

Medicare Cost Report Instructions

CHAPTER 34

INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT
FORM CMS-265-94

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3400. GENERAL

Form CMS-265-94 must be completed by all renal dialysis facilities which are not hospital-based for cost reporting periods ending on or after December 31, 1994. Submit the form to your Medicare intermediary no later than the last day of the **fifth** month following the close of your cost reporting year. Round all reported amounts to the nearest dollar (unless specifically stated otherwise in the instructions) with negative figures or reductions in expenses shown in parentheses ().

You may submit computer prepared forms in lieu of the forms provided by CMS. Computer prepared forms are acceptable if they are reviewed and approved for provider use by CMS before use. (See §108.)

In addition to completing Form CMS-265-94, submit a copy of your facility's audited (if available) or unaudited financial statement for the accounting period as specified in this cost report.

All facilities providing end stage renal disease (ESRD) services to Medicare patients must meet conditions for coverage before they can qualify for Medicare reimbursement. These criteria are contained in 42 CFR 405.2100ff.

The final cost report of a facility which voluntarily or involuntarily ceases to participate in the health insurance program is due no later than **150** days following the effective date of the termination of the facility agreement including termination of the facility agreement as a result of a change of ownership. There are no provisions for an extension of the cost report due date for facilities which cease to participate in the program.

Failure to file this cost report may result in suspension of future payments until it is filed or revocation of your facility's certification to participate in the program.

If your costs have been determined on the cash basis of accounting, make adjustments to conform to the Medicare program requirement that the accrual method of accounting be used.

You are required to record the necessary accounting data in accordance with the Medicare principles of reimbursement. These principles are contained in the Provider Reimbursement Manual (CMS Pub. 15). If you do not have this publication, contact your intermediary.

3400.1 Rounding Standards for Fractional Computations.--Throughout the Independent Renal Dialysis Facility Cost Report, required computations result in the use of fractions. Utilize the following rounding standards for such computations.

1. Round to two decimal places:
 - a. Percentages (e.g., percent ownership of facility, percent of customary work week devoted to business);
 - b. Averages;
 - c. Full time equivalents;
 - d. Payment rate; and
 - e. Average cost per treatment.
2. Round to six decimal places:
 - a. Ratios (e.g., unit cost multipliers)

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost allocated. This residual is adjusted to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount allocated.

3400.2 Acronyms and Abbreviations.--Throughout the Independent Renal Dialysis Cost Report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below:

CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CCPD	-	Continuous Cycling Peritoneal Dialysis
CFR	-	Code of Federal Regulations
ESRD	-	End Stage Renal Disease
FTE	-	Full Time Equivalent
CMS	-	Centers for Medicare and Medicaid Services
CMS Pub.	-	Centers for Medicare and Medicaid Services' Publication
MCP	-	Monthly Capitation Method
RO	-	Regional Office

3401. RECOMMENDED SEQUENCE FOR COMPLETING FORM HCFA-265-94

<u>Step No.</u>	<u>Worksheet</u>	<u>Instructions</u>
1	S, Part I	Read §3404.1.
2	S-1	Read §3405. Complete the entire worksheet.
3	A	Read §3406. Complete columns 1 through 4.
4	A-1	Read §3407. Complete entire worksheet if applicable.
5	A	Read §3406. Complete columns 5 and 6.
6	A-2	Read §3408. Complete entire worksheet.
7	A	Read §3406. Complete columns 7 and 8.
8	A-3	Read §3409. Complete entire worksheet if applicable.
9	A-4	Read §3410. Complete entire worksheet if applicable.
10	B and B-1	Read §3411. Complete entire worksheets.
11	C	Read §3412. Complete entire worksheet.
12	D	Read §3413. Complete entire worksheet.
13	S, Part II	Read §3404.2.

3402. SEQUENCE OF ASSEMBLY

The following list of assembly of worksheets is provided so all facilities are consistent in the order of submission of their annual cost report. All facilities using Form HCFA-265-94 are to adhere to this sequence. When worksheets are not completed because they are not applicable, blank worksheets are not included in the assembly of the cost report.

<u>Worksheet</u>	<u>Part(s)</u>
S	I & II
S-1	
A	
A-1	
A-2	
A-3	
A-4	I & II
B	
B-1	
C	
D	

3403. METHOD OF PAYMENT

3403.1 Payment for Physician Services.--Physician services are paid differently depending upon whether the service is an administrative service, routine professional service, or a service rendered to patients undergoing self-dialysis and home dialysis training. For a complete definition of these services and a description of the methods of payment for these services, see 42 CFR 414.313, 42 CFR 414.314, and 42 CFR 414.316 respectively.

A. Administrative Services.--Administrative services are physician services that benefit the facility generally and are supervisory in nature. They are services not directly related to the care of an individual patient, but are supportive of the facility as a whole and of benefit to patients in general. Examples of administrative services include supervision of staff, staff training, participation in staff conferences and in the management of the facility, and advising staff on the procurement of supplies.

Administrative services are considered services to you. Therefore, the costs associated with them are included as part of your cost on the cost report. You are paid the cost of these services through the composite rate.

B. Physician Routine Professional Services.--Physician routine professional services for outpatient maintenance dialysis are services furnished to individual patients. Physician routine professional services are reimbursed under the monthly capitation payment (MCP) method (see 42 CFR 414.314) unless an election is made by all of the physicians in the facility to be paid under the initial payment method.

Under the MCP method, the carrier pays the physician an amount for each patient to cover all professional services by the physician. The associated costs are not included as part of your cost. They are, however, reported on the cost report as a separate line item.

Under the initial method of payment, the intermediary pays you for physicians' routine professional services. Payment under this method is in the form of an add-on to the composite rate and is included as part of your costs.

There are certain services which are not included in either the add-on under the initial method or in the MCP amount under the MCP method. These services are paid under the physician fee schedule and therefore not included in your costs. These services are explained in 42 CFR 414.313(b) and 42 CFR 414.314(b) respectively.

C. Physician Payment for Self-Dialysis and Home Dialysis Training.-- Payment for physician services rendered to dialysis patients undergoing self-dialysis training is a flat amount per patient. The payment is made in addition to any amounts payable under the initial or MCP methods. It is paid directly to the physician by the carrier and **not** included in your cost.

3403.2 Facility Payment for Self-Dialysis Training.--The base composite rate applies to outpatient maintenance dialysis furnished in the facility. A higher rate, consisting of the base plus a specified add-on, is paid for self-dialysis training sessions.

The Medicare program pays you for training both the patient and his/her dialysis partner if a partner is required. However, payment does not include travel to the facility and lost wages of the attendant during the training period. (See HCFA Pub.15-I, §2707 for specific instructions regarding payment for training services.)

3403.3 Facility Payment for Laboratory Services Included in Composite Rate.-Certain laboratory services (as defined in §207.1 of the Renal Dialysis Facility Manual) are paid through your per dialysis composite rate. Payment for these laboratory services is not made on any other basis. This means that even though these laboratory tests may be furnished one time per month, you are paid for such services over the course of the month through the composite rate. (See HCFA Pub. 15-I, §2709.2 for special instructions for routine laboratory tests for continuous ambulatory peritoneal dialysis (CAPD) and continuous cycling peritoneal dialysis (CCPD).)

3403.4 Facility Payment for Home Dialysis.--For rules that apply to Medicare beneficiaries dialyzing at home, see §2740 of the HCFA Pub. 15-I.

3404. WORKSHEET S - INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT CERTIFICATION

The intermediary should indicate in the appropriate box whether this is the initial cost report (first cost report filed for the period), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened. The intermediary should also indicated in HCRIS on line 1, column 3 of worksheet S the following codes that correspond to the filing status of the cost report: 1=As submitted; 2=Settled; 3=Settled with Audit; 4=Reopened; and 5=Amended.

3404.1 Part I - General--

Line 1--Enter name of the facility.

Line 1.01--Enter the street address and P.O. Box (if applicable).

Line 1.02--Enter the city, state, and zip code.

Line 1.03--Enter the county where the facility is located.

Line 2--Enter your provider number.

Line 3--Enter the date the facility was certified.

Line 4--Enter the name and phone number of the person to be contacted if any questions arise about the information in this report.

Line 5--Enter the inclusive dates covered by this cost report. Generally, a cost reporting period consists of 12 consecutive calendar months or 13 four-week periods with an additional day (two in a leap year) added to the last week in the period to make it coincide with the end of the calendar year or month. See CMS Pub. 15-I, chapter 24, for situations where a short period cost report may be filed. A new facility may select an initial cost reporting period of at least one month, but not in excess of 13 months. (See CMS Pub. 15-I, §2414.1.)

A 30-day extension of the due date for a cost report may, for good cause, be granted by the program. To be granted this extension, you must submit a written request and obtain written approval from the servicing intermediary prior to your cost report due date.

Line 6

Column 1--Type of Control--Indicate the ownership or auspices of the facility by entering the number below that corresponds to the type of control of the facility.

Voluntary Non Profit
1=Corporation
2=Other (specify)

Proprietary
3=Individual
4=Corporation
5=Partnership
6=Other (specify)

Government
7=Federal
8=State
9=County
10=City
11=Other (specify)

Column 2--If item 2, 6, or 11 is selected, "Other (specify) category, specify the type of provider in column 2 of the worksheet.

Line 7.--Indicate whether the physicians providing outpatient maintenance dialysis and other physician services for ESRD patients are paid under the initial method or the MCP method. Indicate the date of election of the initial method if applicable.

Column 1--Type of Reimbursement--Enter the number 1 for the initial method and number 2 for the MCP method.

Column 2--If the initial method is selected, enter the date of election of the initial method.

Line 8.--Indicate whether you were previously certified as a hospital-based unit. In Column 1 enter "Y" for yes or "N" for no.

Line 9.--If you are part of a chain organization, enter a "Y" for yes in Column 1 and enter the name and address of the organization on the lines listed below. Otherwise enter "N" for no in column 1. See CMS Pub. 15-I, §2150 for a definition of a chain organization.

Line 9.01--Enter the name of the Home Office.

Line 9.02--Enter the street address and P. O. Box (if applicable) of the Home Office.

Line 9.03--Enter the city, state and zip code of the Home Office.

3404.2 Part II - Certification by Officer or Administrator of Facility.--Prepare and sign this certification after the cost report has been completed in its entirety.

Section 1128B(a) of the Act states that, "Whoever knowingly and willfully makes or causes to be made any false statement or representation of material fact in any application for any benefit or payment under this title--shall (i) in the case of such a statement, representation, concealment, failure or conversion by any person in connection with the furnishing (by that person) of items or service for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than 5 years or both, or (ii) in the case of such statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than 1 year or both."

3405. WORKSHEET S-1 - INDEPENDENT RENAL DIALYSIS FACILITY
STATISTICAL DATA

In accordance with 42 CFR 413.24(a) and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to the renal dialysis department. The data maintained by you includes patient data, the number of treatments, number of machines, and home program data. In addition, full time equivalent (FTE) data is required by staff employees and contract employees.

Column Descriptions

Column 1--Enter the statistics for Outpatient Hemodialysis patients on lines 1 through 11.

Column 2--Enter the statistics for Outpatient Peritoneal Dialysis patients on lines 1 through 11.

Column 3--Enter the statistics for Training Hemodialysis patients on lines 1 through 11.

Column 4--Enter the statistics for Training Peritoneal Dialysis patients on lines 1 through 11.

Line Descriptions

Enter the statistics on lines 1 through 11 that refer to services furnished by you to patients that are in your facility or some other institution. Do not include services furnished to patients in their homes. Identify information as being either maintenance dialysis or training dialysis by either hemodialysis or peritoneal dialysis.

Line 1--Enter the number of treatments furnished directly at the facility and which were not billed to the Medicare program.

Line 2--Enter the number of treatments furnished under arrangements and which were not billed directly to the Medicare program by you. An arrangement is an agreement between you and another institution in which you agree to furnish specified services to patients of the other institution, but the other institution retains responsibility for those services and for obtaining reimbursement for services furnished to them.

Line 3--Enter the number of patients at the end of the cost reporting period in the dialysis program.

The statistics reported in lines 4 through 8 are used to calculate your utilization rate.

Line 4--Enter the average number of times per week a patient receives dialysis at the facility. This is computed by reporting your standard medical practice, if there is one (e.g., if you commonly dialyze hemodialysis patients 3 times per week, report 3), or by counting the number of patient-weeks in the reporting period and dividing that number into the number of treatments by mode of dialysis.

Line 5--Enter the average number of days that you furnished dialysis in an average week. This is computed by counting the number of days you were open for business during the period covered by the cost report and dividing this amount by the number of weeks in that period. Normally, the cost reporting period is 12 months, so the number of weeks in the denominator is 52.

Line 6--Enter the average time of a typical patient dialysis session, including setup time in hours, rounded to the nearest half-hour.

Line 7--Enter the number of machines regularly available for use.

Line 8.--Enter the number of standby machines held in reserve for patient overflow, emergency, and machine breakdown.

Line 9.--Enter in each column the number of **staff** shifts in a typical week during the cost reporting period.

Line 10.--Enter in each column the hours per shift in a typical week during the cost reporting period **for the first shift on line 10.01, second shift on line 10.02, and the third shift on line 10.03.**

Line 11.--Enter on lines 11.01 through 11.04 the total number of treatments (by type of treatment) furnished to patients and the frequency of the treatment. Enter on line 11.01 the total number of treatments (by type of treatment) furnished to patients who receive dialysis one time per week. Enter on line 11.02 the total number of treatments (by type of treatment) furnished to patients who receive dialysis two times per week. Enter on line 11.03 the total number of treatments (by type of treatment) furnished to patients who receive dialysis three times per week. Enter on line 11.04 the total number of treatments (by type of treatment) furnished to patients who receive dialysis more than three times per week. Enter in each column of line 11.05 the sum of the amounts entered on lines 11.01 through 11.04.

Line 12

Column 1-- Type of dialyzers used--Indicate the type of dialyzers used by entering the number below that corresponds to the type.

1=Hollow Fiber, 2=Parallel Plate, 3=Coil, 4=Other

Column 2--If the dialyzers are reused, indicate the number of times. If none are reused, enter zero.

Column 3--If "4, Other" is indicated in column 1, then indicate the type of dialyzer used.

Line 13.--Enter the number of backup sessions furnished to home patients. A backup session is a maintenance dialysis session furnished in the facility to a home patient. A patient who receives backup dialysis is considered a home patient if there is a reasonable expectation that the need for in-facility backup dialysis is only temporary and that the patient will return to home dialysis within a reasonable period of time.

Column 1--Enter the number of back up sessions for CAPD patients.

Column 2--Enter the number of back up sessions for other patients.

Column 3--Enter the number of back up sessions for CCPD patients.

Line 14.--Medicare pays for epoetin based on a set statutory fee per 1,000 units furnished. (See PRM-I §2710.3). On line 14, enter the total units furnished by the facility during its cost reporting period divided by 1,000. For example, if a facility furnished 10,255,751 units, it would report 10,256 units on line 14. Round all numbers to whole numbers.

Line 15.--Enter the number of patients who are awaiting transplants.

Line 16.--Indicate the number of patients who received transplants during this reporting period.

Home Program

The data requested on lines 17 to 18 pertain to a home dialysis program only.

Line 17.--**Column 1**, enter the number of patients that began home dialysis training during this reporting period.

Line 18.--Enter the number of patients in the home program on the last day of your cost reporting period.

Line 19.--

Column 1--Type of dialyzers used--Indicate the type of dialyzers used by entering the number below that corresponds to the type.

1=Hollow Fiber, 2=Parallel Plate, 3=Coil, 4=Other

Column 2--If the dialyzers are reused, indicate the number of times. If none are reused, enter zero.

Column 3-- If "4, Other" is indicated in column 1, then indicate the type of dialyzer used.

Lines 20 through 29.--Enter the number of hours in your normal work week in the space provided. The items in this part provide statistical data related to your human resources. The human resource statistics are required for each of the job categories specified in lines 20 through 28. Enter any additional category as needed on line 29.

Column Descriptions

Column 1.--Enter the FTE employees on the payroll. These are staff for which an IRS Form W-2 is issued. Staff FTEs are computed as follows. The sum of all hours for which employees were paid during the year is divided by 2080 hours. Round to two decimal places.

Column 2.--Enter the FTEs contracted and consultant staff worked during the year and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude hours so paid from the numerator in the calculations.

Personnel who are involved in more than one activity must have their time prorated among those activities. For example, physicians who provide professional services and administrative services are counted in both the physicians line and the administrative line according to the number of hours spent in each activity. (See 42 CFR 414.300.) To make this allocation, use the time log records if available, then use the results of time logs kept for a sample period (e.g., for 1 week per quarter, have all employees keep a time log), or use estimates based on personal interviews.

3406. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts.

The cost centers on this worksheet are listed in a manner which facilitates the combination of the various groups of cost centers for purposes of cost finding. All of the cost centers listed do not apply to all facilities using these forms. Complete only those lines which are applicable.

Where the cost elements of a cost center are separately maintained on your books, a reconciliation of the costs per the accounting books and records to those on this worksheet must be maintained by you and is subject to review by the intermediary.

Do not change standard (i.e., preprinted) HCFA line numbers and cost center descriptions. If you need to use additional or different cost center descriptions, do so by adding additional lines to the cost report. Do this in such a manner that the entries bear a logical relationship to the standard line description preceding the added line. Identify the line added as a numeric subscript of the immediately preceding line. That is, if two lines are added between lines 3 and 4, identify them as lines 3.01 and 3.02. If you add additional lines for reimbursable cost centers, add corresponding columns on Worksheets B and B-1 for each additional cost center.

Columns 1, 2, 3, and 4.--The expenses listed in these columns must be in accordance with your accounting books and records. List on the appropriate lines in columns 1, 2, 3, and 4 the total expenses incurred during the cost reporting period. The expenses must be detailed between salaries (columns 1 and 2) and other than salaries (column 3). The sum of columns 1, 2, and 3 must equal column 4. Any needed reclassifications and adjustments must be recorded in columns 5 and 7, as appropriate.

Column 5.--Enter any reclassifications among the cost center expenses which are needed to effect proper cost allocation.

Worksheet A-1 is provided to compute the reclassifications affecting the expenses specified therein. This worksheet need not be completed by all facilities but must be completed only to the extent that the reclassifications are needed and are appropriate in the particular facility's circumstances. Show reductions to expenses in parentheses ().

The net total of the entries in column 5 must equal zero on line 27.

Column 6.--Adjust the amounts entered in column 4 by the amounts entered in column 5 (increase or decrease) and extend the net balances to column 6. The total of column 6 must equal the total of column 4 on line 27.

Column 7.--Enter on the appropriate lines in column 7 the amounts of any adjustments to expenses indicated on Worksheet A-2, column 2. Indicate those adjustments to expenses that are reductions in the expense by showing the figure in parentheses (). The total on Worksheet A, column 7, line 27, must equal Worksheet A-2, column 2, line 21. The amounts entered on Worksheet A, column 7, lines 13, 19, and 23 must equal the amounts entered on Worksheet A, column 6, lines 13, 19, and 23 respectively.

Column 8.--Adjust the amounts in column 6 by the amounts in column 7 (increase or decrease) and extend the net balances to column 8.

The amounts in column 8 marked with an asterisk (*) in the left and right margins are transferred to the appropriate columns and lines on Worksheets B and B-1. See the instructions for Worksheets B and B-1.

Line Descriptions

Line 1.--This cost center includes capital-related costs on buildings and fixtures and expenses pertaining to buildings and fixtures such as depreciation, insurance, interest, rent, and property taxes.

Line 2.--This cost center includes capital-related costs on movable equipment and expenses pertaining to moveable equipment, such as depreciation, insurance, interest, personal property taxes, and rent. It includes items such as office furniture and equipment. Moveable equipment does not refer to dialysis machines or support equipment. Therefore, do not include costs related to depreciation and/or rental and maintenance on the dialysis machines and support equipment on this line. Enter these costs on line 6.

Line 3.--This cost center includes the direct expenses incurred in the operation and maintenance of the plant and equipment and protecting employees, visitors, and facility property. Operation and maintenance of plant includes the maintenance and service of utility systems, such as heat, light, water (excluding water treatment for dialysis purposes), air conditioning, and air treatment; the maintenance and repair of buildings, parking facilities, and equipment; painting; elevator maintenance; and performance of minor renovation of buildings and equipment. The utility cost of water is included on this line. The cost of water treatment for dialysis purposes is not entered on this line. It is included in line 6, machine capital-related or rental and maintenance.

Line 6.--This cost center includes capital-related costs for moveable equipment other than those included on line 2. Enter only the capital-related costs of moveable equipment, rented and/or purchased, and maintenance on the dialysis machine and any support equipment. See HCFA Pub. 15-I, chapter 27, §2703 for the definition of support equipment. Enter these costs on line 2. Include the costs of water treatment for dialysis purposes on this line.

Water treatment for dialysis includes the equipment and associated maintenance and repair and installation costs necessary to render the water acceptable for use in dialysis. Examples of such equipment are water softener (resin or deionizer type) and reverse osmosis machines. This equipment prepares the water that is fed directly into the dialysis machine.

Line 7.--This cost center includes direct salaries of all personnel who furnish direct care to dialysis patients. Direct salaries include gross salaries and wages of all such personnel, e.g., registered and licensed practical nurses, nurses aides, technicians, social workers, and dieticians.

Salaries paid to physicians are not included in this cost center. They are allocated to cost centers on line 12 and either line 16 or line 19. Administrative costs are reported on line 12 and routine professional costs related to costs of direct patient care are reported on line 16 or 19. To compute this allocation, first separate the costs of physician administrative services versus direct patient care services. Separate these costs by the time spent in each activity. The remainder, costs of direct patient care, are split

between routine professional services, line 16 or line 19, and other medical services which may be billed for separately by the physician to the Medicare carrier. If you pay malpractice insurance premiums applicable to physicians, see instructions for malpractice cost adjustments on Worksheet A-2, lines 16 and 17.

Line 9.--This cost center includes the direct cost of total drugs used in furnishing dialysis services. It includes the costs of parenteral drugs used in the dialysis procedure that are covered under the composite rate payment. (See CMS Pub. 15-I, §2710.2.) In addition to drugs included in the composite rate, this cost center includes separately billable injectable drugs provided to the facility's patients. (See CMS Pub. 15-I, §2711.2.) Do not include any costs for the approved drug epoetin on this line. Report costs for epoetin on line 23.

Line 10.--This cost center includes the direct cost of total dialysis supplies used in furnishing dialysis services. It includes the cost of supplies that are covered under the composite rate payment and separately billable supplies. Exclude the costs of meals served to patients. If these costs are included, adjust them out on Worksheet A-2, line 9.

Line 11.--This cost center includes the cost of all laboratory services (i.e., laboratory services that are either included or not included in the composite rate payment) performed either by your staff or an independent laboratory. Independent facilities are not certified to perform any separately billable clinical diagnostic laboratory tests. Therefore, independent facilities cannot be paid for any separately billable clinical diagnostic laboratory tests. (See CMS Pub. 15-I, §§2710.1 and 2711.1.)

Line 12.--This cost center is used to record the expenses of several costs incurred in maintaining the facility. Examples are fiscal services, legal services, accounting, recordkeeping, data processing, purchasing, taxes, telephone, home office costs, malpractice costs, and physicians' administrative services. The physicians' administrative services are services rendered by physicians that are directly related to the support of the facility and not directly related to the care of individual patients. (See §3403.1A.) Malpractice costs include allowable insurance premiums, direct losses, and expenses related to direct losses. The cost of malpractice insurance premiums paid by the facility, applicable to physicians, is adjusted out in column 7. See line 7 instructions for adjustment of malpractice costs.

Line 16.--Enter the cost of physician routine professional services covered under the initial method of physician payment. See 42 CFR 414.310 for a definition of these services.

Line 17.--Use this line to record the cost applicable to any reimbursable cost center not provided for on this worksheet.

Line 18.--Enter the sum of lines 12 through 17.

Line 19.--This cost center includes compensation (i.e., direct salaries, fringe benefits, etc.) of physicians for professional services which are related to the care of the patient and medical management over the period of time the patient is on dialysis.

These costs are adjusted out on Worksheet A-2, line 10, and are not transferred in the cost report because they are not included in the composite rate. See line 7 instructions for adjustment of malpractice costs.

Line 20.--This cost center includes the direct expenses incurred in obtaining blood directly from donors and whole blood and packed red blood cells from suppliers. Include in this cost center in column 3 (Other) the processing fee charged by suppliers. These items are billed separately and reimbursement for them is not included in the composite rate.

Line 21.--This cost center includes the direct costs associated with hepatitis B vaccine. Payment for hepatitis B vaccine follows the same general principles that are applicable to any injectable drug or biological. (See CMS Pub. 15-I, §2711.4.)

Line 22.--A nonreimbursable cost center must be established to accumulate the cost incurred by you for services related to the physicians' private practices. Examples of such costs are depreciation costs for the space occupied, moveable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services.

Line 23.--This cost center includes the cost of the approved drug epoetin (EPO) furnished to both in-facility and home ESRD patients. These costs are adjusted out on Worksheet A-2, line 15 and line 16, and are not transferred to any worksheets in the cost report.

Line 24.--This cost center includes the direct cost of support services provided to Method II home patients. Under this option, the patient elects to make his/her own arrangements for securing the necessary supplies and equipment to dialyze at home through a Method II supplier. (See CMS Pub. 15-I, §2740.)

Lines 25 and 26.--Use these lines to record the cost applicable to any nonreimbursable cost centers not provided for on this worksheet, e.g., Supplementary Medical Insurance premiums paid by the facility on behalf of beneficiaries financially unable to pay the premiums. Label the lines used to indicate the purpose of their use.

Line 27.--Enter the sum of the amounts on lines 5 through 11 and 18 through 26.

3407. WORKSHEET A-1 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain amounts to effect proper cost allocation under cost finding. Specifically identify the cost centers affected in your accounting records. If more lines are needed than provided on this worksheet, submit additional copies of this worksheet and enter the additional information on them. The following are some examples of costs which are reclassified on this worksheet.

1. If the total employee health and welfare benefits are included in administrative and general on Worksheet A, column 4, line 12, then reclassify these costs to Worksheet A, column 5, line 8. Reclassify employee health and welfare benefits relating to physicians' routine professional services to Worksheet A, column 5, line 16 or 19.

2. Reclassify the insurance expense applicable to the building and/or fixtures, moveable equipment, dialysis machines, and supportive equipment included in administrative and general on Worksheet A, column 4, line 12, to Worksheet A, column 5, lines 1, 2, and 6, respectively.

3. Reclassify any interest expense applicable to funds borrowed for administrative and general purposes (operating expenses, etc.) or for the purchase of buildings and/or fixtures, moveable equipment, dialysis machines, or supportive equipment included in interest on Worksheet A, column 4, line 13, to Worksheet A, column 5, lines 12, 1, 2, and 6, respectively.

4. Reclassify rent expenses applicable to the rental of buildings and fixtures and to moveable equipment included in administrative and general from Worksheet A, column 5, line 12, to Worksheet A, column 5, lines 1 and 2, respectively. See instructions for Worksheet A-3 for treatment of rental expense for related organizations. Reclassify expenses (such as insurance, interest and taxes) applicable to machine depreciation or rental and maintenance of dialysis machines and supportive equipment to Worksheet A, column 5, line 6.

5. Reclassify any taxes (real property taxes and/or personal property taxes) applicable to buildings, fixtures, moveable equipment, dialysis machines, and support equipment included in administrative and general on Worksheet A, column 4, line 12, to Worksheet A, column 5, lines 1, 2, and 6, respectively.

Transfer the amount of increase (column 4) and decrease (column 7) of Worksheet A-1, applicable to the various cost centers, to Worksheet A, column 5.

You may have charged some of these amounts to the proper cost center before the end of the accounting period. Therefore, complete Worksheet A-1 only to the extent that expenses differ from the result that would be obtained using the instructions in the preceding paragraphs.

3408. WORKSHEET A-2 - ADJUSTMENTS TO EXPENSES

This worksheet provides for the adjustments to the expenses listed on Worksheet A, column 6. These adjustments, which are required under the Medicare principles of reimbursement, are to be made on the basis of cost, or amount received. Enter the total amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Once an adjustment to an expense is made on the basis of cost, you may not in future cost reporting periods determine the required adjustment to the expense on the basis of revenue. The following symbols are to be entered in column 1 to indicate the basis for adjustment: "A" for costs and "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

Types of items to be entered on Worksheet A-2 are (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, grants, gifts, etc. and (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement. (See CMS Pub. 15-I, §2328.)

Where an adjustment to an expense affects more than one cost center, you must record the adjustment to each cost center on a separate line on Worksheet A-2.

Line Descriptions

Line 1.--Investment income on restricted and unrestricted funds which are commingled with other funds must be applied together against, but should not exceed, the total interest expense included in allowable costs. (See CMS Pub. 15-I, chapter 2.)

Apply the investment income on restricted and unrestricted funds which are commingled with other funds against the administrative and general, the capital-related - buildings and fixtures, the capital-related - moveable equipment and any other appropriate cost centers on the basis of the ratio that interest expense charged to each cost center bears to the total interest expense charged to all of your cost centers.

Line 5.--Enter any adjustments to the various cost centers which have been included as costs paid directly by the carrier for physician's services which are separately billable, i.e., declotting of shunts for facilities whose physicians are paid under the MCP method.

Line 6.--Enter allowable home office costs which have been allocated to you and which are not already included in your cost report. Use additional lines to the extent that various facility cost centers are affected. (See CMS Pub. 15-I, chapter 21.)

Line 7.--The amount entered is obtained from Worksheet A-3, Part B, column 6, line 5. Note that Worksheet A-3, Part B, lines 1-4, represent the detail of the various cost centers to be adjusted on Worksheet A.

Line 8.--Remove the direct cost plus applicable overhead of operating vending machines from allowable cost. If cost cannot be calculated, then income received may be used.

Line 9.--Enter any adjustments to the cost for meals served to patients. Under Part B of Medicare, only medical services are covered in an outpatient setting. Therefore, food costs must be excluded from the total costs.

Line 10.--Enter the total compensation of physician routine professional services which are paid under the MCP method and related to the care of patients. This must equal the amount on Worksheet A, column 7, line 19.

Line 11.--Enter the direct cost **including applicable overhead** of dialysis services furnished to a hospital under arrangements.

Lines 13 and 14.--Where capital-related expenses computed in accordance with the Medicare principles of reimbursement differ from capital-related expenses per your books, enter the difference on lines 13 and 14. (See CMS Pub. 15-I, chapter 1.)

Line 15.--Enter rebates taken on epoetin purchases.

Line 16.---Enter the cost of the approved drug epoetin (EPO) furnished to both in-facility and home ESRD patients. This amount must equal the amount on Worksheet A, column 7, line 23 less the amount, if any, entered on line 15 of this worksheet.

Lines 17 through 20.--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Appropriately label the line to indicate the nature of the required adjustments. The cost of malpractice insurance premiums paid by the facility specifically identified as physicians' malpractice premiums must be entered on this line.

Line 21.--Enter the sum of lines 1 through 20. Transfer the amounts in column 2 to Worksheet A, column 7.

3409. WORKSHEET A-3 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organization except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control. In addition, certain information concerning the related organizations with which you have transacted business is shown. (See CMS Pub. 15-I, chapter 10.)

Part A.--If there are any costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10, check "Yes" and complete Parts B and C.

If there are no costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10, check "No" and do not complete the rest of the form.

Part B.--Costs incurred and adjustments required for services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. Such cost must not exceed the amount a prudent and cost conscious buyer would pay for comparable services, facilities, or supplies that could be purchased elsewhere.

Complete each line as necessary and complete all columns for each of those lines.

Column 1.--Enter the line number from Worksheet A which corresponds to the cost center for which the adjustment is being made.

Column 2.--Enter the cost center from Worksheet A for which the adjustment is being made.

Column 3.--Enter the item of service, facility, or supply which you obtained from the related organization.

Column 4.--Enter the cost charged to your organization by the related organization for the service, facility, or supply which was obtained from the related organization.

Column 5.--Enter the allowable cost to your organization for the service, facility, or supply which was obtained from the related organization. The allowable cost is the lesser of the amount a prudent and cost conscious buyer pays for a comparable service, facility, or supply purchased elsewhere or the actual cost incurred by the related party. (See CMS Pub. 15-I, chapter 10.)

Column 6.--Enter the amount in column 4 less the amount in column 5. Transfer the(se) amount(s), as subtraction(s), to the corresponding line of Worksheet A, column 7.

Part C.--This part is used to show your interrelationship to organizations furnishing services, facilities, or supplies to you. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a financial interest in you, a common ownership of the facility, or control over the facility as defined in HCFA Pub. 15-I, chapter 10, must be shown in columns 1 through 6, as appropriate.

Complete only those columns which are pertinent to the type of relationship which exists.

Column 1.--Enter the appropriate symbol which describes your interrelationship to the related organization.

Column 2.--If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2.

Column 3.--If the individual in column 2 or the organization in column 4 has a financial interest in your facility, enter the percent of ownership in the facility.

Column 4.--Enter the name of the related corporation, partnership, or other organization.

Column 5.--If the individual in column 2 or your facility has a financial interest in the related organization, enter the percent of ownership in such organization.

Column 6.--Enter the type of business in which the related organization engages (e.g., laboratory drugs and/or supplies).

3410. WORKSHEET A-4 - STATEMENT OF TOTAL COMPENSATION TO OWNERS AND STATEMENT OF TOTAL COMPENSATION TO ADMINISTRATORS, ASSISTANT ADMINISTRATORS, AND/OR MEDICAL DIRECTORS OR OTHERS PERFORMING THESE DUTIES (OTHER THAN OWNERS)

Administrative services are those services directly related to the support of your facility and are not related directly to the dialysis patients' care. When listing the percent of work devoted to the business by a person who performs more than one duty, the person's combined percentage may not total over 100 percent. For example, if one person is both an administrator and a medical director, and he/she spends 60 percent of his/her workweek as an administrator, he/she can spend a maximum of only 40 percent as the medical director. Use a separate line per person per function. When one person performs more than one function, indicate this in column 1 by entering "same as line."

Part I shows the title, function, and percentage of time devoted to the business for the owners and employees related to the owners. In addition, show the total compensation (including fringe benefits, perquisites, and maintenance) included in allowable cost which was earned by sole proprietors, partners, and corporation officers, as owner(s) of your organization. Compensation is the total benefit received and receivable by the owner for the services he/she renders to the institution. It includes salary amounts earned for managerial, administrative, professional, and other services; the amounts paid by the institution for the personal benefit of the owner; the cost of the assets and services which the owner receives from the institution; and deferred compensation.

Part II shows the title, percent of time devoted to the business and total compensation (including fringe benefits, perquisites, and maintenance) earned by employed administrators, assistant administrators, medical directors, or others performing these duties. (See HCFA Pub. 15-I, §2723.3.)

3411. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND
WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Worksheet B provides for cost finding by using a combined methodology of cost centers and apportioning the costs to those cost centers which receive the services. The cost centers that are serviced include all cost centers within your organization; that is, separately billable, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet A, column 8.

Worksheet B-1 provides for the statistics necessary to allocate the cost to the revenue producing and nonreimbursable cost centers on Worksheet B.

To facilitate the allocation process, the general format of Worksheets B and B-1 are identical. The column and line numbers for the general service cost centers are identical on the two worksheets. In addition, the line numbers for each reimbursable and nonreimbursable cost center are identical on the two worksheets.

The statistical bases shown at the top of each column on Worksheet B-1 are the recommended bases of allocation of the cost centers indicated. Use these statistical bases of allocation unless you have intermediary approval in writing to use different bases. (See CMS Pub. 15-1, §2313.)

Certain cost centers are combined on Worksheet B-1 for cost allocation purposes. These combinations are not optional; that is, facilities must combine and allocate these costs as shown on the worksheet. The total costs of each combined group of cost centers are allocated in one process to the revenue producing and nonreimbursable cost centers.

Column Descriptions

Columns 6, 7, and 8.--These columns refer to drugs, supplies, and laboratory services, i.e., routine and nonroutine furnished to both Medicare and non-Medicare patients, furnished by, billed by, and reimbursed to your facility. Do not include any of these items and services that were billed by any physicians since these costs are not part of your facility's costs. To determine the costs allocated to the various cost centers, use actual costs if separate expense accounts are maintained, or allocate these costs based on the supplier's charge as reported on the costed requisitions. The cost or costed requisitions used for allocation purposes must bear a consistent relationship to the costs of all items and services. (See CMS Pub. 15-I, §§2710 and 2711.)

Line Descriptions

Items and services that are covered under the composite rate are those commonly furnished as part of a typical dialysis service. These costs are reimbursed through your dialysis rate and may not be separately billed. The costs of items and services covered under the composite payment rate are allocated to the various modes of treatment on lines 7 through 16, Worksheet B. The costs of separately billable items and services are not allocated to various modes of treatment because they are not considered one of the dialysis service costs that are used in computing the composite payment rate.

Line 2.--Separately billable injectable drugs are drugs that are not reimbursed under the composite payment rate but may be medically necessary for a patient. (See CMS Pub. 15-I, §2711.2.)

Effective for cost reporting periods beginning on or after January 1, 2005, A&G costs will no longer be allocated to separately billable drugs resulting in worksheet B, column 10, line 2 being shaded. However, for cost reporting periods which begin prior to January 1, 2005, worksheet B, column 10, line 2 shall remain unshaded.

Line 3.--These include medical supplies that are not related to the dialysis treatment. Facilities are primarily engaged in treating the patient's ESRD condition, and therefore this line should have a negligible or zero amount.

Line 4.--These lab tests are other than those included and explained in §207.1 of the Renal Dialysis Facility Manual. You may not bill for separately billable lab tests. They must be billed by the laboratory performing the tests. If you do not bill for these tests, then enter zeroes on this line.

Use the following procedures in completing these worksheets.

NOTE: EPO furnished to an in-facility ESRD beneficiary in a dialysis facility is paid by an add-on amount which is paid in addition to the composite rate for each administration of EPO. In the case of a home patient receiving EPO in a dialysis facility, only the add-on amount is paid. This is the only way payment is made when EPO is administered in a dialysis facility. Since only the cost of the EPO is included in this amount, there is no overhead to be allocated to the epoetin cost center. There is no line for EPO on these worksheets to accommodate this process.

1. Enter on Worksheet B-1, columns 2 through 10, line 22, and Worksheet B, columns 2 through 10, line 1, the following costs to be allocated. Obtain these costs from Worksheet A as follows:

<u>FROM</u>	<u>TO</u>
Worksheet A, column 8	Worksheet B-1, line 22 and Worksheet B, line 1
<u>Lines</u>	<u>Column</u>
5 Capital-Related, Operation and Maintenance of Plant and Housekeeping	2
6 Machine Capital-Related or Rental and Maintenance	3
7 Salaries for Direct Patient Care	4
8 Employee Health and Welfare Benefits for Direct Patient Care	5
9 Drugs	6
10 Supplies	7
11 Laboratory	8
18 Administrative and General and Other Cost Centers	10

2. On Worksheet B, column 1, line 1, enter the total of columns 2 through 10, line 1.

3. On Worksheet B, column 1, lines 5, 6, and 17 through 20, enter the direct costs of the revenue producing and nonreimbursable cost centers which are obtained from Worksheet A, column 8, lines 20 through 22 and 24 through 26 respectively.

4. On Worksheet B, column 1, line 21, enter the total of column 1, lines 1 through 20. This total must equal the amount on Worksheet A, column 8, line 27.

5. On Worksheet B-1, columns 2 through 8, enter on lines 2 through 20 the portion of the total statistical base over which the expenses of the cost centers are to be allocated. The statistical base to be used in each column is cited in the column heading and reflects only those statistics applicable to the revenue producing and nonreimbursable cost centers. Enter in columns 2 through 8, line 21, the sum of lines 2 through 20.

6. On Worksheet B-1, columns 2 through 8, line 23, determine the unit cost multiplier by dividing the amount on line 22 by the total statistics on line 21. The unit cost multiplier is rounded to the nearest six decimal places (e.g., \$4,000 / 15,000 square feet = .2666667).

7. On Worksheet B-1, multiply the appropriate unit cost multipliers computed in step 6 by the individual cost center statistics in columns 2 through 8. Enter the resulting amounts in the corresponding columns and lines of Worksheet B.

8. On Worksheet B, columns 2 through 8, enter on line 21 the sum of the amounts computed on lines 2 through 20. Do not include in these totals the amounts entered on line 1. For each column, the amount on line 21 must equal the amount on line 1.

9. On Worksheet B, column 9, lines 2 through 20, enter the sum of columns 1 through 8.

10. On Worksheet B, column 9, line 21, enter the total of lines 2 through 20. This total plus the amount in column 10, line 1, must equal the amount in column 1, line 21.

11. Transfer the total on Worksheet B, column 9, line 21, to Worksheet B-1, column 10, line 21. *For cost reporting periods beginning on or after January 1, 2005, transfer the total on Worksheet B, column 9, line 21, less the amount on Worksheet B, column 9, line 2 to Worksheet B-1, column 10, line 21.*

12. On Worksheet B-1, column 10, line 23, determine the unit cost multiplier by dividing the amount on line 22 by the amount on line 21.

13. Multiply the unit cost multiplier computed in step 12 by the individual cost center amounts on Worksheet B, column 9. Enter the resulting amounts on Worksheet B, column 10, lines 1 through 20. Enter on line 21 of Worksheet B the total of the amounts thus computed. The amount on line 21 must equal the amount on line 1.

14. On Worksheet B, column 11, lines 2 through 16 and lines 17 through 20, enter the total of columns 9 and 10.

15. On Worksheet B, column 11, line 16.01, enter the subtotal of lines 2 through 16.

16. On Worksheet B, column 11, line 21, enter the total of lines 16.01 through 20. The amount on line 21 must equal the amount in column 1, line 21.

17. Transfer the expenses from Worksheet B as follows:

<u>From Worksheet B</u>	<u>To</u>
Column 11, line 7	Worksheet C, column 2, line 1
Column 11, line 8	Worksheet C, column 2, line 2
Column 11, line 9	Worksheet C, column 2, line 3
Column 11, line 10	Worksheet C, column 2, line 4
Column 11, line 11	Worksheet C, column 2, line 5
Column 11, line 12	Worksheet C, column 2, line 6
Column 11, line 13	Worksheet C, column 2, line 7
Column 11, line 14	Worksheet C, column 2, line 8
Column 11, line 15	Worksheet C, column 2, line 9
Column 11, line 16	Worksheet C, column 2, line 10

The totals in column 11, lines 2 through 6 and lines 17 through 20, are not transferred because only the figures for the reimbursable cost centers are transferred to Worksheet C.

3412. WORKSHEET C - COMPUTATION OF AVERAGE COST PER TREATMENT

This worksheet records the apportionment of total costs to the types of dialysis treatment furnished by you and shows the computation of expenses of dialysis items and services that you furnished to Medicare dialysis patients. This information is used for overall program evaluation, determining the appropriateness of program reimbursement rates, and meeting statutory requirements of determining the cost of ESRD care. *For cost reporting periods that straddle April 1, 2005 where multiple payment rates are applicable for the portion of the cost reporting period prior to April 1, 2005, complete a separate Worksheet C for each rate period prior to April 1, 2005; and, subscript columns 4 and 6 on the penultimate Worksheet C to report the average composite rate for each modality in column 6.01 for services rendered on or after April 1, 2005. For cost reporting periods beginning on or after April 1, 2005, complete only one Worksheet C as only one average composite rate will apply to each modality.*

Column 1.--Enter the total number of treatments/patient weeks by type for all renal dialysis patients from your records. These statistics include all treatments furnished to all patients, both Medicare and non-Medicare.

Column 2.--Enter the total cost transferred from Worksheet B, column 11, lines 7 through 16.

Column 3.--The amounts entered are determined by dividing the cost entered on each line in column 2 by the number of treatments/patient weeks entered on each line in column 1.

Columns 4 through 7.--Refer only to treatments furnished to Medicare beneficiaries that were billed to and reimbursed by the program directly.

Column 4.--Enter the number of treatments billed to the Medicare program directly. Enter on lines 9 and 10 the patient weeks. Obtain this information from your records. *For cost reporting periods which straddle April 1, 2005, subscript this column by adding column 4.01 to identify total treatments rendered on or after April 1, 2005. Enter in column 4 the total number of treatments rendered prior to April 1, 2005. For cost reporting periods beginning on or after April 1, 2005, eliminate column 4.01 and enter all treatments in column 4.*

Column 5.--The amounts entered are determined by multiplying the number of treatments or patient weeks by the average cost per treatment entered on each corresponding line in column 3. Transfer the total from column 5, line 11, to Worksheet D, line 1. *For cost reporting periods which straddle April 1, 2005, enter the result of column 3 times the sum of columns 4 and 4.01.*

Column 6.--Enter your Medicare program payment rates by type of treatment for the cost reporting period. If your cost reporting period covers a time when you had more than one rate for a particular treatment type (e.g., the composite rate may have been updated or an exception amount approved during the period), complete a separate Worksheet C to calculate the total payment for each composite rate. When you complete a separate Worksheet C because more than one payment rate was in effect during the cost reporting period, also complete a summary Worksheet C showing the totals of the separate Worksheet Cs. Do not complete column 6 on the summary Worksheet C. However, complete columns 4, 5, and 7, which consist of the sum of the respective amounts computed on the separate Worksheet C for each payment rate. *For cost reporting periods which straddle April 1, 2005, subscript this column by adding column 6.01 and enter the average composite rate by type of treatment for services rendered on or after April 1, 2005. Enter in column 6 the standard payment rate for services rendered prior to April 1, 2005. For cost reporting periods beginning on or after April 1, 2005, eliminate column 6.01 and enter all average composite rates in column 6.*

The ESRD composite payment rate is an average payment calculated based on the total Medicare payments (by type of treatment) divided by the total corresponding ESRD treatments. For example, the total Medicare payment for Hemo Dialysis is divided by the total ESRD Hemo Dialysis treatments. For cost reporting periods which straddle April 1, 2005, columns 4 and 6 must be

subscribed. (See CR 3720 dated February 18, 2005.)

When the facility reports only one payment rate, enter the rate in column 6.

Column 7.--The amounts entered are determined by multiplying the number of treatments or patient weeks entered on each line in column 4 by the payment rate entered on each corresponding line in column 6. *For cost reporting periods which straddle April 1, 2005, add results of column 4 times column 6 and column 4.01 times column 6.01.*

Lines 9 and 10.--Report CAPD and CCPD in terms of weeks. Patient weeks are computed by totaling the number of weeks each patient dialyzed at home by CCPD and/or CAPD. Obtain this information from your records.

3413. WORKSHEET D - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII, PART B

Under the composite rate system, the intermediary pays the facility its allowable ESRD bad debts, up to the facility's reasonable costs as determined under Medicare principles. Allowable bad debts must relate to specific Medicare deductibles and coinsurance amounts. If you have completed more than one Worksheet C, make a consolidated bad debt computation.

Line 1.--Enter the amount from Worksheet C, column 5, line 11. If you have completed more than one Worksheet C, enter the sum of the total from each Worksheet C, column 5, line 11.

Line 2.--Enter the amount from Worksheet C, column 7, line 11, minus any applicable Part B deductibles. This represents the total reimbursement due to you which includes program payment plus the beneficiaries' liabilities for deductible and coinsurance amounts. It is equal to the sum of the number of Medicare treatments furnished, by mode of treatment, times the respective rate by mode. If you have completed more than one Worksheet C, enter the sum of the total from each Worksheet C, column 7, line 11.

Line 3.--Enter 80 percent of the amount on line 2.

Line 4.--Enter the amount on line 1 minus the amount on line 3.

Line 5.--Enter the amount shown in your records for deductibles and coinsurance billed to Medicare (Part B) patients. The deductibles and coinsurance only include the amounts relative to the expenses and payments listed on lines 1 and 2 that apply to Medicare beneficiaries under the composite payment rate. These amounts, at a minimum, should be 20 percent of the payment due on line 2.

Line 6.--To determine the amount to be entered on this line, you must determine what amount of the figure entered on line 5 is uncollectible. After determining the uncollectible amount, reduce any amount recovered during the cost reporting period covered by this report that had been uncollectible in a cost reporting period prior to the period covered by this report. The resulting amount is then entered on line 6.

Line 7.--Subtract the amount on line 6 from the amount on line 5 and enter the result.

Line 8.--Subtract the amount on line 7 from the amount on line 4 and enter the difference. If the amount on line 7 exceeds the amount on line 4, do not complete line 9.

Line 9.--Enter the lesser of the amount on line 6 or the amount on line 8.

Line 9.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount on line 9, i.e., line 9.01 is a subset of line 9. (1/1/2005b)

EXHIBIT 1- Form CMS-265-94

The following is a listing of the Form CMS –265-94 worksheets and the page number location.

<u>Worksheets</u>	<u>Page(s)</u>
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Wkst. S-1.....	34-304
Wkst. A	34-305
Wkst. A-1.....	34-306
Wkst. A-2.....	34-307
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting. Each electronic cost report submission (file) has three types of records. The first group (type one records) contains information for identifying, processing, and resolving problems. The text used throughout the cost report for variable line labels (e.g., Worksheet A) and variable column headers (Worksheet B-1) is included in the type two records. Refer to Table 5 for cost center coding. The data detailed in Table 3 are identified as type three records. The encryption coding at the end of the file, records 1, 1.01, and 1.02, are type 4 records.

The medium for transferring cost reports submitted electronically to fiscal intermediaries is 3½" diskette. These disks must be in IBM format. The character set must be ASCII. You must seek approval from your fiscal intermediary regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.
2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.
3. No record may exceed 60 characters.

Below is an example of a set of type 1 records with a narrative description of their meaning.

1	2	3	4	5	6
1234567890123456789012345678901234567890123456789012345678901234567890					
1	1	250000200400120043666A99P00120050312004366			

Record #1: This is a cost report file submitted by Provider 279999 for the period from January 1, 2004 (2004001) through December 31, 2004 (2004366). It is filed on FORM CMS-265-94. It is prepared with vendor number A99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is alpha. Positions 39 and 40 remain constant for approvals issued after the first test case. This file is prepared by the independent renal dialysis facility on January 31, 2005 (2005031). The electronic cost report specification dated December 31, 2004 (2004366) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:

RDNNNNNN.YYL, where

1. RD (Independent Renal Dialysis Facility Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit Medicare independent renal dialysis facility provider number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from independent renal dialysis facility with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	X	1	Constant "1"
2. NPI	10	9	2-11	Numeric only
3. Spaces	1	X	12	
4. Record Number	1	X	13	Constant "1"
5. Spaces	3	X	14-16	
6. ESRD Provider Number	6	9	17-22	Field must have 6 numeric characters.
7. Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8. Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9. MCR Version	1	X	37	Constant "6" (for FORM CMS-265-94)
10. Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 32-503.
11. Vendor Equipment	1	X	41	P = PC; M = Main Frame
12. Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13. Creation Date	7	9	45-51	YYYYDDD – Julian date; date on which the file was created (extracted from the cost report)
14. ECR Spec. Date	7	9	52-58	YYYYDDD – Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after <i>2005091 (4/1/2005). Prior approval(s) 2004366.</i>

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Numbers 2 - 99

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	9	1	Constant "1"
2. Spaces	10	X	2-11	
3. Record Number	2	9	12-13	#2-99 - Reserved for future use.
4. Spaces	7	X	14-20	Spaces (optional)
5. ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	9	1	Constant "2"
2. Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3. Spaces	2	X	9-10	
4. Line Number	3	9	11-13	Numeric
5. Subline Number	2	9	14-15	Numeric
6. Column Number	3	X	16-18	Alphanumeric
7. Subcolumn Number	2	9	19-20	Numeric
8. Cost Center Code	4	9	21-24	Numeric. Refer to Table 5 for appropriate cost center codes.
9. Labels/Headings				
a. Line Labels	36	X	25-60	Alphanumeric, left justified
b. Column Headings Statistical Basis & Code	10	X	21-30	Alphanumeric, left justified

The type 2 records contain both the text that appears on the pre-printed cost report and any labels added by the preparer. Of these, there are three groups: (1) Worksheet A cost center names (labels); (2) column headings for stepdown entries; and (3) other text appearing in various places throughout the cost report.

A Worksheet A cost center label must be furnished for every cost center with cost or charge data anywhere in the cost report. The line and subline numbers for each label must be the same as the line and subline numbers of the corresponding cost center on Worksheet A. The columns and subcolumn numbers are always set to zero.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 1 - RECORD SPECIFICATIONS

Column headings for the General Service cost centers on Worksheets B and B-1 are supplied once. They consist of one to three records. Each statistical basis shown on Worksheet B-1 is also to be reported. The statistical basis consists of one or two records (lines 4-5). Statistical basis code is supplied only to Worksheet B-1 columns and is recorded as line 6. The statistical code must agree with the statistical bases indicated on lines 4 and 5, i.e., code 1 = square footage, code 2 = dollar value, and code 3 = all others. Refer to Table 2 for the special worksheet identifier to be used with column headings and statistical basis and to Table 3 for line and column references.

The following type 2 cost center descriptions are to be used for all Worksheet A standard cost center lines.

<u>Line</u>	<u>Description</u>
1	CAP REL COSTS-BLDG & FIXT
2	CAP REL COSTS-MVBLE EQUIP
3	OPERATION & MAINTENANCE OF PLANT
4	HOUSEKEEPING
6	MACHINE CAP-REL OR RENTAL & MAINT
7	SALARIES FOR DIRECT PATIENT CARE
8	EMP HEALTH & WELFARE BENEFITS
9	DRUGS
10	SUPPLIES
11	LABORATORY
12	ADMINISTRATIVE & GENERAL
13	INTEREST EXPENSE
14	LAUNDRY AND LINEN
15	MEDICAL RECORDS
16	PHY ROUT PRO SERVICES-INITIAL METHOD
19	PHY ROUT PRO SERVICES-MCP METHOD
20	WHOLE BLOOD & PACKED RED BLOOD CELLS
21	HEPATITIS B VACCINE
22	PHYSICIANS' PRIVATE OFFICES
23	EPOETIN
24	METHOD II PATIENTS (DIRECT DEALING)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 1 - RECORD SPECIFICATIONS

Type 2 records for Worksheet B-1, columns 2-8, for lines 1-6 are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

		LINE				
	1	2	3	4	5	6
	CAP REL OP	OF MAINT	& HOUSE	SQUARE	FEET	1
2	MACH CAP	REL OR	& MAINT	PERCENT OF	TIME SPENT	3
	<i>SALARIES</i>	REN	<i>PAT CARE</i>	HRS OF	SERVICE	
3	<i>EMP</i> H&W	FOR DIRECT	DIR PAT CR	GROSS	SALARIES	
	DRUGS	BENEFITS		CHARGES		
4	SUPPLIES			CHARGES		
	LABORATORY			CHARGES		
5						
6						
7						
8						

Examples of type 2 records are below. Either zeros or spaces may be used in the line, subline, column, and subcolumn number fields (positions 11-20). However, spaces are preferred. Refer to Table 5 and 6 for additional cost center code requirements.

Examples:

Worksheet A line labels with embedded cost center codes:

2A000000	1	0100CAP REL COSTS-BLDG & FIXT
2A000000	2	0200CAP REL COSTS-MVBLE EQUIP
2A000000	9	0900DRUGS
2A000000	15	1500MEDICAL RECORDS
2A000000	19	1900PHY ROUT PRO SERVICES-MCP METHOD
2A000000	23	2300EPOETIN

Examples of column headings for Worksheets B-1 and B; statistical bases used in cost allocation on Worksheet B-1; and statistical codes used for Worksheet B-1 (line 6) are displayed below.

2B10000*	1	2	CAP REL OP
2B10000*	2	2	OF MAINT
2B10000*	3	2	& HOUSE
2B10000*	4	2	SQUARE
2B10000*	5	2	FEET
2B10000*	6	2	1
2B10000*	1	3	MACH CAP
2B10000*	2	3	REL OR REN
2B10000*	3	3	& MAINT
2B10000*	4	3	PERCENT OF
2B10000*	5	3	TIME SPENT

2B10000* 6 3 3

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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 3 Records for Nonlabel Data

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	9	1	Constant "3"
2. Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3. Spaces	2	X	9-10	
4. Line Number	3	9	11-13	Numeric
5. Subline Number	2	9	14-15	Numeric
6. Column Number	3	X	16-18	Alphanumeric
7. Subcolumn Number	2	9	19-20	Numeric
8. Field Data				
a. Alpha Data	36	X	21-56	Left justified. (Y or N for yes/no answers; dates must use MM/DD/YYYY format - slashes, no hyphens.) Refer to Table 6 for additional requirements for alpha data.
	4	X	57-60	Spaces (optional).
b. Numeric Data	16	9	21-36	Right justified. May contain embedded decimal point. Leading zeros are suppressed; trailing zeros to the right of the decimal point are not. Positive values are presumed; no A+@ signs are allowed. Use leading minus to specify negative values. Express percentages as decimal equivalents, i.e., 8.75% is expressed as .087500. All records with zero values are dropped. Refer to Table 6 for additional requirements regarding numeric data.

A sample of type 3 records are below.

3A000000	12	1	36000
3A000000	15	2	12064
3A000000	19	1	144000

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 1 - RECORD SPECIFICATIONS

The line numbers are numeric. In several places throughout the cost report (see list below), the line numbers themselves are data. The placement of the line and subline numbers as data must be uniform.

Worksheet A-1, columns 3 and 6
Worksheet A-2, column 4
Worksheet A-3, Part B, column 1

Examples of records (*) with a Worksheet A line number as data are below.

	3A100010	1	0	EMP. HEALTH & WELFARE BENE	
	3A100010	1	1	A	
*	3A100010	1	3		8.00
	3A100010	1	4		61743
*	3A100010	1	6		12.00
	3A100010	1	7		82263
	3A100010	2	0	EMP HEALTH & WELFARE BENE	
	3A100010	2	1	A	
*	3A100010	2	3		19.00
	3A100010	2	4		20520
	3A200000	17	0	MIS INCOME	
	3A200000	17	1	B	
	3A200000	17	2		-1993
*	3A200000	17	4		12.00
*	3A30000B	1	1		11.00
	3A30000B	1	3	LABORATORY	
	3A30000B	1	4		23121
	3A30000B	1	5		18000

RECORD NAME: Type 4 Records - File Encryption

This type 4 record consists of 3 records: 1, 1.01, and 1.02. These records are created at the point in which the ECR file has been completed and saved to disk and insures the integrity of the file.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 2 - WORKSHEET INDICATORS

This table contains the worksheet indicators that are used for electronic cost reporting. A worksheet indicator is provided for only those worksheets for which data are to be provided.

The worksheet indicator consists of seven digits in positions 2-8 of the record identifier. The first two digits of the worksheet indicator (positions 2 and 3 of the record identifier) always show the worksheet. The third digit of the worksheet indicator (position 4 of the record identifier) is always 0. For Worksheets A-1 and A-2, if there is a need for extra lines on multiple worksheets, the fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record identifier) identify the page number. The seventh digit of the worksheet indicator (position 8 of the record identifier) represents the worksheet or worksheet part.

Worksheets That Apply to the Independent Renal Dialysis Facility Cost Report

<u>Worksheet</u>	<u>Worksheet Indicator</u>	
S, Part I	S000001	
S-1	S100000	
A	A000000	
A-1	A100010	(a)
A-2	A200000	
A-3, Part A	A30000A	
A-3, Part B	A30000B	
A-3, Part C	A30000C	
A-4, Part I	A400001	
A-4, Part II	A400002	
B-1 (For use in column headings)	B10000*	
B	B000000	
B-1	B100000	
C	C000010	(b)
D	D000000	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES:

(a) Multiple Worksheets for Reclassifications and Adjustments Before Stepdown

The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01-99 to accommodate reports with more lines on Worksheets A-1. For reports that do not need additional worksheets, the default is 01. For reports that do need additional worksheets, the first page is numbered 01. The number for each additional page of the worksheet is incremented by 1.

b) Multiple ESRD Payment Rates

The sixth digit of the worksheet indicator (position 7 of the record) is numeric from 1 to 9 to accommodate two or more payment rates in effect during one cost reporting period. If there is only a single payment rate, the default is 1. This applies only to Worksheet C. *NOTE: For cost reporting periods beginning on or after April 1, 2005, the sixth digit of the worksheet indicator (position 7 of the record) will always default to 1, as Worksheet C is no longer subscriptable.*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
DESIGNATIONS

This table identifies those data elements necessary to calculate a independent renal dialysis cost report. It also identifies some figures from a completed cost report. These calculated fields (e.g., Worksheet B, column 8) are needed to verify the mathematical accuracy of the raw data elements and to isolate differences between the file submitted by the independent renal dialysis facility and the report produced by the fiscal intermediary. Where an adjustment is made, that record must be present in the electronic data file. For explanations of the adjustments required, refer to the cost report instructions.

Table 3 "Usage" column is used to specify the format of each data item as follows:

9	Numeric, greater than or equal to zero.
-9	Numeric, may be either greater than, less than, or equal to zero.
9(x).9(y)	Numeric, greater than zero, with x or fewer significant digits to the left of the decimal point, a decimal point, and exactly y digits to the right of the decimal point.
X	Character.

Consistency in line numbering (and column numbering for general service cost centers) for each cost center is essential. The sequence of some cost centers does change among worksheets.

Table 3 refers to the data elements needed from a standard cost report. When a standard line is subscripted, the subscripted lines must be numbered sequentially with the first subline number displayed as "01" or " 1" (with a space preceding the 1) in field locations 14-15. It is unacceptable to format in a series of 10, 20, or skip subline numbers (i.e., 01, 03), except for skipping subline numbers for prior year cost center(s) deleted in the current period or initially created cost center(s) no longer in existence after cost finding. Exceptions are specified in this manual. For Other (specify) lines, i.e., Worksheet settlement series, all subscripted lines should be in sequence and consecutively numbered beginning with subscripted line number 01. Automated systems should reorder these numbers where providers skip or delete a line in the series.

Drop all records with zero values from the file. Any record absent from a file is treated as if it were zero.

All numeric values are presumed positive. Leading minus signs may only appear in data with values less than zero that are specified in Table 3 with a usage of "-9". Amounts that are within preprinted parentheses on the worksheets, indicating the reduction of another number, are reported as positive values.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S				
Name	1	1	36	X
Street	1.01	1	36	X
P.O. Box	1.01	2	9	X
City	1.02	1	36	X
State	1.02	2	2	X
Zip Code	1.02	3	10	X
County	1.03	1	36	X
Facility Number (xxxxxxx)	2	1	6	X
Date Certified (MM/DD/YYYY)	3	1	10	X
Name	4	1	36	X
Phone number (xxx-xxx-xxxx)	4	2	12	X
Cost reporting period beginning date (MM/DD/YYYY)	5	1	10	X
Cost reporting period ending date (MM/DD/YYYY)	5	2	10	X
Type of control: (See Table 3B)	6	1	2	9
Other(Specify)	6	2	36	X
Type of physicians' reimbursement: (See Table 3B)	7	1	1	9
Date of election of initial method (MM/DD/YYYY)	7	2	10	X
Was this facility previously certified as a Hospital-based unit/ (y/n)	8	1	1	X
If you are part of a chain organization check "yes", otherwise check "no". (y/n)	9	1	1	X
If you checked "yes", enter the				
Name	9.01	1	36	X
Street	9.02	1	36	X
P.O. Box	9.02	2	9	X
City	9.03	1	36	X
State	9.03	2	2	X
Zip code of the organization	9.03	3	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-1				
Renal Dialysis Statistics				
Number of treatments not billed to Medicare and furnished directly	1	1-4	11	9
Number of treatments not billed to Medicare and furnished under arrangement	2	1-4	11	9
Number of patients currently in dialysis program	3	1-4	11	9
Average time per week patient receives dialysis	4	1-4	5	9(2).99
Number of days in average week for patient dialysis treatments	5	1-4	4	9.99
Average time of patient dialysis treatment including set up time	6	1-4	5	9(2).99
Number of machines regularly available for use	7	1-4	11	9
Number of standby machines	8	1-4	11	9
Number of shifts in typical week during regular reporting period	9	1-4	11	9
Hours per shift in typical week during regular reporting period:				
First shift	10.01	1-4	9	9
Second shift	10.02	1-4	9	9
Third shift	10.03	1-4	9	9
Number of treatments provided:				
One (1) time per week	11.01	1-4	11	9
Two (2) times per week	11.02	1-4	11	9
Three (3) times per week	11.03	1-4	11	9
More than three (3) times per week	11.04	1-4	11	9
Total Treatments	11.05	1-4	11	9
Type of dialyzers used: (See Table 3C)	12	1	1	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-1 (Continued)				
If dialyzers are reused, indicate the number of times	12	2	11	9
If other is selected, specify type	12	3	36	X
Number of back-up sessions furnished to home patients:				
CAPD	13	1	11	9
Other	13	2	11	9
CCPD	13	3	11	9
Number of units of epoetin furnished during cost reporting period	14	1	11	9
Transplant Statistics:				
Number of patients who are awaiting transplants	15	1	11	9
Number of patients who received transplants during this period	16	1	11	9
Home Program:				
Number of patients commencing home dialysis training during this period	17	1	11	9
Number of patients currently in home program	18	1	11	9
Types of dialyzers used: (See Table 3C)	19	1	1	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-1(Continued)				
If dialyzers are reused, indicate the number of times:	19	2	11	9
If other is selected, specify type	19	3	36	X
Number of hours in a normal work week	20	0	6	9(3).99
Text as needed for blank line	29	0	36	X
Number of full time equivalent employees				
Staff	20-29	1	6	9(3).99
Contract	20-29	2	6	9(3).99
WORKSHEET A				
Physicians salaries by department	9-12,14-17,19-26	1	9	-9
Total physicians salaries	27	1	9	9
Other salaries by department	3-4,6-12,14-17,20-26	2	9	-9
Total other salaries	27	2	9	9
Other direct costs by department	1-4,6,8-17,19-26	3	9	-9
Total other direct costs	27	3	9	9
Net expenses for allocation by department	1-4,6-17,19-26	8	9	-9
Total expenses for allocation	27	8	9	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET A-1				
For each expense reclassification:				
Explanation	1-35	0	36	X
Reclassification identification code	1-35	1	2	X
Increases:				
Worksheet A line number	1-35	3	6	9(3).99
Reclassification amount	1-35	4	9	9
Decreases:				
Worksheet A line number	1-35	6	6	9(3).99
Reclassification amount	1-35	7	9	9
WORKSHEET A-2				
Description of adjustment	17-20	0	36	X
Basis (A or B)	1,3-6,8-20	1	1	X
Amount	1-6,8-20,	2	9	-9
Worksheet A line number	1,3-6, 8-9,11,12, 17-20	4	6	9(3).99
WORKSHEET A-3				
<u>Part A</u> - Are there any related organization costs included on Worksheet A? (Y/N)	1	1	1	X
<u>Part B</u> - For costs incurred and adjustments required as a result of transactions with related organization(s):				
Worksheet A line number	1-4	1	6	9(3).99
Expense item(s)	1-4	3	36	X
Amount included in Worksheet A	1-4	4	9	-9
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
 DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET A-3 (Continued)				
Amount allowable in reimbursable cost	1-4	5	9	-9
<u>Part C</u> - For each related organization:				
Type of interrelationship (A through G)	1-4	1	1	X
If type is G, specify description of relationship	1-4	0	36	X
Name of related individual or organization	1-4	2	36	X
Percentage of ownership	1-4	3	6	9(3).99
organization Name of related individual or organization	1-4	4	36	X
provider Percentage of ownership of	1-4	5	6	9(3).99
Type of business	1-4	6	36	X
WORKSHEET A-4				
Owners Compensation-Part I				
Title	1-10	1	36	X
Function	1-10	2	36	X
Sole proprietorship				
Percentage of work week devoted to business	1-10	3	6	9(3).99
Partners				
(loss) Percent share of operating profit	1-10	4A	6	9(3).99
business Percentage of week devoted to	1-10	4B	6	9(3).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET A-4 (Continued)				
Corporation				
Percent of provider's stock owned	1-10	5A	6	9(3).99
to Percentage of work week devoted business	1-10	5B	6	9(3).99
allowable Total compensation included in cost	1-10	6	11	9
Part II				
Title	1-10	1	36	X
to Percentage of work week devoted business	1-10	2	6	9(3).99
Total compensation	1-10	3	11	9

WORKSHEETS B and B-1

Column heading (cost center name)	1-3 +	2-9	10	X
Statistical basis	4, 5 +	2-9	10	X

- + Refer to Table 1 for specifications and Table 2 for the worksheet identifier for column headings. There may be up to five type 2 records (3 for cost center name and 2 for the statistical basis) for each column. However, for any column that has less than five type 2 record entries, blank records or the word blank is not required to maximize each column record count.

WORKSHEET B

Costs after cost finding by department	2-20 (excluding line 16.01)	11	9	-9
Total costs after cost finding	21	11	9	9

WORKSHEET B-1

All cost allocation statistics	2-20	2-8	9	9
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET C				
Total number of treatments	1-8,11	1	11	9
Total CAPD patient weeks	9	1	11	9
Total CCPD patient weeks	10	1	11	9
Number of treatments-Medicare	1-8,11	4 & 4.01	11	9
CAPD patient weeks-Medicare	9	4 & 4.01	11	9
CCPD patient weeks-Medicare	10	4 & 4.01	11	9
Payment Rates	1-10	6 & 6.01	6	9(3).99
WORKSHEET D				
Total expenses related to care of Medicare beneficiaries	1	1	11	9
<i>Total Payment Due</i>	<i>2</i>	<i>1</i>	<i>11</i>	<i>9</i>
Part B deductibles & coinsurance billed	5	1	11	9
Reimbursable bad debts	6	1	11	9
<i>Reimbursable bad debts for dual eligible beneficiaries</i>	<i>9.01</i>	<i>1</i>	<i>11</i>	<i>9</i>

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet B

TABLE 3B-TABLES TO WORKSHEET S

Type of Control

- 1 = Voluntary Non Profit, Corporation
- 2 = Voluntary Non Profit, Other
- 3 = Proprietary, Individual
- 4 = Proprietary, Corporation
- 5 = Proprietary, Partnership
- 6 = Proprietary, Other
- 7 = Government, Federal
- 8 = Government, State
- 9 = Government, County
- 10 = Government, City
- 11 = Government, Other

Type of Reimbursement

- 1 = Initial Method
- 2 = MCP Method

TABLE 3C-TABLES TO WORKSHEET S-1

Type of Dialyzers Used

- 1 = Hollow Fiber
- 2 = Parallel Plate
- 3 = Coil
- 4 = Other

TABLE 3D- LINES THAT CANNOT BE SUBSCRIBED
(BEYOND THOSE PREPRINTED)

<u>Worksheet</u>	<u>Lines</u>
S	1-9
S-1	<i>1-11, 13-18, 20-28</i>
A	5,18,27
A-1	1-36
A-2	1-16,21
A-3-Part A	All
A-3, Part B	1-3,5
A-3, Part C	1-3
A-4, Part I	1-9
A-4, Part II	1-9
B	1-19, 21
B-1	1-19,21-23
C	ALL
D	<i>1-8</i>

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 5 - COST CENTER CODING

INSTRUCTIONS FOR PROGRAMMERS

Cost center coding is required because there are thousands of unique cost center names in use by providers. Many of these names are peculiar to the reporting provider and give no hint as to the actual function being reported. Using codes to standardize meanings makes practical data analysis possible. The method to accomplish this must be rigidly controlled to assure accuracy.

For any added cost center names (the preprinted cost center labels must be precoded), preparers must be presented with the allowable choices for that line or range of lines from the lists of standard and nonstandard descriptions. They then select a description that best matches their added label. The code associated with the matching description, including increments due to choosing the same description more than once, will then be appended to the user's label by the software.

Additional guidelines are:

- Do not allow any pre-existing codes for the line to be carried over.
- Do not precode all Other lines.
- For cost centers, the order of choice must be standard first, then specific nonstandard, and finally the nonstandard "Other . . ."
- For the nonstandard "Other . . .", prompt the preparers with, "Is this the most appropriate choice?," and then offer the chance to answer yes or to select another description.
- Allow the preparers to invoke the cost center coding process again to make corrections.
- For the preparers' review, provide a separate printed list showing their added cost center names on the left with the chosen standard or nonstandard descriptions and codes on the right.
- On the screen next to the description, display the number of times the description can be selected on a given report, decreasing this number with each usage to show how many remain. The numbers are shown on the cost center tables.
- Do not change standard cost center lines, descriptions and codes. The acceptable formats for these items are listed on page 34-524 of the Standard Cost Center Descriptions and Codes. The proper line number is the first two digits of the cost center code.

INSTRUCTIONS FOR PREPARERS

Coding of Cost Center Labels

Cost center coding standardized the meaning of cost center labels used by health care providers on the Medicare cost reporting forms. The use of this coding methodology allows providers to continue to use their labels for cost centers that have meaning within the individual institution.

The four digit codes that are required to be associated with each label provide standardized meaning for data analysis. Normally, it is necessary to code only added labels because the preprinted standard labels are automatically coded by CMS approved cost report software.

Additional cost center descriptions have been identified. These additional descriptions are hereafter referred to as the nonstandard labels. Included with the nonstandard descriptions is an "Other . . ." designation to provide for situations where no match in meaning can be found. Refer to Worksheet A, line 17 or 26.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 5 - COST CENTER CODING**

Both the standard and nonstandard cost center descriptions along with their cost center codes are shown on Table 5. The "use" column on that table indicates the number of times that a given code can be used on one cost report. You are required to compare your added label to the descriptions shown on the standard and nonstandard tables for purposes of selecting a code. Most CMS approved software provides an automated process to present you with the allowable choices for the line/column being coded and automatically associates the code for the selected matching description with your label.

Additional Guidelines

Categories

Make a selection from the proper category such as general service description for general service lines, nonreimbursable cost center descriptions for nonreimbursable cost center lines, etc.

Use of a Cost Center Coding Description More Than Once

Often a description from the "standard" or "nonstandard" tables applies to more than one of the labels being added or changed by the preparer. In the past, it was necessary to determine which code was to be used and then increment the code number upwards by one for each subsequent use. This was done to provide a unique code for each cost center label. Now, most approved software associate the proper code, including increments as required, once a matching description is selected. Remember to use your label. You are matching to CMS's description only for coding purposes.

Cost Center Coding and Line Restrictions

Use cost center codes only in designated lines in accordance with the classification of cost center(s), e.g., lines 22 through 26 may only contain cost center codes within the nonreimbursable services cost center category of both standard and nonstandard coding. Refer to Table 1 for Type 2 cost center descriptions.

STANDARD COST CENTER DESCRIPTIONS AND CODES

	<u>CODE</u>	<u>USE</u>
GENERAL SERVICE COST CENTERS		
Capital Related - Buildings and Fixtures	0100	(01)
Capital Related - Movable Equipment	0200	(01)
Operation and Maintenance of Plant	0300	(01)
Housekeeping	0400	(01)
Machine Capital-Related or Rental and Maintenance	0600	(01)
Salaries for Direct Patient Care	0700	(01)
Emp. Health & Welfare Benefits for Direct Patient Care	0800	(01)
Drugs	0900	(01)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES (Continued)

Supplies	1000	(01)
Laboratory	1100	(01)
Administrative and General	1200	(01)
Interest Expense	1300	(01)
Laundry and Linen	1400	(01)
Medical Records	1500	(01)
Physicians' Routine Professional Services-Initial Method	1600	(01)
Physicians' Routine Professional Services-MCP Method	1900	(01)
Whole Blood and Packed Red Blood Cells	2000	(01)
Hepatitis B Vaccine	2100	(01)
NON REIMBURSABLE COST CENTER		
Physicians' Private Offices	2200	(01)
Epoetin	2300	(01)
Method II Patients (Direct Dealing)	2400	(01)

NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

	<u>CODE</u>	<u>USE</u>
GENERAL SERVICE COST CENTERS		
Other	1700	(10)
NONREIMBURSABLE COST CENTERS		
Other Nonreimbursable	2500	(01)
Other Nonreimbursable	2600	(10)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 6 - EDITS

Medicare cost reports submitted electronically must be subjected to various edits, which are divided into two categories: Level I and level II edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software that produces an electronic cost report file for Medicare ESRD must automate all of these edits. Failure to properly implement these edits may result in the suspension of a vendor's system certification until corrective action is taken. The vendor's software should provide meaningful error messages to notify the home health agency of the cause of every exception. The edit message generated by the vendor systems must contain the related 4 digit and 1 alpha character, where indicated, reject/edit code specified below. Any file containing a level I edit will be rejected by your fiscal intermediary without exception.

Level I edits (1000 series reject codes) test that the file conforms to processing specifications, identifying error conditions that would result in a cost report rejection. These edits also test for the presence of some critical data elements specified in Table 3. Level II edits (2000 series edit codes) identify potential inconsistencies and/or missing data items that may have exceptions and should not automatically cause a cost report rejection. Resolve these items and submit appropriate worksheets and/or data supporting the exceptions with the cost report. Failure to submit the appropriate data with your cost report may result in payments being withheld pending resolution of the issue(s).

The vendor requirements (above) and the edits (below) reduce both intermediary processing time and unnecessary rejections. Vendors should develop their programs to prevent their client home health agencies from generating either a hard copy substitute cost report or electronic cost report file where level I edits exist. Ample warnings should be given to the provider where level II edit conditions are violated.

NOTE: Dates in brackets [] at the end of an edit indicate the effective date of that edit for cost reporting periods ending on or after that date. Dates followed by a "b" are for cost reporting periods beginning on or after the specified date. Dates followed by an "s" are for services rendered on or after the specified date unless otherwise noted. [10/31/2000]

I. Level I Edits (Minimum File Requirements)

<u>Reject Code</u>	<u>Condition</u>
1000	The first digit of every record must be either 1, 2, 3, or 4 (encryption code only). [12/31/2004]
1005	No record may exceed 60 characters. [12/31/2004]
1010	All alpha characters must be in upper case. This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [12/31/2004]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [12/31/2004]
1020	The independent renal dialysis facility provider number (record #1, positions 17-22) must be valid and numeric. [12/31/2004]
1025	All dates (record #1, positions 23-29, 30-36, 45-51, and 52-58) must be in Julian format and legitimate. [12/31/2004]
1030	The fiscal year beginning date (record #1, positions 23-29) must be less than the fiscal year ending date (record #1, positions 30-36). [12/31/2004]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94

TABLE 6 - EDITS

<u>Reject Code</u>	<u>Condition</u>
1035	The vendor code (record #1, positions 38-40) must be a valid code. [12/31/2004]
1050	The type 1 record #1 must be correct and the first record in the file. [12/31/2004]
1055	All record identifiers (positions 1-20) must be unique. [12/31/2004]
1060	Only a Y or N is valid for fields which require a Yes/No response. [12/31/2004]
1075	Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [12/31/2004]
1080	For every line used on Worksheets A, there must be a corresponding type 2 record. [12/31/2004]
1090	Fields requiring numeric data (charges, treatments, costs, FTEs, etc.) may not contain any alpha character. [12/31/2004]
1100	In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [12/31/2004]
1005S	The cost report ending date (Worksheet S, column 2, line 4) must be on or after December 31, 2004. [12/31/2004]
1015S	The cost report period beginning date (Worksheet S, column 1, line 5) must precede the cost report ending date (Worksheet S, column 2, line 5). [12/31/2004]
1020S	The independent renal dialysis facility name, address, provider number, and certification date (Worksheet S, line 1, column 1; line 1.01, column 1; line 1.02, columns 1, 2, & 3; and line 1.03, column 1) must be present and valid. [12/31/2004]
<i>1021S</i>	<i>The type of control (Worksheet S, line 6, column 1) must be present and a valid code of 1 thru 11. [4/1/2005]</i>
1025S	The independent renal dialysis total number of hours per work week must be greater than zero (0) (Worksheet S-1, line 20, column 0). [12/31/2004]
1030S	The total number FTEs for Social Workers must be greater than zero (0) (Worksheet S-1, line 25, sum of columns 1 and 2). [12/31/2004]
1000A	All amounts reported on Worksheet A, columns 1-3, line 27, must be greater than or equal to zero. [3/31/1997]
1020A	For reclassifications reported on Worksheet A-1 the sum of all increases (column 4) must equal the sum of all decreases (column 7). [12/31/2004]
1025A	For each line on Worksheet A-1, if there is an entry in columns 3, 4, 6, or 7, there must be an entry in column 1. There must be an entry on each line of column 4 for each entry in column 3 (and vice versa), and there must be an entry on each line of column 7 for each entry in column 6 (and vice versa). [12/31/2004]
1040A	For Worksheet A-2 adjustments on lines <i>1,3-6,8,9,11</i> , and <i>12</i> , and if either columns 2 or 4 has an entry, then both columns 2 and 4 must have entries, and if any one of columns 0, 1, 2, or 4 for lines 17-20 and subscripts thereof has an entry, then all columns 0, 1, 2, and 4 must have entries. Only valid line numbers may be used in column 4. [12/31/2004]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 6 - EDITS

<u>Reject Code</u>	<u>Condition</u>
1045A	If there are any transactions with related organizations or home offices as defined in CMS Pub. 15-I, chapter 10 (Worksheet A-3, Part A, column 1, line 1 is "Y"), Worksheet A-3, Part B, columns 4 or 5, sum of lines 1-4 must be greater than zero; and Part C, column 1, any one of lines 1-4 must contain any one of alpha characters A through G. Conversely, if Worksheet A-3, Part A, column 1, line 1 is "N", Worksheet A-3, Parts B and C must not be completed. [12/31/2004]
1000B	On Worksheet B-1, all statistical amounts must be greater than or equal to zero. [4/1/2005]
<i>1010B</i>	<i>Edit 1010B - For each overhead cost center with a net expense for cost allocation greater than zero (Worksheet A, column 8, lines 1-4 & 6-11, respectively), the corresponding total cost allocation statistics (Worksheet B-1, columns 2-8, respectively, sum of lines 2-20) must also be greater than zero. Exclude from this edit any column that uses accumulated cost as its basis for allocation and any reconciliation column. [4/1/2005]</i>
1005B	Worksheet B, column 11, line 21 must be greater than zero. [12/31/2004]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 6 – EDITS

II. Level II Edits (Potential Rejection Errors)

These conditions are usually, but not always, incorrect. These edit errors should be cleared when possible through the cost report. When corrections on the cost report are not feasible, provide additional information in schedules, note form, or any other manner as may be required by your fiscal intermediary (FI). Failure to clear these errors in a timely fashion, as determined by your FI, may be grounds for withholding payments.

<u>Edit</u>	<u>Condition</u>
2000	All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts). [12/31/2004]
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file . [12/31/2004]
2010	The cost center codes (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique. [12/31/2004]
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code. [12/31/2004]
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [12/31/2004]
2025	Only nonstandard cost center codes within a cost center category may be placed on standard cost center lines of that cost center category. [12/31/2004]
2030	The standard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [12/31/2004]

<u>Cost Center</u>	<u>Line</u>	<u>Code</u>
Cap Rel-Bldg & Fixt	1	0100
Cap Rel-Mvble Equip	2	0200
Operation and Maintenance of Plant	3	0300
Housekeeping	4	0400
Machine Cap-Rel or Rental and Maintenance	6	0600
Salaries for Direct Patient Care	7	0700
Emp. Health and wel Bene for Direct Pat Care	8	0800
Drugs	9	0900
Supplies	10	1000
Laboratory	11	1100
Administrative and General	12	1200

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 6 – EDITS

<u>Edit</u>	<u>Condition</u>	<u>Line</u>	<u>Code</u>
	<u>Cost Center</u>		
	Interest Expense	13	1300
	Laundry and Linen	14	1400
	Medical Records	15	1500
	Phy Routine Pro Services-Initial Method	16	1600
	Phy Routine Pro Services-MCP Method	19	1900
	Whole Blood and Packed Red Blood Cells	20	2000
	Hepatitis B Vaccine	21	2100
	Physicians' Private Offices	22	2200
	Epoetin	23	2300
	Method II Patients (Direct Dealing)	24	2400
2035	The administrative and general standard cost center code (1200) may appear only on line 12. [12/31/2004]		
2040	All calendar format dates must be edited for 10 character format, e.g., 01/01/2004 (MM/DD/YYYY). [12/31/2004]		
2045	All dates must be possible, e.g., no "00", no "30", or "31" of February. [12/31/2004]		
2015S	The independent renal dialysis facility certification date (Worksheet S, column 1, line 3) should be on or before the cost report beginning date (Worksheet S, column 1, line 5). [12/31/2004]		
2020S	The length of the cost reporting period should be greater than 27 days and less than 459 days. [12/31/2004]		
2100S	The following statistics from Worksheet S-1, should be greater than zero:		
	a. Total treatments for the independent renal dialysis facility (column 1-4, line 11.05) [12/31/2004]		

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 6 - EDITS

<u>Edit</u>	<u>Condition</u>
2000A	Worksheet A-1, column 1 (reclassification code) must be alpha characters. [12/31/2004]
2020A	Worksheet A-3, Part A, must contain a "Y" or "N" response. [12/31/2004]
2000B	At least one cost center description (lines 1-3), at least one statistical basis label (lines 4-5), and one statistical basis code (line 6) must be present for each general service cost center. This edit applies to all general service cost centers required and/or listed. [12/31/2004]
2005B	The column numbering among these worksheets must be consistent. For example, data in capital related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [12/31/2004]
NOTE:	CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet user requirements.

