This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO: 0938-0236

INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT CERTIFICATION	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET S

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically filed cost report Date (mm/dd/yyyy): _____ Time: _____ 2. [ ] Manually submitted cost report 3. If this is an amended report enter the number of times the provider resubmitted this cost report. _____	
Contractor use only	4. [ ] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	5. Date Received: _____ 6. Contractor No._____ 7. [ ] First Cost Report for this Provider CCN 8. [ ] Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. If line 4, column 1 is "4", enter number of times reopened _____ 11. Contractor Vendor Code _____

PART II - GENERAL

1	Name:				1
2	Street:		P.O. Box:		2
3	City:	State:	Zip Code:		3
4	County:	CBSA:			4
5	Provider CCN:				5
6	Date Certified:				6
7	Contact Person Name :		Phone Number:		7
8	Cost reporting period (mm/dd/yyyy)	From: To:			8
			1	2	
9	Type of control (see instructions)				9
10	Is this facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no.				10
			1	2	
11	Type of physicians' reimbursement (see instructions)				11
12	Was this facility previously certified as a hospital-based unit? Enter "Y" for yes or "N" for no.				12
13	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. ***See instructions for "new" providers.***				13
			1	2	
14	If you responded "N" to line 13, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)				14
15	Malpractice premiums				15
16	Malpractice paid losses				16
17	Malpractice self insurance				17
18	Are malpractice premiums and/or paid losses reported in other than the Administrative and General cost center? Enter "Y" for yes or "N" for no. If yes, submit a supporting schedule listing cost centers and amounts contained therein.				18
19	Are you part of a chain organization? Enter "Y" for yes or "N" for no. If yes, complete lines 20 through 22.				19
20	Name:				20
21	Street:		P.O. Box:		21
22	City:	State:	Zip Code:		22

PART III - CERTIFICATION BY OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES, AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____{Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider

_____
Title

_____
Date

INDEPENDENT RENAL DIALYSIS FACILITY STATISTICAL DATA	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET S-1

RENAL DIALYSIS STATISTICS

		OUTPATIENT		TRAINING		
		HEMODIALYSIS	PERITONEAL DIALYSIS	HEMODIALYSIS	PERITONEAL DIALYSIS	
		1	2	3	4	
1	Number of treatments not billed to Medicare and furnished directly					1
2	Number of treatments not billed to Medicare and furnished under arrangements					2
3	Number of patients currently in dialysis program					3
4	Average times per week patient receives dialysis					4
5	Number of days in an average week for patient dialysis treatments					5
6	Average time of patient dialysis treatment including set up time					6
7	Number of machines regularly available for use					7
8	Number of standby machines					8
9	Number of shifts in typical week during regular reporting period					9
10	Hours per shift in typical week during regular reporting period					10
.01	First shift					.01
.02	Second Shift					.02
.03	Third shift					.03
11	Number of treatments provided					11
.01	One (1) time per week					.01
.02	Two (2) times per week					.02
.03	Three (3) times per week					.03
.04	More than three (3) times per week					.04
.05	Total					.05

		Type of Dialyzers	Dialyzer Reuse Count	Other Dialyzers	
		1	2	3	
12	Column 1: Type of dialyzers used (see instructions) Column 2: Number of times dialyzers are reused (see instructions) Column 3: If column 1 is "Other," enter type of dialyzer used				12
13	Number of back-up sessions furnished to home patients (see instructions)				13

14	Number of units of Epoetin furnished during cost reporting period		14
15	Number of units of Aranesp furnished during cost reporting period		15

TRANSPLANT STATISTICS

16	Number of patients who are awaiting transplants		16
17	Number of patients who received transplants during this period		17

HOME PROGRAM

18	Number of patients commencing home dialysis training during this period		18
19	Number of patients currently in home program		19

		Type of Dialyzers	Dialyzer Reuse Count	Other Dialyzers	
		1	2	3	
20	Column 1: Type of dialyzers used (see instructions) Column 2: Number of times dialyzers are reused (see instructions) Column 3: If column 1 is "Other," enter type of dialyzer used				20

RENAL DIALYSIS FACILITY--NUMBER OF EMPLOYEES (FULL TIME EQUIVALENTS)

21	Enter the number of hours in your normal work week		21

		Staff	Contract	Total	
		1	2	3	
22	Physicians				22
23	Registered Nurses				23
24	Licensed Practical Nurses				24
25	Nurses Aides				25
26	Technicians				26
27	Social Workers				27
28	Dieticians				28
29	Administrative				29
30	Management				30
31	Other (Specify)				31

INDEPENDENT RENAL DIALYSIS FACILITY REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET S-2

	PROVIDER ORGANIZATION AND OPERATION	Y/N	DATE	V/I	
		1	2	3	
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, enter the date (mm/dd/yyyy) of the change in column 2. (see instructions)				1
2	Has the provider terminated participation in the Medicare Program? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the termination date (mm/dd/yyyy); and, enter in column 3, "V" for voluntary or "I" for involuntary.				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that were 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 similary relationships? Enter "Y" for yes or "N" for no in column 1. (see instructions)				3

	FINANCIAL DATA AND REPORTS	Y/N	A/C/R	DATE	
		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Enter "Y" for yes or "N" for no. Column 2: If yes, enter in column 2: "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy of financial statements or enter date available (mm/dd/yyyy) in column 3. (see instructions) If no, see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation.				5

	BAD DEBTS	Y/N	
6	Is the provider seeking reimbursement for bad debts? Enter "Y" for yes or "N" for no. If yes, see instructions.		6
7	If line 6 is yes, did the provider's bad debt collection policy change during the cost reporting period? "Y" for yes or "N" for no. If yes, submit copy.		7
8	If line 6 is yes, were patient deductibles and/or co-payments waived? Enter "Y" for yes or "N" for no. If yes, see instructions.		8

	PS&R REPORT DATA	Y/N	DATE	
		1	2	
9	Was the cost report prepared using the PS&R report only? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions.)			9
10	Was the cost report prepared using the PS&R report for totals and the provider's records for allocation? Enter "Y" for yes or "N" for no in col.1. If yes, enter in col. 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions)			10
11	If line 9 or 10 is yes, were adjustments made to PS&R report data for additional claims that have been billed but are not included on the PS&R report used to file the cost report? Enter "Y" for yes or "N" for no. If yes, see instructions.			11
12	If line 9 or 10 is yes, were adjustments made to PS&R report data for corrections of other PS&R report information? Enter "Y" for yes or "N" for no. If yes, see instructions.			12
13	If line 9 or 10 is yes, were adjustments made to PS&R report data for Other? Enter "Y" for yes or "N" for no. If yes, describe the other adjustments: _____			13
14	Was the cost report prepared only using the provider's records? Enter "Y" for yes or "N" for no. If yes, see instructions.			14

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET A

		FACILITY HEALTH CARE COSTS	SALARIES		OTHER	TOTAL (col. 1 through col. 3)	RECLASS. TO EXPENSES (from Wkst. A-1)	RECLASSIFIED TRIAL BALANCE (col 4. +/- col. 5)	ADJUSTMENTS TO EXPENSES (from Wkst. A-2)	NET EXPENSES FOR COST ALLOCATION (col. 6+/-col. 7)	
			PHYSICIAN COMPENSATION	OTHER							
			1	2	3	4	5	6	7	8	
		COST CENTERS									
1	0100	Cap Rel Costs-Bldg & Fixt									1
2	0200	Cap Rel Costs-Mvble Equip									2
3	0300	Operation & Maintenance of Plant									3
4	0400	Housekeeping									4
5		Subtotal (sum of lines 1 through 4)*									5
6	0600	Machine Cap-Rel or Rental & Maint*									6
7	0700	Salaries for Direct Patient Care*									7
8	0800	EH&W Benefits for Direct Pt. Care									8
9	0900	Supplies*									9
10	1000	Laboratory*									10
11	1100	Administrative & General									11
12	1200	Drugs*									12
13	1300	Interest Expense									13
14	1400	Laundry and Linen									14
15	1500	Medical Records									15
16	1600	Phy Rout Prof Svcs-Initial Method									16
17	1700	Other (Specify)									17
18		Subtotal (sum of line 11 plus lines 13 through 17)*									18
19	1900	Phy Rout Prof Svcs-MCP Method									19
20	2000	Whole Blood & Packed Red Blood Cells*									20
21	2100	Vaccines*									21
		NONREIMBURSABLE COSTS CENTERS									
22	2200	Physicians Private Offices*									22
23	2300	ESAs (prior to January 1, 2011)									23
24	2400	Method II Patients (prior to January 1, 2011)									24
25	2500	Other Nonreimbursable (Specify)*									25
26	2600	Other Nonreimbursable (Specify)*									26
27		Total									27

* Transfer the amounts in column 8 to Worksheet B and B-1, as appropriate.

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET A-1

	EXPLANATION OF ENTRY	CODE (1)	INCREASE			DECREASE			
			COST CENTER	LINE NO.	AMOUNT (2)	COST CENTER	LINE NO.	AMOUNT (2)	
		1	2	3	4	5	6	7	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
100	Total Reclassifications (Sum of col. 4 must equal sum of col. 7)								100

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, col. 5, line as appropriate.

ADJUSTMENTS TO EXPENSES	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET A-2

	DESCRIPTION (1)	BASIS FOR ADJUSTMENT (2)	AMOUNT	Expense classification on Worksheet A from which amount is to be deducted or to which the amount is to be added		
				COST CENTER	LINE NO.	
		1	2	3	4	
1	Investment income on commingled restricted and unrestricted funds (chapter 2)					1
2	Trade, quantity and time discounts on purchases (chapter 8)					2
3	Rebates and refunds of expenses (chapter 8)					3
4	Rental of building or office space to others					4
5	Physician non-routine professional patient care services					5
6	Home office costs (chapter 21)					6
7	Adjustment resulting from transactions with related organizations (chapter 10)	From Wkst. A-3				7
8	Vending machines					8
9	Meals served to patients					9
10	Physicians' professional services--MCP Method	**A**		**Physicians' professional services--MCP**	**19**	10
11	Services under arrangement					11
12	Provision for doubtful accounts					12
13	Capital Related--Buildings & Fixtures			**Capital Related--Buildings & Fixtures**	**1**	13
14	Capital Related--Moveable Equipment			**Capital Related--Moveable Equipment**	**2**	14
15	Rebates on Epoetin prior to January 1, 2011			**Epoetin**	**23**	15
16	Epoetin	**A**		**Epoetin**	**23**	16
17	Rebates on Aranesp prior to January 1, 2011			**Aranesp**	**23**	17
18	Aranesp	**A**		**Aranesp**	**23**	18
19	Rebates on Epoetin on or after January 1, 2011			**Epoetin**	**12**	19
20	Rebates on Aranesp on or after January 1, 2011			**Aranesp**	**12**	20
21	Physician malpractice premiums					21
22	Other (specify)					22
23	Other (specify)					23
24	Other (specify)					24
100	Total (Transfer to Wkst. A, col. 7, line 27)					100

(1) Description-all chapter references in this column pertain to CMS Pub. 15-2

(2) Basis for adjustment (see instructions)

A. Costs-if cost, including applicable overhead, can be determined

B. Amount Received-if cost cannot be determined

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET A-3

A. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-1, Chapter 10?
[ ] Yes (If yes, complete Parts B and C)
[ ] No

B. Costs incurred and adjustments required as result of transactions with related organizations:

	LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COL. 6			AMOUNT ALLOWABLE IN COST	AMOUNT INCLUDED IN WKST. A COL. 6	NET ADJUSTMENT (col. 4 minus col. 5)	
	LINE NO.	COST CENTER	EXPENSES ITEMS				
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS (sum of lines 1-4) (Transfer col. 6, lines 1-4 to Wkst. A, col. 7 as appropriate) (Transfer col. 6, line 5 to Wkst. A-2, col. 2, line 7)						5

C. Interrelationship of facility to related organization(s):

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the provider to furnish the information requested on Part C of this worksheet.

This information will be used by the Centers for Medicare and Medicaid Services and its contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to the facility by common ownership or control, represent reasonable costs as determined under 1861(v)(1)(a) of the Social Security Act. If the provider does not provic all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				RELATED ORGANIZATION(S)			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in the facility
B. Corporation, partnership, or other organization has financial interest in the facility
C. Facility has financial interest in corporation, partnership, or other organization(s)
D. Director, officer, administrator, or key person of the facility or relative of such person has financial interest in related organization
E. Individual is director, officer, administrator, or key person of the facility and related organization
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the facility
G. Other (financial or non-financial) specify _____

STATEMENT OF COMPENSATION	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET A-4

PART I. STATEMENT OF TOTAL COMPENSATION TO OWNERS

(Include compensation of employees related to owners)

			SOLE PROPIETORSHIPS	PARTNERS		CORPORATION OWNERS		TOTAL COMPENSATION	
	TITLE	FUNCTION (A)	PERCENTAGE OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	PERCENT SHARE OF OPERATING PROFIT OR (LOSS)	PERCENTAGE OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	PERCENTAGE OF PROVIDER'S STOCK OWNED	PERCENTAGE OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	INCLUDED IN ALLOWABLE COSTS FOR THE PERIOD (B)	
	1	2	3	4a	4b	5a	5b	6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10

PART II. STATEMENT OF TOTAL COMPENSATION TO ADMINISTRATORS, ASSISTANT ADMINISTRATORS AND/OR MEDICAL DIRECTORS OR OTHERS PERFORMING THESE DUTIES (OTHER THAN OWNERS) (To be completed by all facilities)

	TITLE	PERCENTAGE OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	TOTAL COMPENSATION INCLUDED IN ALLOWABLE COSTS FOR THE PERIOD (B)	
	1	2	3	
1				1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10

(A) Function or job description of each owner. If employee is related to owner, cite relationship.

(B) Compensation as used in this worksheet has the same definition as 42 CFR 413.102

COST ALLOCATION-GENERAL SERVICE COSTS		PROVIDER CCN:	PERIOD: From: To:	WORKSHEET B

		NET EXP. FOR ALLOC (from Wkst. A col. 8)	CAP REL OP OF MAINT & HOUSE	STEP DOWN OF COL. 2	MACH CAP REL OR & MAINT	SALARIES FOR DIR PT CARE	EH&W BENE FOR DIR PT CARE	SUPPLIES	LABOR-ATORY	
		1	2	3	4	5	6	7	8	
1	COSTS TO BE ALLOCATED			0						1
2	Drugs Included in Composite Rate									2
3	ESAs									3
4	ESRD Related Other Drugs									4
5	Non-ESRD Related Drugs, Supplies & Lab									5
6	Whole Blood and Packed Red Blood Cells									6
7	Vaccines									7
	REIMBURSABLE COST CENTERS									
8	Maintenance-Hemodialysis		0							8
8.01	Maintenance-Hemo Adult									8.01
8.02	Maintenance-Hemo Pediatric									8.02
9	Maintenance -IPD									9
9.01	Maintenance-IPD Adult									9.01
9.02	Maintenance-IPD Pediatric									9.02
10	Training-Hemodialysis									10
10.01	Training-Hemo Adult									10.01
10.02	Training-Hemo Pediatric									10.02
11	Training-IPD									11
11.01	Training-IPD Adult									11.01
11.02	Training-IPD Pediatric									11.02
12	Training-CAPD									12
12.01	Training-CAPD Adult									12.01
12.02	Training-CAPD Pediatric									12.02
13	Training-CCPD									13
13.01	Training-CCPD Adult									13.01
13.02	Training-CCPD Pediatric									13.02
14	Home Program-Hemodialysis									14
14.01	Home Program-Hemo Adult									14.01
14.02	Home Program-Hemo Pediatric									14.02
15	Home Program-IPD									15
15.01	Home Program-IPD Adult									15.01
15.02	Home Program-IPD Pediatric									15.02
16	Home Program-CAPD									16
16.01	Home Program-CAPD Adult									16.01
16.02	Home Program-CAPD Pediatric									16.02
17	Home Program-CCPD									17
17.01	Home Program-CCPD Adult									17.01
17.02	Home Program-CCPD Pediatric									17.02
18	Subtotal (lines 2-17.02)									18
	NONREIMBURSABLE COST CENTERS									
19	Physicians' Private Offices	0								19
20	Method II Patients prior to 1/1/2011	0								20
21	Other Nonreimbursable									21
22	Other Nonreimbursable									22
23	Totals (see instructions)			0		0	0	0	0	23

*Transfer the amounts to Worksheet C, column 2, as appropriate

The total of column 1, line 23 must equal the amount on Worksheet A, column 8, line 27.

FORM CMS-265-11 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4211)

COST ALLOCATION-GENERAL SERVICE COSTS						PROVIDER CCN:		PERIOD: From: To:		WORKSHEET B
		SUB-TOTAL (cols. 1-8)	A & G & OTHER COST CENTERS	DRUGS	DRUGS INCLUD. IN COMP RATE	SUB-TOTAL (see in-structions)	ESAs	ESRD RELATED DRUGS	TOTAL EXPENSES ALL PAT. SVCS. (cols. 11A-13)	
		8A	9	10	11	11A	12	13	13A	
1	COSTS TO BE ALLOCATED					0	0	0		1
2	Drugs Included in Composite Rate			0						2
3	ESAs			0						3
4	ESRD Related Other Drugs			0						4
5	Non-ESRD Related Drugs, Supplies & Lab	0	0	0		0			0	5
6	Whole Blood and Packed Red Blood Cells		0							6
7	Vaccines		0							7
	REIMBURSABLE COST CENTERS									
8	Maintenance-Hemodialysis									8
8.01	Maintenance-Hemo Adult					0			0	8.01
8.02	Maintenance-Hemo Pediatric	0	0			0			0	8.02
9	Maintenance -IPD									9
9.01	Maintenance-IPD Adult	0	0			0			0	9.01
9.02	Maintenance-IPD Pediatric	0	0			0			0	9.02
10	Training-Hemodialysis									10
10.01	Training-Hemo Adult	0	0			0			0	10.01
10.02	Training-Hemo Pediatric	0	0			0			0	10.02
11	Training-IPD									11
11.01	Training-IPD Adult	0	0			0			0	11.01
11.02	Training-IPD Pediatric	0	0			0			0	11.02
12	Training-CAPD									12
12.01	Training-CAPD Adult	0	0			0			0	12.01
12.02	Training-CAPD Pediatric	0	0			0			0	12.02
13	Training-CCPD									13
13.01	Training-CCPD Adult	0	0			0			0	13.01
13.02	Training-CCPD Pediatric	0	0			0			0	13.02
14	Home Program-Hemodialysis									14
14.01	Home Program-Hemo Adult	0	0			0			0	14.01
14.02	Home Program-Hemo Pediatric	0	0			0			0	14.02
15	Home Program-IPD									15
15.01	Home Program-IPD Adult	0	0			0			0	15.01
15.02	Home Program-IPD Pediatric	0	0			0			0	15.02
16	Home Program-CAPD									16
16.01	Home Program-CAPD Adult	0	0			0			0	16.01
16.02	Home Program-CAPD Pediatric	0	0			0			0	16.02
17	Home Program-CCPD									17
17.01	Home Program-CCPD Adult	0	0			0			0	17.01
17.02	Home Program-CCPD Pediatric	0	0			0			0	17.02
18	Subtotal (lines 2-17.02)					0			0	18
	NONREIMBURSABLE COST CENTERS									
19	Physicians' Private Offices	0	0			0			0	19
20	Method II Patients prior to 1/1/2011	0	0			0			0	20
21	Other Nonreimbursable	0	0			0			0	21
22	Other Nonreimbursable	0	0			0			0	22
23	Totals (see instructions)	0	0	0	0	0	0	0	0	23

*Transfer the amounts to Worksheet C, column 2, as appropriate

The total of column 1, line 23 must equal the amount on Worksheet A, column 8, line 27.

FORM CMS-265-11 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4211)

COST ALLOCATION-GENERAL SERVICE COSTS | PROVIDER CCN: | PERIOD: From: To: | WORKSHEET B-1

			CAP REL OP OF MAINT & HOUSE (SQUARE FEET) (1)	STEP DOWN OF COL 2 (# OF TREAT-MENTS) (3)	MACH CAP REL OR REN & MAINT (%TIME) (3)	SALARIES FOR DIR PT CARE (HRS. SVC.) (3)	EH&W BENE FOR DIR PT CARE (GROSS SALARIES) (3)	SUPPLIES (CHARGES) (3)	LABORATORY (CHARGES) (3)	UNIT COST MULTI-PLIER COMPU-TATION	DRUGS (CHARGES) (3)	DRUGS INCLUD. IN COMP RATE (CHARGES) (3)	ESAs (CHARGES) (3)	ESRD RELATED DRUGS (CHARGES) (3)	
		1	2	3	4	5	6	7	8	9	10	11	12	13	
1	COSTS TO BE ALLOCATED														1
2	Drugs Included in Composite Rate														2
3	ESAs														3
4	ESRD Related Other Drugs														4
5	Non-ESRD Related Drugs, Supplies & Lab														5
6	Whole Blood and Packed Red Blood Cells														6
7	Vaccines														7
	REIMBURSABLE COST CENTERS														
8	Maintenance-Hemodialysis														8
8.01	Maintenance-Hemo Adult														8.01
8.02	Maintenance-Hemo Pediatric														8.02
9	Maintenance -IPD														9
9.01	Maintenance-IPD Adult														9.01
9.02	Maintenance-IPD Pediatric														9.02
10	Training-Hemodialysis														10
10.01	Training-Hemo Adult														10.01
10.02	Training-Hemo Pediatric														10.02
11	Training-IPD														11
11.01	Training-IPD Adult														11.01
11.02	Training-IPD Pediatric														11.02
12	Training-CAPD														12
12.01	Training-CAPD Adult														12.01
12.02	Training-CAPD Pediatric														12.02
13	Training-CCPD														13
13.01	Training-CCPD Adult														13.01
13.02	Training-CCPD Pediatric														13.02
14	Home Program-Hemodialysis														14
14.01	Home Program-Hemo Adult														14.01
14.02	Home Program-Hemo Pediatric														14.02
15	Home Program-IPD														15
15.01	Home Program-IPD Adult														15.01
15.02	Home Program-IPD Pediatric														15.02
16	Home Program-CAPD														16
16.01	Home Program-CAPD Adult														16.01
16.02	Home Program-CAPD Pediatric														16.02
17	Home Program-CCPD														17
17.01	Home Program-CCPD Adult														17.01
17.02	Home Program-CCPD Pediatric														17.02
18	Subtotal (lines 2-16.02)														18
	NONREIMBURSABLE COST CENTERS														
19	Physicians' Private Offices														19
20	Method II Patients prior to 1/1/2011														20
21	Other Nonreimbursable														21
22	Other Nonreimbursable														22
23	Total (see instructions)														23
24	Total Costs to be Allocated														24
25	Unit Cost Multiplier (Line 24 div. by Line 23)														25

COMPUTATION OF AVERAGE COST PER TREATMENT ESRD PPS BUNDLED PAYMENT	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET C

		TOTAL			
		NUMBER OF TREATMENTS	COSTS (Transferred from Wkst. B, col. 13A)	AVERAGE COST OF TREATMENTS (col. 2 divided by col. 1)	
		1	2	3	
8.01	Maintenance-Hemo Adult				8.01
8.02	Maintenance-Hemo Pediatric				8.02
9.01	Maintenance-IPD Adult				9.01
9.02	Maintenance-IPD Pediatric				9.02
10.01	Training-Hemo Adult				10.01
10.02	Training-Hemo Pediatric				10.02
11.01	Training-IPD Adult				11.01
11.02	Training-IPD Pediatric				11.02
12.01	Training-CAPD Adult				12.01
12.02	Training-CAPD Pediatric				12.02
13.01	Training-CCPD Adult				13.01
13.02	Training-CCPD Pediatric				13.02
14.01	Home Program-Hemodialysis Adult				14.01
14.02	Home Program-Hemodialysis Pediatric				14.02
15.01	Home Program-IPD Adult				15.01
15.02	Home Program-IPD Pediatric				15.02
16.01	Home Program-CAPD Adult	Patient Weeks			16.01
16.02	Home Program-CAPD Pediatric	Patient Weeks			16.02
17.01	Home Program-CCPD Adult	Patient Weeks			17.01
17.02	Home Program-CCPD Pediatric	Patient Weeks			17.02
18	Totals (Column 1 - Sum of Lines 8.01 through 15.02) (Column 2 - Sum of Lines 8.01 through 17.02)				18
19	*Total provider treatments (informational only)*				*19*

COMPUTATION OF AVERAGE COST PER TREATMENT BASIC COMPOSITE COST	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET D

		TOTAL			MEDICARE											
		TOTAL NUMBER OF TREAT-MENTS	COSTS (Transfer from Wkst. B, col. 11A)	AVERAGE COST OF TREAT-MENTS (col 2 / col. 1)	NUMBER OF TREAT-MENTS (see instructions)	NUMBER OF TREAT-MENTS (see instructions)	NUMBER OF TREAT-MENTS (see instructions)	TOTAL EXPENSES (see instructions)	AVERAGE PAYMENT RATE (see instructions)	AVERAGE PAYMENT RATE (see instructions)	AVERAGE PAYMENT RATE (see instructions)	TOTAL PAYMENT DUE (col. 4 x col. 6)	TOTAL PAYMENT DUE (col. 4.01 x col. 6.01)	TOTAL PAYMENT DUE (col. 4.02 x col. 6.02)	TOTAL PAYMENT DUE	
		1	2	3	4	4.01	4.02	5	6	6.01	6.02	7	7.01	7.02	8	
1	Maintenance-Hemodialysis		(line 8.01 and line 8.02)													1
2	Maintenance-IPD		(line 9.01 and line 9.02) 0	0												2
3	Training-Hemodialysis		(line 10.01 and line 10.02)	0												3
4	Training-IPD		(line 11.01 and line 11.02) 0	0												4
5	Training-CAPD		(line 12.01 and line 12.02) 0	0												5
6	Training-CCPD		(line 13.01 and line 13.02)	0												6
7	Home Program-Hemodialysis		(line 14.01 and line 14.02)	0												7
8	Home Program-IPD	-	line 15.02) 0	0												8
9	Home Program-CAPD	Patient Weeks 0	(line 16.01 and line 16.02) 0	0												9
10	Home Program-CCPD	Patient Weeks 0	(line 17.01 and line 17.02) 0	0												10
11	Total (see instructions)							0					0		0	11

CALCULATION OF BAD DEBT REIMBURSEMENT	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET E, PARTS I & II

PART I

CALCULATION OF REIMBURSABLE BAD DEBTS TITLE XVIII-PART B

1	Total Expenses Related to Care of Medicare Beneficiaries (from Wkst. D, col. 5, line 11)		1

		Column 1	Column 2	
2	Total payment due net of Part B deductibles (from Wkst. D, col. 7, line 11) (see instructions)			2
2.01	Total payment due net of Part B deductibles (from Wkst. D. col. 7.01, line 11) (see instructions)			2.01
2.02	Total payment due net of Part B deductibles (from Wkst. D. col. 7.02, line 11) (see instructions)			2.02
2.03	Total payment due net of Part B deductibles (see instructions)			2.03
3	Outlier payments			3
4				4
5	Program payments (80% of line 2.03, column 2)			5
6	Amount of cost to be recovered from Medicare patients (line 1 minus line 5)			6

		Column 1	Column 2	
7	Deductibles and coinsurance billed to Medicare Part B patients (see instructions)			7
7.01	Deductibles and coinsurance billed to Medicare Part B patients (see instructions)			7.01
7.02	Deductibles and coinsurance billed to Medicare Part B patients (see instructions)			7.02
7.03	Total deductibles and coinsurance billed to Medicare Part B patients for comparison (see instructions)			7.03
		Column 1	Column 2	
8	Bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered prior to 1/1/2011			8
9	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			9
10	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			10
11	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			11
12	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014			12
13	Total bad debts (sum of line 8 through line 12)			13
14	Net deductibles and coinsurance billed to Medicare Part B patients (line 7.03 minus line 13, col. 2)			14
15	Unrecovered from Medicare Part B patients (line 6 minus line 14) (If line 14 exceeds line 6, do not complete line 16)			15
16	Reimbursable bad debts (lesser of line 13 or line 15)			16
17	Reimbursable bad debts for dual eligible beneficiaries (see instructions--informational only)			17
18	Tentative adjustment			18
19	Other adjustment (see instructions)			19
20	Balance due provider/program (line 16 minus line 18 plus or minus line 19) (Indicate overpayment in parentheses) (see instructions)			20

PART II

CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE

1	Total allowable expenses (from Wkst. C, col. 2, line 18)		1
2	Total composite costs (from Wkst. D, col. 2, line 11)		2
3	Facility specific composite cost percentage (line 2 divided by line 1)		3

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET E - 1

PART I

	Description			Part B mm/dd/yyyy 1		
	TO BE COMPLETED BY CONTRACTOR					
1	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Program to Provider	.01			1.01
			.02			1.02
			.03			1.03
		Provider to Program	.50			1.5
			.51			1.51
			.52			1.52
	SUBTOTAL (Sum of lines 1.01 - 1.49 minus sum of lines 1.50 - 1.98) (Transfer to Wkst E, Part I, line 18)		.99			1.99
2	Determine net settlement amount (balance due) based on the cost report. (1)	Program to provider	.01			2.01
		Provider to program	.50			2.50
3	Name of Contractor			Contractor Number		3

(1) On lines 3, 5, and 6, where an amount is due "Provider to Program," show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

PART II

TO BE COMPLETED BY PROVIDER

4	LOW VOLUME PAYMENT AMOUNT (see instructions)		4

BALANCE SHEET	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET F

	ASSETS (omit cents)		
	CURRENT ASSETS		
1	Cash on hand and in banks		1
2	Temporary investments		2
3	Notes receivable		3
4	Accounts receivable		4
5	Other receivables		5
6	Less: allowances for uncollectible notes and accounts receivable		6
7	Inventory		7
8	Prepaid expenses		8
9	Other current assets		9
10	Due from other funds		10
11	TOTAL CURRENT ASSETS (Sum of lines 1 through 10)		11
	FIXED ASSETS		
12	Land		12
13	Land improvements		13
14	Less: Accumulated depreciation		14
15	Buildings		15
16	Less Accumulated depreciation		16
17	Leasehold improvements		17
18	Less: Accumulated Amortization		18
19	Fixed equipment		19
20	Less: Accumulated depreciation		20
21	Automobiles and trucks		21
22	Less: Accumulated depreciation		22
23	Major movable equipment		23
24	Less: Accumulated depreciation		24
25	Minor equipment nondepreciable		25
26	Other fixed assets		26
27	TOTAL FIXED ASSETS (Sum of lines 12 through 26)		27
	OTHER ASSETS		
28	Investments		28
29	Deposits on leases		29
30	Due from owners/officers		30
31	Other assets		31
32	TOTAL OTHER ASSETS (Sum of lines 28 through 31)		32
33	TOTAL ASSETS (Sum of lines 11, 27, and 32)		33

	LIABILITIES AND FUND BALANCES (omit cents)		
	CURRENT LIABILITIES		
34	Accounts payable		34
35	Salaries, wages & fees payable		35
36	Payroll taxes payable		36
37	Notes & loans payable (Short term)		37
38	Deferred income		38
39	Accelerated payments		39
40	Due to other funds		40
41	Other current liabilities		41
42	TOTAL CURRENT LIABILITIES (Sum of lines 34 through 41)		42
	LONG TERM LIABILITIES		
43	Mortgage payable		43
44	Notes payable		44
45	Unsecured loans		45
46	Other long term liabilities		46
47			47
48	TOTAL LONG TERM LIABILITIES (Sum of lines 43 through 48)		48
49	TOTAL LIABILITIES (Sum of lines 42 and 49)		49
	CAPITAL ACCOUNTS		
50	FUND BALANCES		50
51	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 49 and 50)		51

( ) = contra amount

STATEMENT OF REVENUES AND EXPENSES	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET F-1

1	Total patient revenues			1
2	Less: Allowances and discounts on patients' accounts			2
3	Net patient revenues (Line 1 minus line 2)			3
4	Operating expenses (From Worksheet A, column 8, line 27)			4
5	Additions to operating expenses (Specify)			5
6				6
7				7
8				8
9				9
10				10
11	Subtractions from operating expenses (Specify)			11
12				12
13				13
14				14
15				15
16				16
17	Less total operating expenses (net of lines 4 thru 16)			17
18	Net income from service to patients (Line 3 minus line 17)			18
	Other income:			
19	Contributions, donations, bequests, etc.			19
20	Income from investments			20
21	Purchase discounts			21
22	Rebates and refunds of expenses			22
23	Sale of Medical and Nursing Supplies to other than patients			23
24	Sale of durable medical equipment to other than patients			24
25	Sale of drugs to other than patients			25
26	Sale of medical records and abstracts			26
27	Other revenues (Specify)			27
28				28
29				29
30				30
31				31
32	Total Other Income (Sum of lines 19 thru 31)			32
33	Net Income or Loss for the period (Line 18 plus line 32)			33