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:

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

b. Bill Processing Option:
Select Option

c. Reimbursement Under:
Select Section

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

CERTIFICATION BY OFFICER OF THE PLAN

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

SIGNATURE (Officer or Administrator of the Plan)

DATE

TITLE

PHONE NUMBER

FORM CMS 276-16 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2302)

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Form Expiration Date: 12/31/2019

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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:
[ ] B Budget Forecast
[X] Interim Reports
[ ] Final Cost Report

b. Bill Processing Option:
Select Option

c. Reimbursement Under:
Select Section

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SIGNATURE (Officer or Administrator of the Plan)

DATE

TITLE

PHONE NUMBER

FORM CMS 276-16 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2302)

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Form Expiration Date: 12/31/2019

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

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

FORM CMS 276-16 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2305 - 2305.3)

BUDGET FORECAST

WORKSHEET A
PARTS I & II

Name of Plan: 0
Plan Number: 0

Budget Period From: 01/00/1900
To: 01/00/1900

	PART I - PRIOR YEAR COST & STATISTICAL DATA Period From: To:	TRIAL BALANCE PER BOOKS	PMPM COSTS	TOTAL MEDICARE PMPM COSTS	MEDICARE PART A PMPM COSTS	MEDICARE PART B PMPM COSTS	MEDICARE RATIO (COL 3 / COL 2)	MEDICARE PART A RATIO (COL 4 / COL 3)	
		1	2	3	4	5	6	7	
0	Total Member Months	XXXXXXXXXX	-	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXXX	0
1	Hospital Costs.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	1
2	Skilled Nursing Facilities.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	2
3	Home Health Agencies.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	3
4	Other Providers.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	4
5	Non-Providers.....	0	0.0000	0.0000		0.0000	0.0000		5
6	Plan Administration.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	6
7	Special Admin. Costs:.....								7
7a	Accretion/Deletion.....	0	0.0000	0.0000		0.0000	0.0000		7a
7b	Cost Report Certification.....	0	0.0000	0.0000		0.0000	0.0000		7b
7c	Other:	0	0.0000	0.0000		0.0000	0.0000		7c
8	Part B Cost Not Subj to Coins	0	0.0000	0.0000		0.0000	0.0000		8
9	Administrative and General....	0	0.0000						9
10	Total Costs (Sums Ln 1-9)....	0	0.0000	0.0000	0.0000	0.0000			10

	PART II - BUDGET YEAR COST & STATISTICAL DATA	TOTAL PROJECTED COSTS	PROJECTED PMPM COSTS (COL 1 / COL 2, LN 0)	MEDICARE PROJECTED PMPM COSTS (COL 2 * COL 6, Pt. I)	PMPM ADJUSTMENT (FROM ATTACHED WORKSHEET)	ADJUSTED MEDICARE PMPM COSTS (COL3+ COL4)	MEDICARE PART A PMPM COSTS (COL 5 * COL 7, PT. I)	MEDICARE PART B PMPM COSTS (COL 5 - COL 6)	
		1	2	3	4	5	6	7	
0	Total Member Months.....	XXXXXXXXXX	-	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXXX	0
1	Hospital Costs.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	1
2	Skilled Nursing Facilities.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	2
3	Home Health Agencies.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	3
4	Other Providers.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	4
5	Non-Providers.....	0	0.0000	0.0000	0.0000	0.0000		0.0000	5
6	Plan Administration.....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	6
7	Special Admin. Costs:.....							0.0000	7
7a	Accretion/Deletion.....	0	0.0000	0.0000	0.0000	0.0000		0.0000	7a
7b	Cost Report Certification.....	0	0.0000	0.0000	0.0000	0.0000		0.0000	7b
7c	Other:	0	0.0000	0.0000	0.0000	0.0000		0.0000	7c
8	Part B Cost Not Subj to Coins	0	0.0000	0.0000	0.0000	0.0000		0.0000	8
9	3rd Party Insurer Revenue....				0.0000	0.0000	0.0000	0.0000	9
10	Administrative and General	0	0.0000						
11	Total Costs (Sum Lns 1-10)....	0	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	10
12	Est. Deductible & Coinsurance					0.0000	0.0000	0.0000	11
13	Medicare Costs (Ln 11 - 12)					0.0000	0.0000	0.0000	12
14	Medicare Primary Rate (Ln13*Pt.IV,Ln4)					0.0000	0.0000	0.0000	13

FORM CMS 276-16

(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 2303.1-2303.2)

BUDGET FORECAST

WORKSHEET A
PARTS III, IV & V

Name of Plan: 0
Plan Number: 0

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

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

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

	PART V - ANNUAL PROJECTIONS	PMPM	Projection Ratio	
		1	2	
1	Total Medicare Cost Per Capita Rate (Part II, Col 5, Line 13)	0.0000	XXXXXXXXX	1
2	Total Costs Per Member Per Month (Part II, Col 2, Line 11)	0.0000	0.0000	2

FORM CMS 276-16
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 2303.1-2303.2)

BUDGET FORECAST WORKSHEET B

Name of Plan: 0 Budget Period From: 01/00/1900
Plan Number: 0 To: 01/00/1900

	DETERMINATION OF BUDGETED VOLUNTARY UNDER COLLECTION OF PREMIUMS FOR THE BUDGET PERIOD PREMIUM DETERMINATIONS ARE COVERED BY THIS PART Period From: 01/00/1900 To: 01/00/1900	TOTALS	AMOUNT PER MEMBER MONTH	
		1	2	
1	Total deductible and coinsurance (Worksheet A, Part III, Col 1, Line 13)	XXXXXXXXXX	0.0000	1
2	(Over)/Involuntary Under collection for the period (Worksheet N, Col 3, Line 11/12b, respectively)		XXXXXXXXXX	2
3	Medicare Member Months for the period (Worksheet L, Column 2, Line 1)		XXXXXXXXXX	3
4	Ratio of (Wkst B, Col 1, Line 3) to (Worksheet A, Part IV, Col 2, Line 1)	0.0000	XXXXXXXXXX	4
5	Adjusted (Over)/Under Collection for the period (Line 2 times Line 4)	XXXXXXXXXX	0.0000	5
6	Total allowed to be collected during the budget period (Line 1 plus Line 5)	XXXXXXXXXX	0.0000	6
7	Total amounts to be charged in budget year, including Medicare enrollee copayments (Attach Worksheet)	XXXXXXXXXX		7
		XXXXXXXXXX		
8	Budgeted Voluntary under collection for the budget period (Line 6 minus Line 7)	XXXXXXXXXX	0.0000	8

FORM CMS 276-16

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

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

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

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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

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CERTIFICATION BY OFFICER OF THE PLAN

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SIGNATURE (Officer or Administrator of the Plan)

DATE

TITLE

PHONE NUMBER

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Form Expiration Date: 12/31/2019

PLAN STATISTICS

WORKSHEET D
PART I
Page 1

Name of Plan: 0
Plan #: H-xxxx

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

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				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

FORM HCFA 276-16
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 2306)

PART 1

Name of Plan: 0
Plan #: H-xxxx

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

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 HCFA 276-16
(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: 01/00/00
TO: 01/00/00

	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
	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 HCFA 276-16
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 2306)

PLAN STATISTICS

Name of Plan: 0

Plan #: H-xxxx

WORKSHEET D
PART II
Page 2

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

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	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	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)	0.0000	0.0000

(3)
Part B Member Months = Total Member Months

FORM CMS 276-16
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2306)

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 276-16
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2307)

WORKSHEET F

RECLASSIFICATIONS

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

Plan #: H-xxxx 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					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 276-16

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

RECLASSIFICATIONS

Name of Plan: 0 WORKSHEET F

Plan #: H-xxxx PERIOD FROM: 01/00/00 Page 2

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 276-16

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

RECLASSIFICATIONS

Name of Plan: 0 PERIOD FROM: 01/00/00
Plan #: H-xxxx 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 276-16
(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 276-16
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2308)

SUMMARY OF RECLASSIFICATIONS WORKSHEET F

Name of Plan: 0 Page 5

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 276-16

(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

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

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

ADJUSTMENTS TO EXPENSES — WORKSHEET G

Name of Plan: 0 — PART I

Plan #: H-xxxx — PERIOD FROM: 01/00/00 — Page 1

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 276-16
(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 PART I

TO: 01/00/00 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 276-16
(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 PART I

TO: 01/00/00 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		

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

FORM CMS 276-16
(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 PART I

TO: 01/00/00 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 276-16
(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 1	Amount (To Wkst E as appropriate) 2	TRANSFER TO WORKSHEET E LINE # AS SHOWN 3	CC LINE NUMBER Wkst E 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 276-16
(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	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%	
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 276-16

(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 276-16

(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 276-16

(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 276-16
(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 276-16
(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	0	0.0000	0	0
20	Durable Medical Equipment		0	0	0	0.0000	0	0
21	Ambulance		0	0	0	0.0000	0	0
22	Emergency-Urgently Needed Svcs		0	0	0	0.0000	0	0
23	_____		0	0	0	0.0000	0	0
24	Mental Health Svcs		0	0	0	0.0000	0	0
25	_____		0	0	0	0.0000	0	0
26	_____		0	0	0	0.0000	0	0
27	_____		0	0	0	0.0000	0	0
28	_____		0	0	0	0.0000	0	0
29	_____		0	0	0	0.0000	0	0
30	_____		0	0	0	0.0000	0	0
31	_____		0	0	0	0.0000	0	0
32	_____		0	0	0	0.0000	0	0
33	_____		0	0	0	0.0000	0	0
34	_____		0	0	0	0.0000	0	0
35	Total (Sum Lines 1 thru 34)							0
36	Member Months - Part B (W/S D, Part II, Pg 2, Pt E, Col 2, Line 1)							0
37	Cost PMPM (Line 35 / Line 36)							0.0000
38	Enter on Worksheet, Col, Line							M, 3, 5

FORM CMS 276-16
(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 276-16

(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 276-16
(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2315)

MEDICARE PREMIUM RECONCILIATION WORKSHEET N

Name of Plan: 0 Period From: 01/00/00

Plan Number: H-xxxx To: 01/00/00

Under and Over Collection of Medicare Premiums - Current Year Premium Determinations Covered by this Part		Totals 1	Member Months 2	Cost Per Member Month 3	Line
0	Total Medicare Member Months	XXXXXXXXXXXX	0	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 XXXXXXXXXXXX	-	3
4	Less: Accounts Receivable for premiums/dues and copayments (beg of period)	-	XXXXXXXXXXXX XXXXXXXXXXXX	-	4
5	Net Collections for period (Line 3 minus Line 4)	-	XXXXXXXXXXXX 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 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 10)	XXXXXXXXXXXX	XXXXXXXXXXXX	0.0000	8a
	b. Part B Coinsurance (Worksheet M, Col 3, Line 12)	XXXXXXXXXXXX	XXXXXXXXXXXX	0.0000	8b
	c. CO on claims processed by MACs (Worksheet G, Col 2, Line 23/Col 2, Ln 0)	XXXXXXXXXXXX	XXXXXXXXXXXX	#DIV/0!	8c
	d. Total (Sum of Lines 8a thru 8c)	XXXXXXXXXXXX	XXXXXXXXXXXX	#DIV/0!	8d
9a	(Over)/Involuntary Under collection from prior period (Worksheet N, Line 11/12b, respectively) ****Note**Prior Period = Current Period -2 Years**	XXXXXXXXXXXX	-	XXXXXXXXXXXX	9
9b	Prior Period Member Months (Worksheet N, Line 0)	XXXXXXXXXXXX	-	XXXXXXXXXXXX	
9c	Gross (over)/under collections from prior period	0	XXXXXXXXXXXX	XXXXXXXXXXXX	
9d	Adjusted (over)/under collection from the prior period	XXXXXXXXXXXX	XXXXXXXXXXXX	#DIV/0!	
10	Total amount allowed to be charged (Line 8d plus line 9d)	XXXXXXXXXXXX	XXXXXXXXXXXX	#DIV/0!	10
11	Actual (Over) under collection for the period (Line 10 minus Line 7). Stop here if (over)collection	XXXXXXXXXXXX	XXXXXXXXXXXX	#DIV/0!	11
12	Budgeted Voluntary under collection for the period (Worksheet B, Line 8)	XXXXXXXXXXXX	XXXXXXXXXXXX	0.0000	12
12a	Actual Voluntary under collection - No recoupment	XXXXXXXXXXXX	XXXXXXXXXXXX	#DIV/0!	12a
12b	Involuntary Under collection - may recoup during subsequent period	XXXXXXXXXXXX	XXXXXXXXXXXX	#DIV/0!	12b

FORM CMS 276-16

(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… … … … … … … … … … … … … … … … … … … …	
13	Capitation… …	
14	Other… ..	
15	ESRD Facilities.....	
16	_____	
17	Durable Medical Equipment.....	
18	Ambulance.....	
19	Emergency-Urgently Needed Svcs.....	
20		
21	Mental Health Svcs	
22	_____	
23	_____	
24	_____	
25	_____	
26	_____	
27	_____	
28	_____	
29	_____	
30	_____	
31	_____	

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.

FORM CMS 276-16

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

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	