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:

[ Budget Forecast

[ Interim Reports

[x Final Cost Report

b. Bill Processing Option:
Select Option

c. Reimbursement Under:
1876

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.

PLAN STATISTICS

WORKSHEET D
PART I
Page 1

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


(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 2306)

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 VISITS | TOTAL MEDICARE VISITS* | MEDICARE PRIMARY VISITS | MEDICARE SECONDARY VISITS |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| | B. HHA'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 |
| | C. Other (Specify Name & Type): | | | | | | | |
| 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


(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 2306)

PLAN STATISTICS

WORKSHEET D
PART II
Page 1

Name of Plan: 0
Plan #: H-xxxx

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

| | LIST OF SUPPLIERS | TYPE OF GROUP (1) | PAYMENT MECHANISM (2) | HOW PHYSICIANS PAID (2) | STATISTICS | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | TOTAL | TOTAL MEDICARE * | MEDICARE PRIMARY | MEDICARE SECONDARY |
| | | 1 | 2 | 3 | 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

FORM HCFA 276-99
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 2306)

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 4 | TOTAL MEDICARE* 5 | MEDICARE PRIMARY 6 | MEDICARE SECONDARY 7 |
|---|---|---|---|---|---|---|---|
| B. Certified Labs: | | | | | | | |
| 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 |
| C. X-Ray Units: | | | | | | | |
| 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 |
| D. Others (Specify): | | | | | | | |
| 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

| | E. MEMBERSHIP: | 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

SUMMARY TRIAL BALANCE

WORKSHEET E

Name of Plan: 0

Plan #: H-xxxx

PERIOD FROM: 12/30/99

TO: 12/30/99

| | COST CENTER | TRIAL BALANCE 1 | RECLASSIFI-CATIONS (WKST F) 2 | ADJUSTMENTS (WKST G) 3 | ALLOWABLE COST (Col 1 thru 3) 4 | A & G ALLOCATION (WKST I, Part I) 5 | TOTALS (Col 4 + Col 5) 6 | TRANSFER TO WKST, LINE 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 | |
| | | ========= | ========= | ========= | ========= | ========= | ========= | |

FORM CMS 276-08

(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2307)

RECLASSIFICATIONS

WORKSHEET F
Page 1

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 (2) INCREASES 4 | AMOUNT (2) (DECREASES) 5 |
|---|---|---|---|---|---|---|
| 1 | | | | | 0 | 0 |
| 2 | | | | | 0 | 0 |
| 3 | | | | | 0 | 0 |
| 4 | | | | | 0 | 0 |
| 5 | | | | | 0 | 0 |
| 6 | | | | | 0 | 0 |
| 7 | | | | | 0 | 0 |
| 8 | | | | | 0 | 0 |
| 9 | | | | | 0 | 0 |
| 10 | | | | | 0 | 0 |
| 11 | | | | | 0 | 0 |
| 12 | | | | | 0 | 0 |
| 13 | | | | | 0 | 0 |
| 14 | | | | | 0 | 0 |
| 15 | | | | | 0 | 0 |
| 16 | | | | | 0 | 0 |
| 17 | | | | | 0 | 0 |
| 18 | | | | | 0 | 0 |
| 19 | | | | | 0 | 0 |
| 20 | | | | | 0 | 0 |
| 21 | | | | | 0 | 0 |
| 22 | | | | | 0 | 0 |
| 23 | | | | | 0 | 0 |
| 24 | | | | | 0 | 0 |
| 25 | | | | | 0 | 0 |
| 26 | | | | | 0 | 0 |
| 27 | | | | | 0 | 0 |
| 28 | | | | | 0 | 0 |
| 29 | | | | | 0 | 0 |
| 30 | | | | | 0 | 0 |
| 31 | | | | | 0 | 0 |
| 32 | | | | | 0 | 0 |
| 33 | | | | | 0 | 0 |
| 34 | | | | | 0 | 0 |
| 35 | | | | | 0 | 0 |
| 36 | | | | | 0 | 0 |
| 37 | | | | | 0 | 0 |
| 38 | | | | | 0 | 0 |
| 39 | | | | | 0 | 0 |
| 40 | | | | | 0 | 0 |
| 41 | | | | | 0 | 0 |
| 42 | | | | | 0 | 0 |
| 43 | | | | | 0 | 0 |
| 44 | | | | | 0 | 0 |
| 45 | | | | | 0 | 0 |
| 46 | | | | | 0 | 0 |
| 47 | | | | | 0 | 0 |
| 48 | | | | | 0 | 0 |
| 49 | | | | | 0 | 0 |
| 50 | | | | | 0 | 0 |
| 51 | Page total | | | | 0 | 0 |
| 52 | a. Subtotal from Page 2 | | | | 0 | 0 |
| | b. Subtotal from Page 3 | | | | 0 | 0 |
| | c. Subtotal from Page 4 | | | | 0 | 0 |
| 53 | Total Reclassifications (Col 4 must equal Col 5) | | | | 0 | 0 |
| | | | | | ============ | ============ |
| | | | | | Net, must be 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

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2308)

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 | AMOUNT (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

RECLASSIFICATIONS

WORKSHEET F
Page 3

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 | AMOUNT (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

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2308)

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 | AMOUNT (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 |

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2308)

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

WORKSHEET G
PART I
Page 1

| 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 Statemenmt) | _ | 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 physicial 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.

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2309.1)

ADJUSTMENTS TO EXPENSES | WORKSHEET G

Name of Plan: 0

Plan #: H-xxxx | PERIOD FROM: 12/30/99 | PART I

TO: 12/30/99 | 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.

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2309.1)

ADJUSTMENTS TO EXPENSES WORKSHEET G

Name of Plan: 0

Plan #: H-xxxx PERIOD FROM: 12/30/99 PART I

TO: 12/30/99 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.

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2309.1)

ADJUSTMENTS TO EXPENSES

WORKSHEET G

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 | | | | | 24 |
| 25 | Plan Administration | ___________ | 0 | | 25 |
| 26 | Special Admin Costs | ___________ | 0 | | 26 |
| 27 | | | | | 27 |
| 28 | Admin & General Costs | ___________ | 0 | | 28 |
| 29 | Total Adjustments (Lines 1 thru 28) | | 0 | | 29 |

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2309.2)

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)-------- ORGANIZATION NAME 4 | OWNERSHIP % 5 | TYPE OF BUSINESS 6 |
|---|---|---|---|---|---|---|
| 1 | _ | | | | 0.00% | |
| 2 | _ | | | | 0.00% | |
| 3 | _ | | | | 0.00% | |
| 4 | _ | | | | 0.00% | |
| 5 | _ | | | | 0.00% | |
| 6 | _ | | | | 0.00% | |
| 7 | _ | | | | 0.00% | |
| 8 | _ | | | | 0.00% | |
| 9 | _ | | | | 0.00% | |
| 10 | _ | | | | 0.00% | |
| 11 | _ | | | | 0.00% | |
| 12 | _ | | | | 0.00% | |
| 13 | _ | | | | 0.00% | |
| 14 | _ | | | | 0.00% | |
| 15 | _ | | | | 0.00% | |
| 16 | _ | | | | 0.00% | |
| 17 | _ | | | | 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　　　　WORKSHEET I

Name of Plan: 0　　　　PART I

Plan #: ## H-xxxx　　PERIOD FROM: 12/30/99

TO: 12/30/99

| COST CENTER | 1<br>EMPLOYEE BENEFITS (Salaries) | 2<br>STATISTICS & DATA PROCESSING (Time Spent) | 3<br>PHARMACY & SUPPLIES (Cost Req's) | 4<br>OTHER (SPECIFY) | 5<br>TOTALS (Sum Cols 1 Thru 4) | 6<br>POOLED ADMIN & GEN COSTS | 7<br>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 |

FORM CMS 276-08

(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2311.1)

ADMINISTRATIVE AND GENERAL STATISTICS — WORKSHEET I, PART II

Name of Plan: ## 0
Plan #: ## H-xxxx
PERIOD FROM: 12/30/99
TO: 12/30/99

| | COST CENTER | EMPLOYEE BENEFITS (Salaries) 1 | STATISTICS & DATA PROCESSING (Time Spent) 2 | PHARMACY & SUPPLIES (Cost Req's) 3 | OTHER (SPECIFY) 4 | TOTALS (From Worksheet E Column 4) 5 | TOTALS (From Wkst I, Pt I, Col 5) 6 | POOLED ADMIN & GEN STATS (Cols 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 |
| | | =========== | ============ | ============ | ============= | ============ | ============ | ============ Col 5 - (1+2+3+4) |
| 30 | COSTS TO BE ALLOCATED............ (Input here) | 0 | 0 | 0 | 0 | 0 | | 0 |
| 31 | UNIT COST MULTIPLIER.................. (Line 30 / Line 29) | 0.000000 | 0.000000 | 0.00000 | 0.000000 | | | 0.000000 |

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2311.1)

Name of Plan: 0
Plan #: H-xxxx

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

| | PROVIDERS | 1<br>PROVIDER NUMBER | 2<br>REIMBURSABLE PART A | 3<br>PART A DEDUCTIBLE + COINSURANCE | 4<br>REIMBURSABLE PART B | 5<br>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 |


(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2312)

Name of Plan: 0
Plan #: H-xxxx

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

| | PROVIDERS | 1<br>PROVIDER NUMBER | 2<br>REIMBURSABLE PART A | 3<br>PART A DEDUCTIBLE+ COINSURANCE | 4<br>REIMBURSABLE PART B | 5<br>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<br>========= | 0<br>========= | 0<br>========= | 0<br>========= |
| 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<br>========= | 0<br>========= | 0<br>========= | 0<br>======== |
| 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

| | COST CENTERS | 1<br>STATISTIC USED | 2<br>TOTAL STATISTICS | 3<br>COVERED MED ENROLLEE STATISTICS | 4<br>SUBPART E LIMITS IF APPLICABLE | 5<br>RATIO Col 3 or Col 4 / Col 2 | 6<br>TOTAL COSTS (Fr Wkst E Col 6) | 7<br>MEDICARE COSTS Col 5 X Col 6 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Clinics (furnished directly)...................... | __________ | 0 | 0 | | 0.00000 | | 0 | |
| 2 | **Physician Groups:** | | | | | | | | |
| 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 Healt | __________ | 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<br>========= | # |
| 36 | Member Months - Part B (W/S D, Part II, Pg 2, Pt E, Col 2, Line 1 | | | | | | | 0<br>========= | |
| 37 | Cost PMPM (Line 51 / Line 52)..................................................... | | | | | | | 0.0000 | |
| 38 | Enter on Worksheet, Col, Line....................................................... | | | | | | | M, 3, 5 | |

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2313)

Name of Plan: 0
Plan #: H-xxxx

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

| | DESCRIPTION | 1<br>MEDICARE<br>PART A | 2<br>MEDICARE<br>PART B | 3<br>TOTAL<br>Col 1+Col 2 | 4<br>NON-<br>MEDICARE<br>Col 5 - Col 2 | 5<br>TOTAL | 6<br>ENTER ON<br>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)

SETTLEMENT SHEET    Name of Plan:    PERIOD FROM: 12/30/99    WORKSHEET M
Plan #: H-xxxx    TO: 12/30/99

| | 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 |
| | | | | | ========= |

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2315)

MEDICARE PREMIUM RECONCILIATION WORKSHEET N

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

FORM CMS 276-08
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2316)

| Special Administration Costs | Amount |
| --- | --- |
| Accretion/Deletion Cost | |
| Certification Cost | |
| Special Studies | |
| Other (Specify) | |
| Total Special Administration Cost | 0 |

SUBPART E LIMITS

Name of Plan: 0 Period From: 0
Plan #: H-xxxx To: 0

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

| | COST CENTERS | COMPARABLE CARRIER PAYMENTS |
|---|---|---|
| 1 | **Physician Groups:** | |
| 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