version 6.0

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 — WORKSHEET S

GENERAL INFORMATION

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 T
REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERA

CERTIFICATION BY OFFICER OF THE PLAN

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

SIGNATURE (Officer or Administrator of the Plan) DATE

TITLE PHONE NUMBER

FORM CMS 276-25 (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 O
OMB control number for this information collection is 0938-0165. The time required to complete this information is estimated to average as follo
24 hours to complete the budget forecast, 80 hours to complete the fourth quarter and final cost reports, 4 hours to complete the semi-annual in
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
interim report. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to
Mail Stop C3-14-16, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Bu
Form Expiration Date:

PLAN STATISTICS

WORKSHEET D
PART I
Page 1

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 0
TO: 0

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

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

(1)
O - OWNED OR CONTROLLED
P - PURCHASED

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

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 2306)

PLAN STATISTICS

WORKSHEET D
PART 1

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 0
TO: 0

LIST OF PROVIDERS	PROVIDER NUMBER	RELATION-SHIP (1)	BILLS PROCESSED BY (2)	TOTAL VISITS	TOTAL MEDICARE VISITS*	COV MED PRIMARY VISITS	COV MED 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

FORM CMS 276-25
(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: 0
TO: 0

LIST OF SUPPLIERS	TYPE OF GROUP (1)	PAYMENT MECHANISM (2)	HOW PHYSICIANS PAID (2)	STATISTICS TOTAL	TOTAL MEDICARE *	COVERED MED PRIMARY	COVERED MED 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 **Physician Groups:**							
42 Fee For Service				0	0	0	0
43 Capitation				0	0	0	0
44 Other				0	0	0	0
45 **Individual Physicians:**							
46 Fee For Service				0	0	0	0
47 Capitation				0	0	0	0
48 Other				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 CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 2306)

PLAN STATISTICS

WORKSHEET D
PART II
Page 2

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 0
TO: 0

	LIST OF SUPPLIERS	TYPE OF GROUP (1) 1	PAYMENT MECHANISM (2) 2	HOW PHYSICIANS PAID (2) 3	STATISTICS TOTAL 4	TOTAL MEDICARE* 5	COVERED MED PRIMARY 6	COVERED MED 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	**Certified Labs**							
9	Fee For Service				0	0	0	0
10	Capitation				0	0	0	0
11	Other				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	**X-Ray Units**							
9	Fee For Service				0	0	0	0
10	Capitation				0	0	0	0
11	Other				0	0	0	0
	D. Others (Specify):							
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

* 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	0	0
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	0

(3)
Part B Member Months = Total Member Months

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2306)
End of Document
End of Document

SUMMARY TRIAL BALANCE

WORKSHEET E

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

	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 | 3-5
7	Individual Physicians		0	0	0	0	0	K | 7-9
8	Certified Labs		0	0	0	0	0	K | 11-13
9	X-Ray Units		0	0	0	0	0	K | 15-17
10	ESRD Facilities		0	0	0	0	0	K | 18
11	Durable Medical Equipment		0	0	0	0	0	K | 20
12	Ambulance		0	0	0	0	0	K | 21
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 | 22
15	Mental Health Services		0	0	0	0	0	K | 24
16	DED+CO on claims processed by MACs		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	Part B Cost Not Subj to Coins.		0	0	0	0	0	L | 21
20	Non-Allowable Costs		0	0	0	0	0	
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 276-25
(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: 01/00/00
TO: 01/00/00

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						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						
41						
42						
43						
44						
45						
46						
47						
48						
49						
50						
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 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2308)

RECLASSIFICATIONS

WORKSHEET F
Page 2

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

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

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2308)

RECLASSIFICATIONS

WORKSHEET F
Page 3

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

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 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2308)

RECLASSIFICATIONS

WORKSHEET F
Page 4

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

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

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2308)

SUMMARY OF RECLASSIFICATIONS

WORKSHEET F
Page 5

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

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 on claims processed by MACs	0	0	0
17	Other - Medicare Bad Debts	0	0	0
18	Other - Blood Deductible	0	0	0
19	Part B Cost Not Subj to Coins.	0	0	0
20	Non-Allowable Costs	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 276-25
(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: 01/00/00

To: 01/00/00 AD181...AN240

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

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

ADJUSTMENTS TO EXPENSES

WORKSHEET G
PART I
Page 1

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

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 processed by MACs	_	0		
24	Adjustment for physicial therapy costs in excess of limit (4)	_	0		
25	Reinsurance	_	0		
26	Depreciation in excess of limits (Attach worksheet)	_	0		
27	Noncovered purchased service (Attach worksheet)	_	0		
28	Medicare Bad Debts	_	0		
29		_	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	Page total		0		
50	a. Subtotal from Page 2		0		
	b. Subtotal from Page 3		0		
	c. Subtotal from Page 4		0		
51	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 276-25
(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: 01/00/00

TO: 01/00/00

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
52			0		
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	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 276-25

(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: 01/00/00

TO: 01/00/00

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
107			0		
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	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 276-25

(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: 01/00/00

TO: 01/00/00

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
162			0		
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	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.

FORM CMS 276-25

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

SUMMARY OF ADJUSTMENTS TO EXPENSES

WORKSHEET G
PART II

Name of Plan: 0

Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

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 claims processed by MACs		0		16
17	Other - Medicare Bad Debts		0		17
18	Other - Blood Deductible		0		18
19	Part B Cost Not Subj to Coins.		0		19
20	Non-Allowable Costs		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 276-25

(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: 01/00/00

Plan #: H-xxxx — TO: 01/00/00

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 amounts in column 5 to Worksheet G, Part I, Column 2 lines 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	RELATED ORGANIZATION(S) OWNERSHIP % 5	RELATED ORGANIZATION(S) 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%	
18					0.00%	
19					0.00%	
20					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.

FORM CMS 276-25

(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2310)

ADMINISTRATIVE AND GENERAL COST ALLOCATION — WORKSHEET I

Name of Plan: 0 — PART I

Plan #: # H-xxxx — PERIOD FROM: 01/00/00 — TO: 01/00/00

COST CENTER	1 EMPLOYEE BENEFITS (Salaries)	2 STATISTICS & DATA PROCESSING (Time Spent)	3 PHARMACY & SUPPLIES (Cost Req's)	4 OTHER (SPECIFY) SEE-WKST I SUPPL	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 on claims processed by MACs	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 Part B Cost Not Subj to Coins.	0	0	0	0	0	0	0
20 Non-Allowable Costs	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 276-25

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

ADMINISTRATIVE AND GENERAL STATISTICS

WORKSHEET I

Name of Plan: # 0

PART II

Plan #: # H-xxxx

PERIOD FROM: 01/00/00

TO: 01/00/00

	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 on claims processed by MACs	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	Part B Cost Not Subj to Coins.	0	0	0	0	0	0	0
20	Non-Allowable Costs	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							
26	Special Administrative Costs							
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
31	UNIT COST MULTIPLIER (Line 30 / Line 29)	0.000000	0.000000	0.00000	0.000000			0.000000

FORM CMS 276-25

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

SUMMARY OF PROVIDER COSTS

WORKSHEET J

PAGE 1

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

	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
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

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2312)

SUMMARY OF PROVIDER COSTS

WORKSHEET J
(Continued)
PAGE 2

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

	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 62 / 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 66 thru 74)					
76	Cost PMPM (Line 75 / 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 79 thru 89)		0	0	0	0
91	Cost PMPM (Line 90 / 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

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2312)

SUMMARY APPORTIONMENT OF NON-PROVIDER COSTS

Worksheet K

Name of Plan: 0
Plan #: H-xxxx

PERIOD FROM: 01/00/00
TO: 01/00/00

	COST CENTERS	1 STATISTIC USED	2 TOTAL STATISTICS	3 COVERED PRIM MED ENROLLEE STATISTICS	4 SUBPART E LIMITS IF APPLICABLE	5 RATIO Col 3 or Col 4 / Col 2	6 TOTAL COSTS (Fr Wkst E Col 6)	7 MEDICARE COSTS Col 5 X Col 6
1	Clinics (furnished directly)		0	0		0.0000		0
2	**Physician Groups:**							
3	Fee For Service		0	0	0	0.0000	0	0
4	Capitation		0	0	0	0.0000	0	0
5	Other		0	0	0	0.0000	0	0
6	**Individual Physicians:**							
7	Fee For Service		0	0	0	0.0000	0	0
8	Capitation		0	0	0	0.0000	0	0
9	Other		0	0	0	0.0000	0	0
10	**Certified Labs:**							
11	Fee For Service		0	0	0	0.0000	0	0
12	Capitation		0	0	0	0.0000	0	0
13	Other		0	0	0	0.0000	0	0
14	**X-Ray Units:**							
15	Fee For Service		0	0	0	0.0000	0	0
16	Capitation		0	0	0	0.0000	0	0
17	Other		0	0	0	0.0000	0	0
18	ESRD Facilities		0	0	0	0.0000	0	0
19					0	0.0000		0
20	Durable Medical Equipment			0	0	0.0000	0	0
21	Ambulance			0	0	0.0000	0	0
22	Emergency-Urgently Needed Svcs		0	0	0	0.0000	0	0
23					0	0.0000		0
24	Mental Health Svcs		0	0	0	0.0000	0	0
25					0	0.0000		0
26					0	0.0000		0
27					0	0.0000		0
28					0	0.0000		0
29					0	0.0000		0
30					0	0.0000		0
31					0	0.0000		0
32					0	0.0000		0
33					0	0.0000		0
34					0	0.0000		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 35 / Line 36)							0.0000
38	Enter on Worksheet, Col, Line							M, 3, 5

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2313)

SUMMARY OF MISCELLANEOUS ITEMS WORKSHEET L

Name of Plan: 0
Plan #: H-xxxx PERIOD FROM: 01/00/00
TO: 01/00/00

	DESCRIPTION	1 MEDICARE PART A	2 MEDICARE PART B	3 TOTAL Col 1+Col 2	4 NON-MEDICARE	5 TOTAL Col 2+Col 4	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 25).....					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 26).....		0				
7	Cost PMPM (Line 6 / Line 1).....		0.0000				M 14
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 15
11							
12	Part B Blood Deductible (Wkst E, Col 6, Line 18).....		0	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	Pt B DED on claims processed by MACs (Wkst E, Col 6, Ln 16).....		0	0			
19	Cost PMPM (Line 18 / Line 1).....		0.0000	0.0000			M 5a
20							
21	Part B Cost Not Subject to Coinsurance (Wkst E, Col 6, Ln 19).....		0	0			
22	Cost PMPM (Line 21 / Line 1).....		0.0000	0.0000			M 16

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2314)

SETTLEMENT SHEET Name of Plan: PERIOD FROM: 01/00/00 WORKSHEET M
Plan #: H-xxxx TO: 01/00/00

	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	DED on claims processed by MACs	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	0.0000
10	Part B Blood Deductible	L		0.0000	0.0000
11	Line 7 Minus (The Sum of Lines 8 - 10)		0.0000	0.0000	0.0000
12	20% of (Col 3 Line 11 minus Col 3 Line 3)			0.0000	0.0000
13	Reimbursable Costs (Line 11 Minus Line 12)		0.0000	0.0000	0.0000
14	Special Administrative Costs	L		0.0000	0.0000
15	Medicare Bad Debts	L	0.0000	0.0000	0.0000
16	Part B Cost Not Subject to Coinsurance	L	0.0000	0.0000	0.0000
17	Total (Sum Lines 13 thru 16)		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 CMS				
23	Balance (Line 21 plus Line 22)				0
	Adjustments:				
24					
25					
26					
27					
28					
29					
30	Balance Due Plan (CMS) (Line 23 + or - Lines 24-29)				0

FORM CMS 276-25
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2315)

MEDICARE PREMIUM RECONCILIATION WORKSHEET N

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

DESCRIPTION	TOTALS 1	MEMBER MONTHS 2	COST PER MEMBER MONTH 3
0 Total Medicare Member Months		0	
1 Total Premiums/Dues collected during the period	-		-
2 Total Copayments collected during the period	-		-
3 Total Collections (Line 1 plus Line 2)	-		-
4 Less: Accounts Receivable for premiums/dues and copayments (beg of period)	-		-
5 Net Collections for period (Line 3 minus Line 4)	-		-
6 Add: Accounts Receivable for premiums/dues and copayments (end of period)	-		-
7 Net Collections and Amounts to be Collected (Line 5 plus Line 6)	-		-
8 Total Medicare Deductible and Coinsurance from Cost Report:			
a. Deductible and copayments (Worksheet M, Col 2 + 3 , Sum lines 8 thru 10)			0.0000
b. Part B Coinsurance (Worksheet M, Col 3, Line 12)			0.0000
c. CO on claims processed by MACs (Worksheet G, Col 2, Line 23/Col 2, Ln 0)			#DIV/0!
d. Total (Sum of Lines 8a thru 8c)			#DIV/0!
9a (Over)/Involuntary Undercollection from prior period (Worksheet N, Line 11/12b,		-	
9b Prior Period Member Months (Worksheet N, Line 0)		-	
9c Gross (over)/under collections from prior period	0		
9d Adjusted (over)/under collection from the prior period			#DIV/0!
10 Total amount allowed to be charged (Line 8d plus line 9d)			#DIV/0!
11 Actual (Over) under collection for the period (Line 10 minus Line 7). Stop here if (over)collection			#DIV/0!
12 Budgeted Voluntary under collection for the period (Worksheet B, Line 8)			0.0000
12a Actual Voluntary under collection - No recoupment			#DIV/0!
12b Involuntary Under collection - may recoup during subsequent period			#DIV/0!

FORM CMS 276-25
(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	Fee For Service……	
3	Capitation……	
4	Other……..	
5	**Individual Physicians:**	
6	Fee For Service……	
7	Capitation……	
8	Other……..	
9	**Certified Labs:**	
10	Fee For Service……	
11	Capitation……	
12	Other……..	
13	**X-Ray Units:**	
14	Fee For Service……	
15	Capitation……	
16	Other……..	
17	ESRD Facilities.....	
18	_____	
19	Durable Medical Equipment.....	
20	Ambulance.....	
21	Emergency-Urgently Needed Svcs.....	
22		
23	Mental Health Svcs	
24	_____	
25	_____	
26	_____	
27	_____	
28	_____	
29	_____	
30	_____	
31	_____	
32	_____	
33	_____	

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS WORKSHEET H

Name of Plan: 0 PERIOD FROM: 01/00/00

Plan #: H-xxxx TO: 01/00/00

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)	NAME OF INDIVIDUAL	OWNERSHIP OF PLAN	----------RELATED ORGANIZATION(S)-------- ORGANIZATION NAME	OWNERSHIP %	TYPE OF BUSINESS
	1	2	3	4	5	6
21	_	_____	_____	_____	0.00%	_____
22	_	_____	_____	_____	0.00%	_____
23	_	_____	_____	_____	0.00%	_____
24	_	_____	_____	_____	0.00%	_____
25	_	_____	_____	_____	0.00%	_____
26	_	_____	_____	_____	0.00%	_____
27	_	_____	_____	_____	0.00%	_____
28	_	_____	_____	_____	0.00%	_____
29	_	_____	_____	_____	0.00%	_____
30	_	_____	_____	_____	0.00%	_____
31	_	_____	_____	_____	0.00%	_____
32	_	_____	_____	_____	0.00%	_____
33	_	_____	_____	_____	0.00%	_____
34	_	_____	_____	_____	0.00%	_____
35	_	_____	_____	_____	0.00%	_____
36	_	_____	_____	_____	0.00%	_____
37	_	_____	_____	_____	0.00%	_____
38	_	_____	_____	_____	0.00%	_____
39	_	_____	_____	_____	0.00%	_____
40	_	_____	_____	_____	0.00%	_____
41	_	_____	_____	_____	0.00%	_____
42	_	_____	_____	_____	0.00%	_____
43	_	_____	_____	_____	0.00%	_____
44	_	_____	_____	_____	0.00%	_____
45	_	_____	_____	_____	0.00%	_____
46	_	_____	_____	_____	0.00%	_____
47	_	_____	_____	_____	0.00%	_____
48	_	_____	_____	_____	0.00%	_____
49	_	_____	_____	_____	0.00%	_____
50	_	_____	_____	_____	0.00%	_____
51	_	_____	_____	_____	0.00%	_____
52	_	_____	_____	_____	0.00%	_____
53	_	_____	_____	_____	0.00%	_____
54	_	_____	_____	_____	0.00%	_____
55	_	_____	_____	_____	0.00%	_____
56	_	_____	_____	_____	0.00%	_____
57	_	_____	_____	_____	0.00%	_____
58	_	_____	_____	_____	0.00%	_____
59	_	_____	_____	_____	0.00%	_____
60	_	_____	_____	_____	0.00%	_____
61	_	_____	_____	_____	0.00%	_____
62	_	_____	_____	_____	0.00%	_____
63	_	_____	_____	_____	0.00%	_____
64	_	_____	_____	_____	0.00%	_____
65	_	_____	_____	_____	0.00%	_____
66	_	_____	_____	_____	0.00%	_____
67	_	_____	_____	_____	0.00%	_____
68	_	_____	_____	_____	0.00%	_____
69	_	_____	_____	_____	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.

A. If the Plan utilizes any allocation method other than pooled A&G allocation, provide a detailed explanation of the allocation methodology for each cost center represented on Worksheet I (see 42 CFR 417.564 for guidance on A&G allocation). The Plan shall describe the specific business component A&G cost, allocation statistic and justification logic used in determining reasonable allocation in relation to the benefits received by component. Please provide response to Part B below as well.

B. If the A&G allocation (Worksheet E, Column 5) exceeds the amount listed for the corresponding cost center (Worksheet E, Column 4), then please provide further explanation below, specifically when allocating cost to Medicare only lines such as Line 16 and Line 19.

	COST CENTER	ALLOWABLE COST (Col 1 thru 3) 4	A & G ALLOCATION (WKST I, Part I) 5	TOTALS (Col 4 + Col 5) 6	Explanation
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	Ambulance	0	0	0	
13	Pharmacy (Outpatient)	0	0	0	
13a	Pharmacy-Medicare Covered Rx	0	0	0	
14	Emergency-Urgent Needed Svcs	0	0	0	
15	Mental Health Services	0	0	0	
16	DED+CO on claims processed by MACs	0	0	0	
17	Other - Medicare Bad Debts	0	0	0	
18	Other - Blood Deductible	0	0	0	
19	Part B Cost Not Subj to Coins.	0	0	0	
20	Non-Allowable Costs	0	0	0	
21	Other - (Specify)	0	0	0	
22	Other - (Specify)	0	0	0	
23	Other - (Specify)	0	0	0	
24	Subtotal (Sum Lines 1-23)	0	0	0	
25	Plan Administration	0	0	0	
26	Special Admin Costs	0	0	0	
27	Subtotal: (Sum Lns 25+26)	0	0	0	
28	Admin & General Costs	0	0	0	
29	Total Program Costs (24+27+28)	0	0	0	