

4200. GENERAL

Form CMS-265-11 must be completed by all independent end stage renal dialysis (ESRD) facilities that are not hospital-based for cost reporting periods ending on or after January 1, 2011. Effective January 1, 2011, §153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) requires the implementation of a bundled ESRD prospective payment system (ESRD PPS). The ESRD PPS provides a single payment to ESRD facilities that will cover all of the resources used in furnishing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis (in the ESRD facility or at a patient's home), drugs, biologicals, laboratory tests, training, and support services. Submit the form to your fiscal intermediary (FI)/Medicare administrative contractor (MAC) (hereafter referred to as contactor) 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 ().

Effective for cost reporting periods ending on and after December 31, 2004, the electronic cost report (ECR) file is considered the official means of cost report submission. The submission of the hard copy cost report is no longer required, except for providers that use the Centers for Medicare & Medicaid supplied free software. Those providers must continue to submit the manually completed hard copy cost report to their contractor (along with the corresponding ECR file) due to an inability of the free software to create a print image file. The free software generated ECR file will, however, be considered the official copy.

NOTE: This form is not used by ESRD facilities that are hospital-based. Hospital-based ESRD facilities continue to use Form CMS-2552.

In addition to completing Form CMS-265-11, 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 ESRD services to Medicare patients must meet conditions for coverage before they can qualify for Medicare reimbursement. These criteria are contained in 42 CFR §494.1.

The final cost report of a facility that 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. The final cost report required from a facility that undergoes a change of ownership is due no later than 150 days following the effective date of the change of ownership.

Failure to submit this cost report may result in suspension of future payments until it is submitted, 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 report the necessary accounting data in accordance with the Medicare principles of reimbursement. These principles are contained in the Provider Reimbursement Manual (CMS Pub. 15).

4200.1 Rounding Standards.--Throughout the ESRD cost report, where computations result in fractions, use the following rounding standards:

1. Round to two decimal places:
 - a. Percentages (e.g., percent ownership of facility, percent of customary work week devoted to business); (see 2b. below for exception)
 - 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)
 - b. Facility specific composite cost percentage

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.

4200.2 Acronyms and Abbreviations.--Throughout the ESRD 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
CBSA	-	Core Based Statistical Area
CCN	-	CMS Certification Number
CCPD	-	Continuous Cycling Peritoneal Dialysis
CFR	-	Code of Federal Regulations
CMS	-	Centers for Medicare and Medicaid Services
CMS Pub.	-	Centers for Medicare and Medicaid Services' Publication
ESA	-	Erythropoiesis Stimulating Agent
ESRD	-	End Stage Renal Disease
FTE	-	Full Time Equivalent
IOM	-	Internet Only Manual
IPD	-	Intermittent Peritoneal Dialysis
MAC	-	Medicare Administrative Contractor
MCP	-	Monthly Capitation Method

4201. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-265-11

<u>Step No.</u>	<u>Worksheet</u>	<u>Instructions</u>
1	S, Parts I & II	Read §4204.1.
2	S-1	Read §4205. Complete the entire worksheet.
3	S-2	Read §4205.1 Complete the entire worksheet.
4	A	Read §4206. Complete columns 1 through 4.
5	A-1	Read §4207. Complete entire worksheet if applicable.
6	A	Read §4206. Complete columns 5 and 6.
7	A-2	Read §4208. Complete entire worksheet.
8	A	Read §4206. Complete columns 7 and 8.
9	A-3	Read §4209. Complete entire worksheet if applicable.
10	A-4	Read §4210. Complete entire worksheet if applicable.
11	B and B-1	Read §4211. Complete entire worksheets.
12	C	Read §4212. Complete entire worksheet.
13	D	Read §4213. Complete entire worksheet.
14	E, Parts I & II	Read §4214. Complete entire worksheet.
15	E-1, Part II	Read §4215.
16	F & F-1	Read §4216. Complete entire worksheet.
17	S, Part III	Read §4204.2.

4202. 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 CMS-265-11 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 & III
S-1	
S-2	
A	
A-1	
A-2	
A-3	
A-4	I & II
B	
B-1	
C	
D	
E	I & II
E-1	I & II
F	
F-1	

4203. METHOD OF PAYMENT

4203.1 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, 414.314, and 414.316 respectively.

A. Administrative Services.--Administrative services are physician services that benefit the facility generally and are supervisory in nature. The services are 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.

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 physician is paid an amount for each patient to cover all professional services rendered 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 contractor pays the provider 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.

Certain services 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, are not included in your costs. These services are explained in 42 CFR §§414.313(b) and 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.

4203.2 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 or lost wages of the attendant during the training period. (See IOM CMS Pub. 100-04, Chapter 8, §50.8 for specific instructions regarding payment for training services.)

4203.3 Facility Payment for Laboratory Services Included in Composite Rate.--The costs of certain ESRD laboratory services performed by either the ESRD facility or an independent laboratory (as defined in IOM CMS Pub. 100-04, Chapter 8, §50.1) are included in the composite rate calculations. Therefore, payment for all of these tests is included in the composite rate and may NOT be billed separately to the Medicare program. 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.

4203.4 Facility Payment for Home Dialysis.--For rules that apply to Medicare beneficiaries dialyzing at home, see IOM CMS Pub. 100-04, Chapter 8, §70.1.

4204. WORKSHEET S - INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT CERTIFICATION

4204.1 Part I – Cost Report Status.--This section is to be completed by the provider and contractor as indicated on the worksheet.

Lines 1 through 3, column 1--The provider must check the appropriate box to indicate on line 1 or 2, respectively, whether this cost report is being filed electronically or manually. For electronic filing, indicate on line 1, columns 2 and 3 respectively, the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the contractor and is archived accordingly. This file is your original submission and is not to be modified. If this is an amended cost report, enter on line 3 the number of times the cost report has been amended.

Line 4, Column 1--Enter the Independent Renal Dialysis Information System (IRDIS) cost report status code on line 4, column 1 of worksheet S that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 5, Column 1--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 6, Column 1--Enter the 5 position Contractor Number.

Lines 7 and 8, Column 1--If this is an initial cost report, enter “Y” for yes in the box on line 7. If this is a final cost report, enter “Y” for yes in the box on line 8. If neither, leave both lines 7 and 8 blank. An initial report is the very first cost report for a particular provider CCN. A final cost report is a terminating cost report for a particular provider CCN.

Line 9, Column 1--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3 or 4.

Line 10, Column 1--If this is a reopened cost report (response to line 4, column 1 is “4”), enter the number of times the cost report has been reopened.

Line 11, Column 1--Enter the software vendor code for the software used by the contractor to process this cost report. Use the format “X99”, where X is the alpha character representing a specific cost report transmittal and 99 is the two digit software vendor code.

4204.2 Part II - General.--

Line 1.--Enter the name of the facility.

Line 2.--Enter the street address and P.O. Box (if applicable).

Line 3.--Enter the city, state, and zip code.

Line 4.--Enter the county where the facility is located and the Core Based Statistical Area (CBSA).

Line 5.--Enter the Provider CCN.

Line 6.--Enter the date the provider was certified.

Line 7.--Enter the name and phone number of the person to be contacted if any questions arise regarding the information in this report.

Line 8.--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. 15-1, 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. 15-1, §2414.1.)

Line 9.--Indicate in column 1 the 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	Proprietary	Government
1=Corporation	3=Individual	7=Federal
2=Other (specify)	4=Corporation	8=State
	5=Partnership	9=County
	6=Other (specify)	10=City
		11=Other (specify)

If item 2, 6, or 11 is selected (Other (specify) category), specify the type of control in column 2.

Line 10.--Indicate whether your facility qualified and was approved as a low-volume facility for this cost reporting period. CMS adjusts the base rate for low-volume ESRD facilities. In order to receive this low-volume adjustment, a facility must attest in accordance with 42 CFR §413.232(f).

Line 11.--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 12.--Indicate whether you were previously certified as a hospital-based unit. Enter "Y" for yes or "N" for no.

Line 13.--Indicate if your facility elected 100% PPS effective January 1, 2011. This election must have been received by the ESRD facility's contractor by November 1, 2010. Requests received after this date will not be accepted regardless of postmark or delivery date.

New providers: ESRD facilities certified for Medicare participation on or after January 1, 2011 do not have the option to choose to be paid a blended rate under the transition but are paid based on 100% of the ESRD PPS payment. ESRD facilities certified for Medicare participation on or after January 1, 2011, enter "Y" for yes.

Line 14.--If your facility did not elect to be paid based on 100% of the ESRD PPS payment and your cost reporting period is a December 31 fiscal year end, enter the transition period in column 2 as follows: For the fiscal year ending December 31, 2011, enter 1; for the fiscal year ending December 31, 2012, enter 2; for the fiscal year ending December 31, 2013, enter 3; and, for the fiscal year ending December 31, 2014, enter 4 for 100% ESRD PPS payment.

If your cost reporting period ends on a date other than December 31, indicate in column 1 the transition period effective for the portion of the cost reporting period prior to January 1. Indicate in column 2 the transition period effective for the portion of the cost reporting on and after January 1. For example, a cost reporting period with a fiscal year ending October 31 would indicate the applicable transition periods as follows:

Fiscal year ending October 31, 2011: Leave column 1 blank as this would be pre-bundled ESRD PPS and enter 1 in column 2 for the period of January 1, 2011 through October 31, 2011.

Fiscal year ending October 31, 2012: Enter 1 in column 1 for the period of November 1, 2011 through December 31, 2011 and enter 2 in column 2 for the period of January 1, 2012 through October 31, 2012.

Fiscal year ending October 31, 2013: Enter 2 in column 1 for the period of November 1, 2012 through December 31, 2012 and enter 3 in column 2 for the period of January 1, 2013 through October 31, 2013.

Fiscal year ending October 31, 2014: Enter 3 in column 1 for the period of November 1, 2013 through December 31, 2013 and enter 4 in column 2 for the period of January 1, 2014 through October 31, 2014.

For all cost reporting periods beginning on or after January 1, 2014, enter 4 in column 2 for 100% ESRD PPS payment.

Payments during the transition period 1 are a blend of 25 percent case-mix adjusted ESRD PPS and 75 percent basic case-mix adjusted composite rate (25/75). Payments during the transition period 2 are a blend of 50 percent case-mix adjusted ESRD PPS and 50 percent basic case-mix adjusted composite rate (50/50). Payments during the transition period 3 are a blend of 75 percent case-mix adjusted ESRD PPS and 25 percent basic case-mix adjusted composite rate (75/25). Payments for services rendered on an after January 1, 2014 are 100% ESRD PPS.

Line 15-17.--Enter the amount of malpractice insurance premiums, paid losses and/or self insurance premiums, respectively.

Line 18.--Are malpractice premiums reported in other than the A&G cost center, enter "Y" for yes or "N" for no. If yes, submit a supporting schedule listing the cost centers and amounts contained therein.

Line 19.--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 lines 20 through 22. Otherwise enter "N" for no in column 1. See CMS Pub. 15-1, §2150 for a definition of a chain organization.

Line 20.--Enter the name of the home office.

Line 21.--Enter the street address and P. O. Box (if applicable) of the home office.

Line 22.--Enter the city, state and zip code of the home office.

4204.3 Part III - Certification by an 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 a material fact in any application for any benefit or payment under a Federal health care program...--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 the program, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion or provision of council or assistance 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 one year or both..."

4205 WORKSHEET S-1 - INDEPENDENT RENAL DIALYSIS FACILITY
STATISTICAL DATA

In accordance with 42 CFR §§413.24(a) and 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 required data includes patient data, the number of treatments, number of machines, and home program data. In addition, full time equivalent (FTE) data is required for 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

Report the statistics on lines 1 through 11 for 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 in the dialysis program at the end of the cost reporting period.

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

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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--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.

ESA STATISTICS--Medicare pays for Erythropoiesis Stimulating Agents (ESAs)(for example, Epoetin and Aranesp). Effective January 1, 2005, ESAs will be paid based on the ASP Pricing File. Effective January 1, 2011 ESAs will be included in the ESRD PPS payment.

Line 14--Enter the total units of Epoetin (EPO) 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 total units of Aranesp furnished by the facility during its cost reporting period. One unit is equal to 1 microgram (mcg). For example, if a facility furnished 1200 mcg, it would report 1200 units on line 15. Round all numbers to whole numbers.

Line 16--Enter the number of patients who are awaiting transplants.

Line 17--Indicate the number of patients who received transplants during this reporting period.

Home Program

The data requested on lines 18 and 19 pertain to a home dialysis program only.

Line 18.--Column 1, enter the number of patients that began home dialysis training during this reporting period.

Line 19.--Enter the number of patients in the home program on the last day of your cost reporting period.

Line 20.--

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 21.--Enter the number of hours in a normal work week in the space provided.

Lines 22 through 31.--The items in this part provide statistical data related to the facility's human resources. The human resource statistics are required for each of the job categories specified in lines 22 through 31. Enter any additional category as needed on line 31.

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 §414.310). 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.

4205.1 WORKSHEET S-2 - INDEPENDENT RENAL DIALYSIS FACILITY REIMBURSEMENT QUESTIONNAIRE.

The information required on this worksheet (formerly Form CMS-339) must be completed by all Independent Renal Dialysis Facilities submitting cost reports to the Medicare contractor under Title XVIII of the Social Security Act (hereafter referred to as "The Act"). Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of cost reports. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor immediately, after submission of the ECR. The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation required to complete the desk review.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

NOTE: The responses on all lines are Yes or No unless otherwise indicated. If in accordance with the following instructions, you are requested to submit documentation, indicate the line number for each set of documents you submit.

Line Descriptions

Lines 1 through 14 are required to be completed by all Independent Renal Dialysis Facilities.

Line 1.--Indicate whether the provider has changed ownership. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Indicate whether the provider has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3.--Indicate whether the provider is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

Note: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, Chapter 10 and 42 CFR §413.17.)

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Line 4.--Indicate whether the financial statements were prepared by a Certified Public Accountant. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If you do not engage public accountants to prepare your financial statements, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5.--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a reconciliation with the cost report.

Line 6.--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR §§413.89(e) and 413.178(d) and CMS Pub. 15-1, §§306 -324 for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 1 or internal schedules duplicating the documentation requested on Exhibit 1 to support the bad debts claimed. Complete a separate Exhibit 1, as applicable, for bad debts for dates of service prior to January 1, 2011 and each subsequent calendar year.

Exhibit 1 displayed at the end of this section requires the following documentation:

Columns 1, 2, 3-- Patient Names, Health Insurance Claim (HIC) Number, Dates of Service (From - To)--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, §314 and 42 CFR §413.89.)

Column 4--Indigency/Welfare Recipient--If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column 1 has a valid Medicaid number, also include this number in this column. See the criteria in PRM-I, §§312 and 322 and 42 CFR §413.89 for guidance on the billing requirements for indigent and welfare recipients.

Columns 5 & 6--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased--This information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2 and 3 of this exhibit. The dates in column 6 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See 42 CFR §413.89(f), and CMS Pub. 15-1, §§308, 310, and 314.)

Column 7--Remittance Advice Dates--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC No., and dates of service shown in columns 1, 2, and 3 of this exhibit.

Columns 8 & 9--Deductibles & Coinsurance--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services.

Column 10--Total Medicare Bad Debts--Enter on each line of this column, the sum of the amounts in columns 8 and 9. Calculate the total bad debts by summing up the amounts on all lines of Column 10. This "total" must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

NOTE: The information in Exhibit 1 or the provider's internal schedules is not captured in the ECR file. Therefore, this exhibit/schedule must be completed and submitted either manually (hard copy), or in electronic media format (e.g. diskette, or CD).

Line 7.--Indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the policy with the cost report.

Line 8.--Indicate whether patient deductibles and/or coinsurance are waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 1 or your internal schedules) submitted with the cost report.

Line 9.--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement Report (PS&R) only. Enter "Y" for yes or "N" for no in columns 1. If column 1 is "Y" enter the paid through date of the PS&R in column 2. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 10.--Indicate whether the cost report was prepared using the PS&R for totals and provider records for allocation. Enter "Y" for yes or "N" for no in columns 1. If column 1 is "Y" enter the paid through date of the PS&R in column 2. Also, submit a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.

Line 11.--If you entered "Y" on either line 9 or 10, column 1, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 12.--If you entered "Y" on either line 9 or 10, column 1, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 13.--If you entered "Y" on either line 9 or 10, column 1, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 14.--Indicate whether the cost report was prepared using provider records only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.
- Reconciliation of remittance totals to the provider's internal records.
- Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

Note: Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material to further describe and validate the reliability of your system.

4206. 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 contractor.

Do not change standard (i.e., preprinted) CMS 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. Column 6 line 27 must equal column 4 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 23. 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. The costs related to depreciation and/or rental and maintenance on the dialysis machines and support equipment is reported 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. 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, nursing aides, technicians, social workers, and dietitians.

Salaries paid to physicians are not included in this cost center. They are allocated to cost centers on line 11 and either line 16 or line 19. Administrative costs are reported on line 11 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, line 19.

Line 8.--This cost center includes the cost of employee health and wellness benefits for direct patient care.

Line 9.--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 10.-- 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. With the implementation of the ESRD PPS, effective for claims with dates of service on or after January 1, 2011, all ESRD-related laboratory services are included in the ESRD PPS base rate. (See 100-04, Chapter 8, §50.1)

Line 11.-- 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 §4203.1A.) 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. If you pay malpractice insurance premiums applicable to physicians, see instructions for malpractice cost adjustments on Worksheet A-2, line 19.

Line 12.-- 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 100-04, Chapter 8, §50.2). In addition to drugs included in the

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composite rate, this cost center includes separately billable injectable drugs provided to the facility's patients. Do not include any costs for the approved drugs Epoetin or Aranesp (ESAs) on this line

for dates of service prior to January 1, 2011 as these costs must be reported on line 23. Effective for claims with dates of service on or after January 1, 2011, all ESRD-related injectable drugs and biologicals and oral equivalents of those injectable drugs and biologicals are included and no longer separately billable. Report all drugs ESRD related and non-ESRD related on this line (See 100-04, Chapter 8, §50.2.1).

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 11 and 13 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.

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, influenza virus and Pneumococcal pneumonia virus (PPV) vaccines and their administration when furnished to eligible beneficiaries in accordance with coverage rules. Vaccines remain separately payable under the ESRD PPS. (see 100-04, Chapter 8, §60.6)

Line 22.--A non-reimbursable 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) or aranesp, furnished to both in-facility and home ESRD patients for services prior to January 1, 2011. These costs are adjusted out on Worksheet A-2, lines 15 through 18 respectively, and are not transferred to any worksheets in the cost report.

Effective January 1, 2011, these costs are reimbursed through the ESRD PPS payment system and are reported on line 12.

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 100-04, Chapter 8, §90). Effective January 1, 2011, §153b of the Medicare Improvements for Patients and

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Providers Act (MIPPA) eliminates Method II and all home dialysis claims must be billed by a renal dialysis facility and paid under the ESRD PPS.

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, 12, 18, and 19 through 26.

4207. 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 11, 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 11, 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 11, 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 11, 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 11, 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.

4208. 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. 15-1, §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. 15-1, 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., declothing 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. 15-1, 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 through 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. 15-1, chapter 1.)

Line 15.--Enter rebates taken on epoetin purchases prior to January 1, 2011.

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. For services rendered on or after January 1, 2011, do not complete this line as EPO will be paid as part of the ESRD PPS payment.

Line 17.--Enter rebates taken on aranesp purchases prior to January 1, 2011.

Line 18.--Enter the cost of the approved drug aranesp 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 17 of this worksheet. For services rendered on or after January 1, 2011, do not complete this line as Aranesp will be paid as part of the ESRD PPS payment.

Line 19.--Enter rebates taken on epoetin purchases on or after January 1, 2011

Line 20.--Enter rebates taken on aranesp purchases on or after January 1, 2011

Line 21.--Enter the cost of malpractice insurance premiums paid by the facility specifically identified as physicians malpractice premiums on this line.

Lines 22 through 99.--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.

Line 100.--Enter the sum of lines 1 through 99. Transfer the amounts in column 2 to Worksheet A, column 7.

4209. 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. 15-1, 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. 15-1, 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. 15-1, chapter 10, check "No" and do not complete the remainder of this 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 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. 15-1, chapter 10.)

Column 5.--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 6.--Enter the amount in column 4 less the amount in column 5. Transfer the(se) amount(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 the facility, a common ownership of the facility, or control over the facility as defined in CMS Pub. 15-1, 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).

4210. WORKSHEET A-4 - STATEMENT OF

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."

4210.1 Part I – Statement of Total Compensation to Owners. -- Include 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.

4210.2 Part I – Statement of Total Compensation to Administrators, Assistant Administrators, Medical Directors or others performing these duties (other than owners). -- Include 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 100-04, Chapter 8, §40.6).

**4211. 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 contractor 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

Column 2 and 3.--These columns are used to allocate costs reported on Worksheet A, lines 1 through 4, to the various cost centers. Column 2 allocates costs to the various cost centers and Column 3 further allocates these costs by modality between Adults and Pediatrics. On Worksheet B-1 enter in Column 2 the square footage statistics for cost centers 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 19 through 22. On Worksheet B-1 enter in column 3, the total number of treatments for Adults and Pediatrics, by modality on subscripted lines 8 through 17.

Enter on Worksheet B, column 2, the costs allocated for cost centers 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 19 through 22. On Worksheet B, column 3, enter on the subscripted lines 8 through 17, the costs allocated in column 2 to their respective modalities between Adults and Pediatrics based on a percentage of treatments to total treatments for each modality times the costs allocated on the respective lines on Worksheet B, column 2.

Columns 7 and 8.--These columns refer to supplies and laboratory services, (i.e., ESRD related and Non-ESRD related) provided to both Medicare and non-Medicare patients. These services are 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 charges 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 100-04, Chapter 8, §50.1.1)

Note: Drugs and biologicals are reported in column 10 and then carved out into columns 11, 12 and 13 in order to determine basic composite rate costs and ESRD PPS costs. Basic composite rate costs will be used in the determination of allowable bad debts and ESRD PPS costs will be informational.

Column 10.--This column refers to drugs (i.e., ESRD related and Non-ESRD related) provided to both Medicare and non-Medicare patients. These drugs and biologicals include erythropoiesis stimulating agents (ESAs) and any oral form of such agents as well as other drugs and biologicals that are furnished by, billed by and reimbursed to your facility. Do not include any drugs that were billed by any physicians since these costs are not part of your facility's costs. This cost will be allocated to lines 2 through 5 accordingly. To determine the costs allocated to lines 2 through 5, use actual costs if separate expense accounts are maintained, or allocate these costs based on the supplier's charges 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 100-04, Chapter 8, §50.2.1)

Columns 11, 12 and 13. – These columns are used to allocate the costs identified on Column 10, lines 2, 3 and 4 to the various modes of treatment on subscribed lines 8 through 17, based on actual costs or supplier's charges.

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 subscribed lines 8 through 17, 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.

Effective January 1, 2011 the ESRD PPS provides a single payment to ESRD facilities that will cover all of the resources used in furnishing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis (in the ESRD facility or at a patient's home), drugs, biologicals, laboratory tests, training, and support services.

Line 2.--Drugs included in basic composite rate are ESRD-related drugs and biologicals that were paid under the composite rate payment system prior to January 1, 2011, and are considered in the calculation of the basic case-mix composite rate effective January 1, 2011.

Line 3.--ESAs (for example, Epoetin and Aranesp) prior to January 1, 2011, are adjusted on Worksheet A-2. For services rendered on or after January 1, 2011, ESAs and any oral form of such agents are included in the ESRD PPS payment and are included on line 3 for proper allocation.

Line 4.--ESRD related other drugs are drugs that are reimbursed under the ESRD PPS payment system effective January 1, 2011. DO NOT include oral-only drugs.

Line 5.--Non-ESRD related drugs, supplies and lab services - for dates of service prior to January 1, 2011, these drugs, supplies and lab services are not reimbursed under the composite payment rate and are separately billable. For dates of service on or after January 1, 2011, include on this line drugs and biologicals, supplies, and lab services administered during dialysis for non-ESRD related conditions as well as oral-only drugs. Non-ESRD related drugs, supplies and lab services as well as oral-only drugs, are excluded from the ESRD PPS payment.

Use the following procedures in completing these worksheets.

1. Enter on Worksheet B-1, columns 2 and 4 through 10, line 24, and Worksheet B, columns 3 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 24 and Worksheet B, line 1
<u>Lines</u>	<u>Column</u>
5 Capital-Related, Operation and Maintenance of Plant and Housekeeping	2 on Wkst. B-1 and 3 on Wkst. B
6 Machine Capital-Related or Rental and Maintenance	4
7 Salaries for Direct Patient Care	5
8 Employee Health and Welfare Benefits for Direct Patient Care	6
9 Supplies	7
10 Laboratory	8
18 Administrative and General and Other	9
12 Drugs	10

2. On Worksheet B, column 1, line 1, enter the total of columns 8A through 10, line 1.

3. On Worksheet B, column 1, lines 6, 7, and 19 through 22, 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 23, enter the total of column 1, lines 1 through 22. This total must equal the amount on Worksheet A, column 8, line 27.

5. On Worksheet B-1, column 2, enter on lines 8 through 22 the portion of the total statistical base over which the expenses of the cost center are to be allocated. The statistical base to be used is cited in the column heading and reflects only those statistics applicable to the revenue producing and nonreimbursable cost centers. Enter in column 2, line 23, the sum of lines 8 through 22.

6. On Worksheet B-1, column 3, enter on subscripted lines 8 through 17 the portion of the total statistical base over which the expenses of the cost center are to be allocated. The statistical base to be used is cited in the column heading and reflects only those statistics applicable to the revenue producing cost centers.

7. On Worksheet B-1, columns 4 through 8, enter on lines 2 through 7, subscripted lines 8 through 17 and lines 19 through 22 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 4 through 8, line 23, the sum of lines 2 through 22.

8. On Worksheet B-1, column 10, enter on lines 2 through 5, 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 column 10 is cited in the column heading and reflects only those statistics applicable to lines 2 through 5. Enter in column 10, line 23, the sum of lines 2 through 5.

9. On Worksheet B-1, columns 2, 4 through 8, and 10, line 25, determine the unit cost multiplier by dividing the amount on line 24 by the total statistics on line 23. The unit cost multiplier is rounded to the nearest six decimal places (e.g., $\$4,000/15,000$ square feet = $.2666666 = .266667$).

10. On Worksheet B-1, column 3, subscripted lines 8 through 17, determine the percentage of Adult treatments and Pediatrics treatments to total treatments by modality. (e.g. line 8.01 Adults/(line 8.01 Adults plus 8.02 Pediatrics)). Multiply the percentages calculated for each modality by their respective costs on Worksheet B, column 2, lines 8 through 17 ((e.g. line 8.01 Adults/(line 8.01 Adults plus 8.02 Pediatrics)) times Worksheet B, column 2, line 8) and enter the results on Worksheet B, column 3, subscripted lines 8 through 17.

11. On Worksheet B-1, multiply the appropriate unit cost multipliers computed in step 9 by the individual cost center statistics in columns 2, 4 through 8, and 10. Enter the resulting amounts in the corresponding columns and lines of Worksheet B.

12. On Worksheet B, columns 3 through 8, and 10, enter on line 23 the sum of the amounts computed on lines 2 through 22. Do not include in these totals the amounts entered on line 1. For each column, the amount on line 23 must equal the amount on line 1.

13. On Worksheet B, column 8A, line 1, enter the sum of columns 3 through 8. On Worksheet B, column 8A, lines 2 through 22, enter the sum of columns 1 through 8.

14. On Worksheet B, column 8A, line 23, enter the total of lines 2 through 22. This total plus the amounts in columns 9 and 10, line 1, must equal the amount in column 1, line 23.

15. Transfer the total on Worksheet B, column 8A, line 23, to Worksheet B-1, column 9, line 23.

16. On Worksheet B-1, column 9, line 25, determine the unit cost multiplier by dividing the amount on line 24 by the amount on line 23.

17. On Worksheet B-1, multiply the appropriate unit cost multiplier computed in step 16 by the individual cost center statistics in column 8A of Worksheet B. Enter the resulting amounts in the corresponding lines of Worksheet B, column 9. On Worksheet B, column 9, enter on line 23 the sum of the amounts computed on lines 2 through 22. The amount on line 23 must equal the amount on line 1.

18. On Worksheet B, column 10 enter as follows:

<u>FROM</u>	<u>TO</u>
Worksheet B, column 10	Worksheet B-1, line 24 and Worksheet B, line 1

<u>Line:</u>		<u>Column</u>
2	Drugs Included in Composite Rate	11
3	ESAs	12
4	ESRD Related Drugs	13

19. On Worksheet B-1, columns 11, 12 and 13, enter on subscripted lines 8 through 17 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 columns 11, 12 and 13 are cited in the column heading and reflects only those statistics applicable to the revenue producing cost centers. Enter in columns 11, 12 and 13, line 23, the sum of lines 2 through 22.

20. On Worksheet B-1, columns 11, 12 and 13, determine the unit cost multiplier by dividing the amount on line 24 by the total statistics on line 23.

21. On Worksheet B-1, multiply the appropriate unit cost multipliers computed in step 20 by the individual cost center statistics in columns 11, 12 and 13. Enter the resulting amounts in the corresponding columns and lines of Worksheet B.

22. On Worksheet B, column 11A, line 5, enter the total of columns 8A through 11. On lines 6 through 17.02 and lines 19 through 22, enter the total of columns 8A, 9 and 11.

23. On Worksheet B, column 11A, line 18, enter the subtotal of lines 2 through 17.02.

24. On Worksheet B, column 11A, line 23, enter the total of lines 18 through 22.

25. On Worksheet B, column 13A, lines 2 through 17.02 and lines 19 through 22, enter the total of columns 11A through 13.

26. On Worksheet B, column 13A, line 18, enter the subtotal of lines 2 through 17.02.

27. On Worksheet B, column 13A, line 23, enter the total of lines 18 through 22. The amount on line 23 must equal the amount in column 1, line 23.

28. Transfer the expenses from Worksheet B as follows:

<u>From Worksheet B</u>	<u>To</u>
Column 13A, line 8.01	Worksheet C, column 2, line 8.01
Column 13A, line 8.02	Worksheet C, column 2, line 8.02
Column 13A, line 9.01	Worksheet C, column 2, line 9.01
Column 13A, line 9.02	Worksheet C, column 2, line 9.02
Column 13A, line 10.01	Worksheet C, column 2, line 10.01
Column 13A, line 10.02	Worksheet C, column 2, line 10.02
Column 13A, line 11.01	Worksheet C, column 2, line 11.01
Column 13A, line 11.02	Worksheet C, column 2, line 11.02
Column 13A, line 12.01	Worksheet C, column 2, line 12.01
Column 13A, line 12.02	Worksheet C, column 2, line 12.02
Column 13A, line 13.01	Worksheet C, column 2, line 13.01
Column 13A, line 13.02	Worksheet C, column 2, line 13.02
Column 13A, line 14.01	Worksheet C, column 2, line 14.01
Column 13A, line 14.02	Worksheet C, column 2, line 14.02
Column 13A, line 15.01	Worksheet C, column 2, line 15.01
Column 13A, line 15.02	Worksheet C, column 2, line 15.02
Column 13A, line 16.01	Worksheet C, column 2, line 16.01
Column 13A, line 16.02	Worksheet C, column 2, line 16.02
Column 13A, line 17.01	Worksheet C, column 2, line 17.01
Column 13A, line 17.02	Worksheet C, column 2, line 17.02

The totals in column 13A, lines 5 through 7 and lines 19 through 22, are not transferred because only the figures for the reimbursable cost centers are transferred to Worksheet C.

4212. WORKSHEET C - COMPUTATION OF AVERAGE COST PER TREATMENT FOR ESRD PPS PAYMENT SYSTEM - INFORMATIONAL

This worksheet records the apportionment of total costs under ESRD PPS. The information on this worksheet is used in the calculation of the Facility Specific Composite Cost ratio computed on Worksheet E part II, and to compute the average cost per treatment under ESRD PPS. 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 PPS care.

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 13A, subscripted lines 8 through 17.

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.

Line 18.--Transfer the expense from Worksheet C, column 2 to Worksheet E part II, line 1.

Line 19.--This line is informational only. This line will be used for contractor verification. Continuous cycling peritoneal dialysis (CCPD) and continuous ambulatory peritoneal dialysis (CAPD) are daily treatment modalities, and ESRD facilities are paid the equivalent of three hemodialysis treatments for each week that CCPD and CAPD treatments are provided.

Report "total provider treatments" on this line. Compute hemodialysis equivalent treatments for lines 16.01, 16.02, 17.01 and 17.02 by multiplying the number of weeks reported in column 1 times 3 treatments for each week. Add to this amount the treatments computed on line 18, column 1.

4213. WORKSHEET D - COMPUTATION OF AVERAGE COST PER TREATMENT UNDER BASIC COMPOSITE RATE

This worksheet records the apportionment of basic composite rate cost to the various modalities of Medicare dialysis treatments.

This information is used for overall program evaluation, determining the appropriateness of bad debt reimbursement, and meeting statutory requirements of determining the cost of ESRD basic composite rate. For cost reporting periods that straddle January 1, 2011, report the rates for each modality on Worksheets D as follows: For the portion of the cost reporting period prior to January 1, 2011, enter the average composite rate for each modality in column 6. For the portion of the cost reporting period on and after January 1, 2011, enter the average ESRD PPS payment rate for each modality in column 6.02. For cost reporting periods that straddle January 1, 2012, January 1, 2013, and January 1, 2014, report the average ESRD PPS payment rate for each modality on Worksheets D as follows: For the portion of the cost reporting period prior to January 1, enter the average ESRD PPS payment rate for each modality in column 6.01. For the portion of the cost reporting period on and after January 1, enter the average ESRD PPS payment rate for each modality in column 6.02.

Column 1.--Enter the total number of treatments/patient weeks by modality for all dialysis patients reported on Worksheet C, column 1, lines 8.01 through 17.02 (i.e. Worksheet C, column 1, lines 8.01 plus 8.02, report on Worksheet D, column 1, line 1). 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 11A, by modality to lines 1 through 10 (i.e. Worksheet B, column 11A, lines 8.01 plus 8.02 report on Worksheet D, column 2, line 1).

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 7.02.--Refer only to treatments furnished to Medicare beneficiaries that were billed to, and reimbursed by the program directly.

Column 4.--For cost reporting periods which straddle January 1, 2011, enter on column 4, the total number of treatments or patient weeks billed to Medicare for services rendered prior to January 1, 2011. For cost reporting periods beginning on or after January 1, 2014, eliminate columns 4.01 and 4.02 and enter all ESRD PPS treatments billed to Medicare in column 4.

Column 4.01.--For cost reporting periods which straddle January 1, 2012, January 1, 2013 or January 1, 2014, enter the total number of treatments or patient weeks billed to Medicare for services rendered prior to January 1. For cost reporting periods beginning on or after January 1, 2014, complete column 4.

Column 4.02.--For cost reporting periods which straddle January 1, 2011, January 1, 2012, January 1, 2013 or January 1, 2014, enter the total number of treatments or patient weeks billed to Medicare for services rendered on and after January 1. For cost reporting periods beginning on or after January 1, 2014, complete column 4.

Column 5.--The amounts entered are determined by multiplying the sum of columns 4, 4.01, and 4.02 by the average cost per treatment entered on each corresponding line in column 3. Transfer the total from column 5, line 11, to Worksheet E Part I, line 1.

Column 6.--For cost reporting periods that straddle January 1, 2011, report your Medicare payment rates for each modality on Worksheets D as follows: For the portion of the cost reporting period prior to January 1, 2011, enter the average composite rate for each modality in column 6.

Column 6.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013, or January 1, 2014, report the average ESRD PPS payment rate for each modality in column 6.01 for the portion of the cost reporting period prior to January 1.

Column 6.02.--For cost reporting periods that straddle January 1, 2011, January 1, 2012, January 1, 2013, or January 1, 2014, report the average ESRD PPS payment rate for each modality in column 6.02 for the portion of the cost reporting period on and after January 1.

The ESRD composite payment rates and the ESRD PPS payment rates are an average payment calculated based on the total Medicare payments (by type of treatment) divided by the total corresponding ESRD treatments per the facility's PS&R data. For example, the total Medicare payment for hemodialysis is divided by the total ESRD hemodialysis treatments.

For cost reporting periods beginning on or after January 1, 2014, eliminate columns 6.01 and 6.02 and enter all ESRD PPS payment rates in column 6, on Worksheet D.

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. Transfer the total from column 7, line 11, to Worksheet E Part I, line 2, column 1.

Column 7.01.--The amounts entered are determined by multiplying the number of treatments or patient weeks entered on each line in column 4.01 by the payment rate entered on each corresponding line in column 6.01. Transfer the total from column 7.01, line 11, to Worksheet E Part I, line 2.01, column 1.

Column 7.02.--The amounts entered are determined by multiplying the number of treatments or patient weeks entered on each line in column 4.02 by the payment rate entered on each corresponding line in column 6.02. Transfer the total from column 7.02, line 11, to Worksheet E Part I, line 2.02, column 1.

Column 8.--Enter the sum of columns 7, 7.01, and 7.02 into their corresponding line in column 8.

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.

Line 11.--Enter in columns 1, 4, 4.01, and 4.02, the sum of lines 1 through 8. Enter in columns 2, 5, 7, 7.01, 7.02, and 8, the sum of lines 1 through 10.

4214. WORKSHEET E - CALCULATION OF REIMBURSABLE BAD DEBTS

4214.1 Part I – Calculation of Reimbursable Bad Debts Title XVIII – Part B.--Under the composite rate system for dates of service prior to January 1, 2011, the contractor pays the facility its allowable ESRD bad debts, up to the facility's reasonable costs as determined under Medicare principles. Under the ESRD PPS payment system, effective for dates of service on and after January 1, 2011, the contractor pays the facility its allowable ESRD bad debts, up to the facility's reasonable costs for those items and services associated with the basic case-mix adjusted composite rate portion of the ESRD PPS payment rate. Allowable bad debts must relate to specific Medicare deductibles and coinsurance amounts.

In order to determine bad debt amounts for only the basic case-mix adjusted composite rate portion of the ESRD PPS payment, we will determine the percentage of basic composite rate costs to total costs on a facility specific basis. The facility specific composite rate percentage will be applied to the facility's total bad debt amounts associated with the ESRD PPS payment. The resulting bad debt amount will be used to determine the allowable Medicare bad debt payment in accordance with 42 CFR §§413.89 and 413.178 of the regulations. During the transition period, a facility will apply the facility specific composite cost percentage to the bad debt amounts associated with only the transition portion of the ESRD PPS payment.

The resulting bad debt amount will be added to the bad debt amount associated with the transition portion of the facility's ESRD reasonable costs to determine the total allowable Medicare bad debt (For example, a facility that does not elect 100% PPS, will be in Transition period 1 for services rendered beginning January 1, 2011 through December 31, 2011. Under Transition period 1, services rendered during this period are paid based on 75% composite rate and 25% ESRD PPS payment rate. The facility specific composite cost percentage will be applied to 25% of the bad debts and the resulting bad debt amount will be added to the transitional 75% to determine the total allowable bad debt pertaining to services rendered during this period).

EXCEPTION: The transition period payment method will not apply to an ESRD for services rendered on and after January 1, 2011, that (1) elected 100% of the payment amount to be based on the ESRD PPS Payment, or (2) was certified for Medicare participation and began providing dialysis services on or after January 1, 2011.

Column 1.--Enter the total amounts by line description.

Column 2.--This column will be used to compute the appropriate reduction to each amount reported in column 1, based on the facility's transition period and application of their Facility Specific composite cost ratio.

Line 1.--Enter in column 1, the sum of the amount from Worksheet D, column 5, line 11. The amount reported is reflective of the provider's basic composite rate cost.

Line 2.--Enter in column 1, the sum of the amount from Worksheet D, column 7, line 11, minus any applicable Part B deductibles. Enter in column 2, the amount reported in column 1. For cost reporting periods beginning on or after January 1, 2014, enter in column 1, the sum of the amount from Worksheet D, column 7, line 11, minus any applicable Part B deductibles. Enter in column 2, the amount reported in column 1 times the facility specific composite cost ratio from Worksheet E, Part II, line 3. For cost reporting periods beginning on or after January 1, 2014, do not complete lines 2.01 and 2.02.

Line 2.01.--Enter in column 1, the sum of the amount from Worksheet D, column 7.01, line 11, minus any applicable Part B deductibles. Enter in column 2, the portion of the amount reported in column 1 as it relates to the ESRD PPS payment times the facility specific composite cost ratio from Worksheet E, Part II, line 3. Add to this amount the composite cost portion of the payment. For cost reporting periods beginning on or after January 1, 2014, do not complete this line.

Line 2.02.--Enter in column 1, the sum of the amount from Worksheet D, column 7.02, line 11, minus any applicable Part B deductibles. Enter in column 2, the portion of the amount reported in column 1 as it relates to the ESRD PPS payment times the facility specific composite cost ratio from Worksheet E, Part II, line 3. Add to this amount the composite cost portion of the payment. For cost reporting periods beginning on or after January 1, 2014, do not complete this line.

Line 2.03.--Enter the sum of lines 2, 2.01 and 2.02 in columns 1 and 2 accordingly.

Line 3.--Enter the amount shown in your records for Outlier Payments applicable to Medicare (Part B) patients. (Informational only)

Line 4.--Reserved for future use.

Line 5.--Enter 80 percent of the amount on line 2.03, column 2.

Line 6.--Enter the amount on line 1 minus the amount on line 5.

Line 7.--Enter in column 1, 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 payments listed on line 2, column 1, and apply to Medicare beneficiaries under the composite payment rate. Enter in column 2, the amount reported in column 1. For cost reporting periods beginning on or after January 1, 2014, enter in column 1, the amount shown in your records for deductibles and coinsurance billed to Medicare (Part B) patients. Enter in column 2, the amount reported in column 1 times the facility specific composite cost ratio from Worksheet E, Part II, line 3. For cost reporting periods beginning on or after January 1, 2014, do not complete lines 7.01 and 7.02.

Line 7.01.--Enter in column 1, 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 payments listed on line 2.01, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2, the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from Worksheet E, Part II, line 3. For cost reporting periods beginning on or after January 1, 2014, do not complete this line.

Line 7.02.--Enter in column 1, 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 payments listed on line 2.02, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2, the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from Worksheet E, Part II, line 3. For cost reporting periods beginning on or after January 1, 2014, do not complete this line.

Line 7.03.--Enter the sum of column 2, lines 7, 7.01 and 7.02. The amount entered, at a minimum, should be 20 percent of the payment due on line 2.03, column 2.

Line 8.--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for services rendered prior to January 1, 2011. Transfer this amount to column 2.

Line 9.--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for services rendered on or after January 1, 2011, but before January 1, 2012. Enter in column 2, 75% of the amount in column 1, plus 25% of the amount in column 1 times the facility specific composite cost ratio on Worksheet part II, line 3. If the provider indicated "Y" on Worksheet S, line 13 and elected 100% PPS, do not complete this line. Complete line 12.

Line 10.--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for services rendered on or after January 1, 2012, but before January 1, 2013. Enter in column 2, 50% of the amount in column 1, plus 50% of the amount in column 1 times the facility specific composite cost ratio on Worksheet E part II, line 3. If the provider indicated "Y" on Worksheet S, line 13 and elected 100% PPS, do not complete this line. Complete line 12.

Line 11.--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for services rendered on or after January 1, 2013, but before January 1, 2014. Enter in column 2, 25% of the amount in column 1, plus 75% of the amount in column 1 times the facility specific composite cost ratio on Worksheet E part II, line 3. If the provider indicated "Y" on Worksheet S, line 13 and elected 100% PPS, do not complete this line. Complete line 12.

Line 12.--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for services rendered on or after January 1, 2014. Enter in column 2, 100% of the amount in column 1, times the facility specific composite cost ratio on Worksheet E part II, line 3. If the provider indicated "Y" on Worksheet S, line 13 and elected 100% PPS, DO NOT complete lines 9, 10 or 11, but enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for all services rendered on or after January 1, 2011. Enter in column 2, 100% of the amount in column 1, times the facility specific composite cost ratio on Worksheet E part II line 3.

Line 13.--Enter in column 1, the sum of lines 8 through 12, column 1. This amount should reconcile to the provider's bad debt listing(s). Enter in column 2, the sum of lines 8 through 12, column 2.

Line 14.--Subtract the amount on line 13, column 2, from the amount on line 7.03 and enter the result.

Line 15.--Subtract the amount on line 14 from the amount on line 6 and enter the difference. If the amount on line 14 exceeds the amount on line 6, do not complete line 16.

Line 16.--Enter the lesser of the amount on line 13, or the amount on line 15.

Line 17.--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 16, i.e., line 17 is a subset of line 16.

Line 18.--Your contractor will enter the Part A tentative adjustments from Worksheet E-1,

column 2, line 1.99.

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Line 19.--Enter OTHER adjustments.

Line 20.--Enter the amount on line 16 minus line 18, plus or minus line 19. Enter a negative amount in parentheses ().

4214.2 Part II – Calculation of Facility Specific Composite Cost Percentage.--A facility specific composite cost percentage will be applied to the facility's total bad debt amounts and associated cost data necessary to compute the ESRD facility bad debt payments. This percentage is computed by taking basic composite rate costs and dividing them by total allowable expenses on a facility-specific basis.

Line 1.--Enter total allowable expenses from Worksheet C, column 2, line 18.

Line 2.--Enter total composite costs from Worksheet D, column 2, line 11.

Line 3.--Compute the facility specific composite cost percentage (line 2 divided by line 1).

4215. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

4215.1 Part I – For Contractor Use Only

Line 1.--List separately each tentative settlement payment with the date of payment.

Line 2.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR or, if this settlement is after a reopening of the NPR, for this reopening. Transfer this amount from worksheet E, Part I, line 20.

Line 3.--Enter the contractor name and the contractor number in columns 1 and 2, respectively.

4215.2 Part II – To be completed by Provider

Line 4.--If your response to worksheet S, Part II, line 10 is "Y", enter the amount of your low volume payment for cost reporting period that begin or overlap January 1, 2012.

4216. WORKSHEETS F AND F-1 - FINANCIAL STATEMENTS

These worksheets are prepared from your accounting books and records. Additional worksheets may be submitted if necessary.

Complete all worksheets in the "F" series. Worksheets F and F-1 are completed by all providers. Cost reports received with incomplete "F" worksheets are returned to the provider for completion and the provider is considered as having failed to file a cost report.