		-	0		-
100		-	0		-
101		-	0		-
102		-	0		-
103		-	0		-
104		-	0		-
105		-	0		-
106		-	0		-
107	Page total (to Page 1, Line 51a).....		0		

(1) Basis for Adjustment:  
 A = Cost - including applicable overhead, if determinable.  
 B = Amounts Received - if cost cannot be determined.

ADJUSTMENTS TO EXPENSES

Name of Plan:

0

Plan #: H-xxxx

PERIOD FROM:

12/30/99

TO:

12/30/99

PART I

PAGE 3

CC LINE	DESCRIPTIONS	BASIS FOR ADJ(1) 1	Amount (To Wkst E as appropriate) 2	COST CENTER (Wkst E) 3	CC LINE NUMBER (Wkst E) 4
108		-	0		-
109		-	0		-
110		-	0		-
111		-	0		-
112		-	0		-
113		-	0		-
114		-	0		-
115		-	0		-
116		-	0		-
117		-	0		-
118		-	0		-
119		-	0		-
120		-	0		-
121		-	0		-
122		-	0		-
123		-	0		-
124		-	0		-
125		-	0		-
126		-	0		-
127		-	0		-
128		-	0		-
129		-	0		-
130		-	0		-
131		-	0		-
132		-	0		-
133		-	0		-
134		-	0		-
135		-	0		-
136		-	0		-
137		-	0		-
138		-	0		-
139		-	0		-
140		-	0		-
141		-	0		-
142		-	0		-
143		-	0		-
144		-	0		-
145		-	0		-
146		-	0		-
147		-	0		-
148		-	0		-
149		-	0		-
150		-	0		-
151		-	0		-
152		-	0		-
153		-	0		-
154		-	0		-
155		-	0		-
156		-	0		-
157		-	0		-
158		-	0		-
159		-	0		-
160		-	0		-
161		-	0		-
162	Page total (to Page 1, Line 51b).....		0		

(1) Basis for Adjustment:  
 A = Cost - including applicable overhead, if determinable.  
 B = Amounts Received - if cost cannot be determined.

ADJUSTMENTS TO EXPENSES

Name of Plan:

0

Plan #: H-xxxx

PERIOD FROM:

12/30/99

TO:

12/30/99

PART I

PAGE 4

CC LINE	DESCRIPTIONS	BASIS FOR ADJ(1) 1	Amount (To Wkst E as appropriate) 2	COST CENTER (Wkst E) 3	CC LINE NUMBER (Wkst E) 4
163		-	0		-
164		-	0		-
165		-	0		-
166		-	0		-
167		-	0		-
168		-	0		-
169		-	0		-
170		-	0		-
171		-	0		-
172		-	0		-
173		-	0		-
174		-	0		-
175		-	0		-
176		-	0		-
177		-	0		-
178		-	0		-
179		-	0		-
180		-	0		-
181		-	0		-
182		-	0		-
183		-	0		-
184		-	0		-
185		-	0		-
186		-	0		-
187		-	0		-
188		-	0		-
189		-	0		-
190		-	0		-
191		-	0		-
192		-	0		-
193		-	0		-
194		-	0		-
195		-	0		-
196		-	0		-
197		-	0		-
198		-	0		-
199		-	0		-
200		-	0		-
201		-	0		-
202		-	0		-
203		-	0		-
204		-	0		-
205		-	0		-
206		-	0		-
207		-	0		-
208		-	0		-
209		-	0		-
210		-	0		-
211		-	0		-
212		-	0		-
213		-	0		-
214		-	0		-
215		-	0		-
216		-	0		-
217	Page total (to Page 1, Line 51c).....		0		-

(1) Basis for Adjustment:  
 A = Cost - including applicable overhead, if determinable.  
 B = Amounts Received - if cost cannot be determined.



SUMMARY OF ADJUSTMENTS TO EXPENSES

WORKSHEET G  
PART II

Name of Plan: 0  
Plan #: H-xxxx

PERIOD FROM: 12/30/99  
TO: 12/30/99

CC LINE	COST CENTER DESCRIPTIONS	LINE NUMBERS FROM PART I	Amount (To Wkst E as appropriate)	TRANSFER TO WORKSHEET E LINE # AS SHOWN	CC LINE NUMBER Wkst E
		1	2	3	4
1	Inpatient .....	_____	0		1
2	Outpatient .....	_____	0		2
3	Skilled Nursing Facilities.....	_____	0		3
4	Home Health Agencies.....	_____	0		4
5	Clinics.....	_____	0		5
6	Physician Groups.....	_____	0		6
7	Individual Physicians.....	_____	0		7
8	Certified Labs.....	_____	0		8
9	X-Ray Units.....	_____	0		9
10	ESRD Facilities.....	_____	0		10
11	Durable Medical Equipment.....	_____	0		11
12	Ambulances.....	_____	0		12
13	Pharmacy (Outpatient).....	_____	0		13
13a	Pharmacy-Medicare Covered Rx.....	_____	0		13
14	Emergency-Urgently Needed Svcs.....	_____	0		14
15	Mental Health Services.....	_____	0		15
16	DED+CO on Svcs pd by the CMS MAC.....	_____	0		16
17	Other - Medicare Bad Debts.....	_____	0		17
18	Other - Blood Deductible.....	_____	0		18
19	Other - (Specify).....	_____	0		19
20	Other - (Specify).....	_____	0		20
21	Other - (Specify).....	_____	0		21
22	Other - (Specify).....	_____	0		22
23	Other - (Specify).....	_____	0		23
24	Plan Administration.....	_____	0		24
25	Special Admin Costs.....	_____	0		25
26	Admin & General Costs.....	_____	0		26
27					27
28	Admin & General Costs.....	_____	0		28
29	Total Adjustments (Lines 1 thru 28).....		0	29	

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

WORKSHEET H

Name of Plan:

0

PERIOD FROM:

12/30/99

Plan #: H-xxxx

TO:

12/30/99

- A. Are there any costs included on Worksheet E which resulted from transactions with related organizations?  
 Select (If "YES", complete Parts B and C.)
- B. Costs incurred and adjustments required as a result of transactions with related organizations.

LINE (Wkst E)	COST CENTER (Worksheet E) 1	EXPENSE ITEMS 2	AMOUNT 3	AMOUNT ALLOWABLE IN COST 4	NET ADJUSTMENTS (1) (5) (5 = 4 - 3)
1			0	0	0
2			0	0	0
3			0	0	0
4			0	0	0
5			0	0	0
6			0	0	0
7			0	0	0
8			0	0	0
9			0	0	0
10			0	0	0
11			0	0	0
12			0	0	0
13			0	0	0
14			0	0	0
15			0	0	0
16			0	0	0
17	TOTALS.....		0	0	0

(1) Transfer the sum of this column to Worksheet G, Part I, Column 2 line 10

C. Interrelationship of Plan to related organization(s):

The Secretary, by virtue of authority granted under section 1814(b)(1) of the Health Insurance for the Aged and Disabled Act, required organizations to furnish the information requested on Part C of this worksheet. The information will be used by the Health Care Financing Administration in determining that the costs applicable to services, facilities and supplies furnished by organizations related to the Plan by common ownership or control, represent reasonable costs as determined under section 1861 of the Health Insurance for the Aged and Disabled Act. If the Plan does not provide all or any part of the requested information, the cost report will be considered incomplete and not acceptable for purposes of claiming reimbursement under Title XVIII.

SYMBOL (2) 1	NAME OF INDIVIDUAL 2	OWNERSHIP OF PLAN 3	-----RELATED ORGANIZATION(S)-----		TYPE OF BUSINESS 6
			ORGANIZATION NAME 4	OWNERSHIP % 5	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	
-				0.00%	

- (2) Use the following symbols to indicate the interrelationship of the Plan to related organizations:
- A Individual has financial interest (stockholder, partner, etc) in both related organization and in the Plan.
  - B Corporation, partnership, or other organization has financial interest in the Plan.
  - D Director, officer, administrator or key person of the Plan or relative of such person has financial interest in related organization.
  - E Individual is director, officer, administrator, or key person of the Plan and related organization.
  - F Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the Plan.
  - G Other (financial or nonfinancial) specify.

ADMINISTRATIVE AND GENERAL COST ALLOCATION

Name of Plan: 0  
Plan #: # H-xxxx

PERIOD FROM: 12/30/99  
TO: 12/30/99

PART I

COST CENTER	1 EMPLOYEE BENEFITS (Salaries)	2 STATISTICS & DATA PROCESSING (Time Spent)	3 PHARMACY & SUPPLIES (Cost Req's)	4 OTHER (SPECIFY)	5 TOTALS (Sum Cols 1 Thru 4)	6 POOLED ADMIN & GEN COSTS	7 TOTALS (Col 5 + Col 6)
1 Inpatient Hospitals .....	0	0	0	0	0	0	0
2 Outpatient Hospitals .....	0	0	0	0	0	0	0
3 Skilled Nursing Facilities.....	0	0	0	0	0	0	0
4 Home Health Agencies.....	0	0	0	0	0	0	0
5 Clinics.....	0	0	0	0	0	0	0
6 Physician Groups.....	0	0	0	0	0	0	0
7 Individual Physicians.....	0	0	0	0	0	0	0
8 Certified Labs.....	0	0	0	0	0	0	0
9 X-Ray Units.....	0	0	0	0	0	0	0
10 ESRD Facilities.....	0	0	0	0	0	0	0
11 Durable Medical Equipment.....	0	0	0	0	0	0	0
12 Ambulance.....	0	0	0	0	0	0	0
13 Pharmacy (Outpatient).....	0	0	0	0	0	0	0
13a Pharmacy-Medicare Covered Rx	0	0	0	0	0	0	0
14 Emergency-Urgent Needed Svcs..	0	0	0	0	0	0	0
15 Mental Health Services.....	0	0	0	0	0	0	0
16 DED+CO pd by MAC/Carrier/Inter	0	0	0	0	0	0	0
17 Other - Medicare Bad Debts.....	0	0	0	0	0	0	0
18 Other - Blood Deductible.....	0	0	0	0	0	0	0
19 Other - (Specify).....	0	0	0	0	0	0	0
20 Other - (Specify).....	0	0	0	0	0	0	0
21 Other - (Specify).....	0	0	0	0	0	0	0
22 Other - (Specify).....	0	0	0	0	0	0	0
23 Other - (Specify).....	0	0	0	0	0	0	0
24 Subtotal (Sum of Lines 1 thru 23).....	0	0	0	0	0	0	0
25 Plan Administration.....				0	0		0
26 Special Administrative Costs.....				0	0		0
27 Subtotal (Sum of 25 and 26).....				0	0		0
Total (Sum of Lines 24 & 27).....	0	0	0	0	0	0	0
28 Admin & General Costs.....	0	0	0	0	0	0	0
29 Net A&G Costs (Lines 24+27+28).....	0	0	0	0	0	0	0
30 Computation - Fr Worksheet, Col.....	Fr Wkst I, Pt II, Col 1	Fr Wkst I, Pt II, Col 2	Fr Wkst I, Pt II, Col 3	Fr Wkst I, Pt II, Col 4		Fr Wkst I, Pt II, Col 7	
31 To Worksheet, Column.....					To Wkst I, Pt II, Col 6		To Wkst E, Col 5

Name of Plan: # 0  
 Plan #: # H-xxxx

PERIOD FROM: 12/30/99  
 TO: 12/30/99

PART II

COST CENTER	EMPLOYEE BENEFITS (Salaries)	STATISTICS & DATA PROCESSING (Time Spent)	PHARMACY & SUPPLIES (Cost Req's)	OTHER (SPECIFY)	TOTALS (From Worksheet E Column 4)	TOTALS (From Wkst I, Pt I, Col 5)	POOLED ADMIN & GEN STATS (Cols 5+6)
	1	2	3	4	5	6	7
1 Inpatient Hospitals .....	0	0	0	0	0	0	0
2 Outpatient Hospitals .....	0	0	0	0	0	0	0
3 Skilled Nursing Facilities.....	0	0	0	0	0	0	0
4 Home Health Agencies.....	0	0	0	0	0	0	0
5 Clinics.....	0	0	0	0	0	0	0
6 Physician Groups.....	0	0	0	0	0	0	0
7 Individual Physicians.....	0	0	0	0	0	0	0
8 Certified Labs.....	0	0	0	0	0	0	0
9 X-Ray Units.....	0	0	0	0	0	0	0
10 ESRD Facilities.....	0	0	0	0	0	0	0
11 Durable Medical Equipment.....	0	0	0	0	0	0	0
12 Ambulance.....	0	0	0	0	0	0	0
13 Pharmacy (Outpatient).....	0	0	0	0	0	0	0
13a Pharmacy-Medicare Covered Rx	0	0	0	0	0	0	0
14 Emergency-Urgent Needed Svcs..	0	0	0	0	0	0	0
15 Mental Health Services.....	0	0	0	0	0	0	0
16 DED+CO pd by MAC/Carrier/Inter	0	0	0	0	0	0	0
17 Other - Medicare Bad Debts.....	0	0	0	0	0	0	0
18 Other - Blood Deductible.....	0	0	0	0	0	0	0
19 Other - (Specify).....	0	0	0	0	0	0	0
20 Other - (Specify).....	0	0	0	0	0	0	0
21 Other - (Specify).....	0	0	0	0	0	0	0
22 Other - (Specify).....	0	0	0	0	0	0	0
23 Other - (Specify).....	0	0	0	0	0	0	0
24 Subtotal (Sum of Lines 1 thru 23).....	0	0	0	0	0	0	0
25 Plan Administration.....				0			
26 Special Administrative Costs.....				0			
27 Subtotal (Sum of 25 and 26) .....				0			
Total (Sum of Lines 24 & 27).....	0	0	0	0	0	0	0
28 Administrative & General Costs.....							
29 TOTAL STATS (Sum of 24 & 27).....	0	0	0	0	0	0	0
30 COSTS TO BE ALLOCATED.....	0	0	0	0	0		Col 5 - (1+2+3+4) 0
(Input here)							
31 UNIT COST MULTIPLIER.....	0.000000	0.000000	0.000000	0.000000			0.000000
(Line 30 / Line 29)							

Name of Plan: 0  
 Plan #: H-xxxx

PERIOD FROM: 12/30/99  
 TO: 12/30/99

PROVIDERS	1 PROVIDER NUMBER	2 REIMBURSABLE PART A	3 PART A DEDUCTIBLE + COINSURANCE	4 REIMBURSABLE PART B	5 PART B DEDUCTIBLE
1 Medicare Memb Mos (WS D, Pt II, Sec E, Ln 3)		0	0	0	0
2 Hospitals		=====	=====	=====	=====
3 _____		0	0	0	0
4 _____		0	0	0	0
5 _____		0	0	0	0
6 _____		0	0	0	0
7 _____		0	0	0	0
8 _____		0	0	0	0
9 _____		0	0	0	0
10 _____		0	0	0	0
11 _____		0	0	0	0
12 _____		0	0	0	0
13 _____		0	0	0	0
14 _____		0	0	0	0
15 _____		0	0	0	0
16 _____		0	0	0	0
17 _____		0	0	0	0
18 _____		0	0	0	0
19 _____		0	0	0	0
20 _____		0	0	0	0
21 _____		0	0	0	0
22 _____		0	0	0	0
23 _____		0	0	0	0
24 _____		0	0	0	0
25 _____		0	0	0	0
26 _____		0	0	0	0
27 _____		0	0	0	0
28 _____		0	0	0	0
29 _____		0	0	0	0
30 _____		0	0	0	0
31 _____		0	0	0	0
32 _____		0	0	0	0
33 _____		0	0	0	0
34 _____		0	0	0	0
35 _____		0	0	0	0
36 _____		0	0	0	0
37 _____		0	0	0	0
38 _____		0	0	0	0
39 _____		0	0	0	0
40 _____		0	0	0	0
41 _____		0	0	0	0
42 _____		0	0	0	0
43 _____		0	0	0	0
44 _____		0	0	0	0
45 _____		0	0	0	0
46 _____		0	0	0	0
47 _____		0	0	0	0
48 Total Hospital .....		0	0	0 #	0
49 Cost PMPM (Line 48 / Line 1).....		0.0000	0.0000	0.0000	0.0000
50 Enter on Worksheet, Col, Line.....		M, 2, 1	M, 2, 1&8	M, 3, 1	M, 3, 1

SUMMARY OF PROVIDER COSTS

Name of Plan: 0  
Plan #: H-xxxx

PERIOD FROM: 12/30/99  
TO: 12/30/99

PROVIDERS	1 PROVIDER NUMBER	2 REIMBURSABLE PART A	3 PART A DEDUCTIBLE+ COINSURANCE	4 REIMBURSABLE PART B	5 PART B DEDUCTIBLE
51 Skilled Nursing Facilities:					
52		0	0	0	0
53		0	0	0	0
54		0	0	0	0
55		0	0	0	0
56		0	0	0	0
57		0	0	0	0
58		0	0	0	0
59		0	0	0	0
60		0	0	0	0
61		0	0	0	0
62 Total (Sum of Lines 52 thru 61).....		0	0	0	0
63 Cost PMPM (Line 63 / Line 1).....		0.0000	0.0000	0.0000	0.0000
64 Enter on Wkst, Col, Line.....		M, 2, 2	M, 2, 2&8	M, 3, 2	M, 3, 2
65 Home Health Agencies:					
66					
67					
68					
69					
70					
71					
72					
73					
74					
75 Total (Sum of Lines 68 thru 76).....					
76 Cost PMPM (Line 78 / Line 1).....					
77 Enter on Wkst, Col, Line.....					
78 Other Providers (Specify Type):					
79		0	0	0	0
80		0	0	0	0
81		0	0	0	0
82		0	0	0	0
83		0	0	0	0
84		0	0	0	0
85		0	0	0	0
86		0	0	0	0
87		0	0	0	0
88		0	0	0	0
89		0	0	0	0
90 Total (Sum Lines 82 thru 92).....		0	0	0	0
91 Cost PMPM (Line 93 / Line 1).....		0.0000	0.0000	0.0000	0.0000
92 Enter on Wkst, Col, Line.....		M, 2, 4	M, 2, 4&8	M, 3, 4	M, 3, 4

SUMMARY APPORTIONMENT OF NON-PROVIDER COSTS

Name of Plan: 0  
 Plan #: H-xxxx

PERIOD FROM: 12/30/99  
 TO: 12/30/99

	1	2	3	4	5	6	7
COST CENTERS	STATISTIC USED	TOTAL STATISTICS	COVERED MED ENROLLEE STATISTICS	SUBPART E LIMITS IF APPLICABLE	RATIO Col 3 or Col 4 / Col 2	TOTAL COSTS (Fr Wkst E Col 6)	MEDICARE COSTS Col 5 X Col 6
1 Clinics (furnished directly).....		0	0		0.00000		0
2 <b>Physician Groups:</b>							
3 _____		0	0	0	0.00000	0	0
4 _____		0	0	0	0.00000	0	0
5 _____		0	0	0	0.00000	0	0 #
6 _____		0	0	0	0.00000	0	0 #
7 Individual Physicians.....		0	0	0	0.00000	0	0 #
8 Certified Labs.....		0	0	0	0.00000	0	0 #
9 _____		0	0	0	0.00000	0	0 #
10 _____		0	0	0	0.00000	0	0 #
11 X-Ray Units.....		0	0	0	0.00000	0	0 #
12 _____		0	0	0	0.00000	0	0 #
13 _____		0	0	0	0.00000	0	0 #
14 ESRD Facilities.....		0	0	0	0.00000	0	0 #
15 _____		0	0	0	0.00000	0	0 #
16 Durable Medical Equipment.....		0	0	0	0.00000	0	0 #
17 Ambulance.....		0	0	0	0.00000	0	0 #
18 Emergency-Urgently Needed Svcs.....		0	0	0	0.00000	0	0 #
19 Professional Component - Mental Health		0	0	0	0.00000	0	0 #
20 Mental Health Svcs - Non-Prof Compo		0	0	0	0.00000	0	0 #
21 _____		0	0	0	0.00000	0	0 #
22 _____		0	0	0	0.00000	0	0 #
23 _____		0	0	0	0.00000	0	0 #
24 _____		0	0	0	0.00000	0	0 #
25 _____		0	0	0	0.00000	0	0 #
26 _____		0	0	0	0.00000	0	0 #
27 _____		0	0	0	0.00000	0	0 #
28 _____		0	0	0	0.00000	0	0 #
29 _____		0	0	0	0.00000	0	0 #
30 _____		0	0	0	0.00000	0	0 #
31 _____		0	0	0	0.00000	0	0 #
32 _____		0	0	0	0.00000	0	0 #
33 _____		0	0	0	0.00000	0	0 #
34 _____		0	0	0	0.00000	0	0 #
35 Total (Sum Lines 1 thru 34).....							0 #
36 Member Months - Part B (W/S D, Part II, Pg 2, Pt E, Col 2, Line 1							=====
							0
37 Cost PMPM (Line 51 / Line 52).....							=====
							0.0000
38 Enter on Worksheet, Col, Line.....							M, 3, 5

Name of Plan: 0  
 Plan #: H-xxxx

PERIOD FROM: 12/30/99  
 TO: 12/30/99

DESCRIPTION	1 MEDICARE PART A	2 MEDICARE PART B	3 TOTAL Col 1+Col 2	4 NON- MEDICARE Col 5 - Col 2	5 TOTAL	6 ENTER ON WKST LINE
1 Member Months (Wkst D, Pt II, Pg 2, Pt E, Col 1 and 2, Ln 1)	0	0		0		
2						
3 Plan Administration (Wkst E, Col 6, Ln 21).....					0	
4 Cost PMPM (Line 3 / Line 1).....	0.0000	0.0000			0.0000	M 6
5						
6 Special Admin Costs (Wkst E, Col 6, Ln 22).....		0				
7 Cost PMPM (Line 6 / Line 1).....		0.0000				M 15
8						
9 Allowable Medicare Bad Debts (Wkst E, Col 6, Line 17).....			0			
10 Cost PMPM (Line 9 / Line 1).....	0.0000	0.0000	0.0000			M 16
11						
12 Part B Blood Deductible.....			0			
13 Cost PMPM (Line 12 / Line 1).....		0.0000	0.0000			M 10
14						
15 Third Party Insurer Revenue (see Instructions).....			0			
16 Cost PMPM (Line 15 / Line 1).....	0.0000	0.0000	0.0000			M 18
17						
18 Part B Ded on Svcs Pd by CMS Carrier (Wkst E, Col 9, Ln 16).....		0	0			
19 Cost PMPM (Line 18 / Line 1).....		0.0000	0.0000			M 5a
20						
21 Pro Component of Mental Hlth Svcs (W/S K, Line 19).....		0	0			
22 Line 21 times 37.5%.....		0	0			
23 Cost PMPM (Line 22 / Line 1).....		0.0000	0.0000			M 11

FORM CMS 276-08  
 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2314)



DESCRIPTION	FROM WKST 1	MEDICARE PART A 2	MEDICARE PART B 3	TOTAL Col 2 + Col 3 4
1 Hospital Costs.....	J	0.0000	0.0000	0.0000
2 Skilled Nursing Facility Costs.....	J	0.0000	0.0000	0.0000
3 Home Health Agency Costs.....	J	0.0000	0.0000	0.0000
4 Other Provider's Costs .....	J	0.0000	0.0000	0.0000
5 Nonprovider Costs.....	K		0.0000	0.0000
5a Part B Deduct on Svcs Pd by CMS' Carriers/Intermediaries/MAC	L		0.0000	0.0000
6 Plan Administration Costs.....	L	0.0000	0.0000	0.0000
7 Totals (Sum Lines 1 - 6).....		0.0000	0.0000	0.0000
8 Part A Deductible and Coinsurance.....	J	0		0.0000
9 Part B Standard Deductible.....				0.0000
10 Part B Blood Deductible.....	L		0.0000	0.0000
11 Copayment on Mental Health Services.....	L		0.0000	0.0000
12 Line 7 Minus (The Sum of Lines 8 - 11).....		0.0000	0.0000	0.0000
13 20% of (Col 3 Line 12 minus Col 3 Line 3).....			0.0000	0.0000
14 Reimbursable Costs (Line 12 Minus Line 13).....		0.0000	0.0000	0.0000
15 Special Administrative Costs.....	L		0.0000	0.0000
16 Medicare Bad Debts.....	L	0.0000	0.0000	0.0000
16a Part B Cost Not Subject to Coinsurance.....		0.0000		0.0000
17 Total (Sum Lines 14 thru 16a).....		0.0000	0.0000	0.0000
18 Less: Third Party Insurer Revenue.....	L	0.0000	0.0000	0.0000
19 Medicare Costs (Line 17 minus Line 18).....		0.0000	0.0000	0.0000
20 Medicare Primary Member Months.....	D	0	0	
21 Reimbursable Costs (Line 19 X Line 20).....		0	0	0
22 Interim Payments (by) to HCFA.....				
23 Balance (Line 21 minus Line 22).....				0
Adjustments from Prior Years:				
24				
25				
26				
27 Balance Due Plan (CMS) (Line 23 + or - Lines 24-26).....				0

Name of Plan: 0  
 Plan Number: H-xxxx

Period From: 12/30/99  
 To: 12/30/99

Under and Over Collection of Medicare Premiums - Current Year				
Premium Determinations Covered by this Part				
	Totals	Member Months	Cost Per Member Month	Line
	1	2	3	
0 Total Medicare Member Months	XXXXXXXXXXXXX		XXXXXXXXXXXXX	0
1 Total Premiums/Dues collected during the period		XXXXXXXXXXXXX	-	1
2 Total Copayments collected during the period		XXXXXXXXXXXXX	-	2
3 Total Collections (Line 1 plus Line 2)	-	XXXXXXXXXXXXX	-	3
4 Less: Accounts Receivable for premiums/dues and copayments (beg of period)		XXXXXXXXXXXXX	-	4
5 Net Collections for period (Line 3 minus Line 4)	-	XXXXXXXXXXXXX	-	5
6 Add: Accounts Receivable for premiums/dues and copayments (end of period)		XXXXXXXXXXXXX	-	6
7 Net Collections and Amounts to be Collected (Line 5 plus Line 6)	-	XXXXXXXXXXXXX	-	7
8 Total Medicare Deductible and Coinsurance from Cost Report:				8
a. Deductible and copayments (Worksheet M, Col 2 + 3 , Sum lines 8 thru 11)	XXXXXXXXXXXXX	XXXXXXXXXXXXX		8a
b. Part B Coinsurance (Worksheet M, Col 3, Line 13)	XXXXXXXXXXXXX	XXXXXXXXXXXXX		8b
c. Part B Coinsurance on services paid by CMS (Worksheet G, Col 2, Lines 23 + 24)	XXXXXXXXXXXXX	XXXXXXXXXXXXX		8c
d. Total (Sum of Lines 8a thru 8c)	XXXXXXXXXXXXX	XXXXXXXXXXXXX	0.0000	8d
9 Voluntary under collection for the period (Worksheet B, Part II, Line 7)	XXXXXXXXXXXXX	XXXXXXXXXXXXX		9
10 Over collection from prior period (Prior Worksheet B, Part II, Excess of Ln 6 over Ln 5)	XXXXXXXXXXXXX	XXXXXXXXXXXXX		10
11 Total amount allowed to be charged (Line 8d minus sum of Lines 9 and 10)	XXXXXXXXXXXXX	XXXXXXXXXXXXX	0.0000	11
12 Under (over) collection for the period (Line 11 minus Line 7)	XXXXXXXXXXXXX	XXXXXXXXXXXXX	0.0000	12



<b>Special Administration Costs</b>	<b>Amount</b>
Accretion/Deletion Cost	
Certification Cost	
Special Studies	
Other (Specify)	
<hr/> Total Special Administration Cost	0

SUBPART E LIMITS

Name of Plan: 0  
 Plan #: H-xxxx

Period From: 0  
 To: 0

Is this Plan an HCPP subject to the Subpart E Limits?



	COST CENTERS	COMPARABLE CARRIER PAYMENTS
1	<b>Physician Groups:</b>	
2	_____	
3	_____	
4	_____	
5	_____	
6	Individual Physicians.....	
7	Certified Labs.....	
8	_____	
9	_____	
10	X-Ray Units.....	
11	_____	
12	_____	
13	ESRD Facilities.....	
14	_____	
15	Durable Medical Equipment.....	
16	Ambulance.....	
17	Emergency-Urgently Needed Svcs.....	
18	Professional Component - Mental Health.....	
19	Mental Health Svcs - Non-Prof Component.....	
20	_____	
21	_____	
22	_____	
23	_____	
24	_____	
25	_____	
26	_____	
27	_____	
28	_____	
29	_____	
30	_____	
31	_____	
32	_____	
33	_____	

Yes  
No