
Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 42, Form CMS-265-11

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal 3

Date: May 2014

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NEW COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: This transmittal updates Chapter 42, Independent Renal Dialysis Facility Cost Report (Form CMS-265-11) to clarify existing instructions. The effective dates vary.

Significant revisions include:

- Worksheet B and B-1 – Clarifies instructions to note that negative amounts are excluded when allocating A&G and Other Cost Centers.
- Worksheet E, Part I, line 19 – Clarifies instructions for the calculation of the sequestration amount.
- Updates specifications for Worksheet S, and Worksheet E, Part I.
- Updates edit 1000D.
- Adds edits 1022S, 1000C, 1010C, 1010D, and 1010E.

REVISED ELECTRONIC SPECIFICATIONS--EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after March 31, 2014.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/ revised information only, and not the entire table of contents.

CHAPTER 42

INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT
FORM CMS-265-11

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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. 15-2, chapter 1, section 110 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. 15-2, §102.1(B).)

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
1=Corporation
2=Other (specify)

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

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

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.--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 percent PPS effective January 1, 2011. Enter "Y" for yes or "N" for no. 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, are paid based on 100 percent of the ESRD PPS payment. ESRD facilities certified for Medicare participation on or after January 1, 2011, must enter "Y" for yes.

Line 14.--If your facility did not elect to be paid based on 100 percent 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 percent 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 period 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 percent 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 and after January 1, 2014 are 100 percent ESRD PPS.

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

4205.1 WORKSHEET S-2 - INDEPENDENT RENAL DIALYSIS FACILITY REIMBURSE-MENT QUESTIONNAIRE

The information required on this worksheet (formerly Form CMS-339) must be completed by all ESRD 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 gather pertinent information about key reimbursement concepts as well as to support certain financial and statistical entries on the 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 *that* 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 consults 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 ESRD facilities.

Line 1.--Indicate whether the provider 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 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 was 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 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.)

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 that 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 that are uncollectible from Medicare beneficiaries. (See 42 CFR §§413.89(e), 413.89(h)(3), and CMS Pub. 15-1, §§306 - 324 for the criteria for an allowable bad debt.) Enter “Y” for yes or “N” for no. If you answer “Y”, submit a completed Exhibit 1 or 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 and 4.--Patient Names, Health Insurance Claim (HIC) Number, Dates of Service (From) and (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 *claimed* bad debt. (See CMS Pub. 15-1, §314 and 42 CFR §413.89.)

Columns 5 and 6.--Indigency/Welfare Recipient--If the patient was deemed indigent, place a check in column 5 and include a valid Medicaid number, where applicable, *in column 6*. See the criteria in CMS Pub. 15-1, §§312 and 322 and 42 CFR §413.89 for guidance on the billing requirements for indigent patients and welfare recipients.

Columns 7 and 8.--Date First Bill Sent to Beneficiary and Date Collection Efforts Ceased--This information is obtained from the provider’s files and must correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2 and 3 of this exhibit. The date in column 8 represents the date that the unpaid account was 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 9.--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 10 and 11.--Deductibles & Coinsurance--Record in these columns the beneficiary’s unpaid deductible and coinsurance amounts that relate to covered services.

Column 12.--Total Medicare Bad Debts--Enter on each line of this column, the sum of the amounts in columns 10 and 11. Calculate the total bad debts amounts on all lines of column 12. 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 on Exhibit 1 (or the provider's schedules) is not captured in the ECR file. The exhibit/schedule may be submitted either manually (hard copy), or electronically (e.g. CD).

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

Line 8.--Indicate whether patient deductibles and/or coinsurance were waived. Enter "Y" for yes or "N" for no. If you answer "Y", ensure the deductibles and/or coinsurance were not included on the bad debt listings (i.e., Exhibit 1 or your 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 column 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.

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 column 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.

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 were 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", submit a schedule of claims not included on the PS&R. This schedule must include claims that are unprocessed or unpaid and must be identified by revenue codes consistent with those reported on the PS&R.

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 that 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", enter a description of the other adjustments and documentation that 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 detailed 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 that 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 that are applicable.

Where the cost elements of a cost center were 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 *that* 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, but rather 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 furnished 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 dieticians.

Salaries paid to physicians are not included in this cost center but 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, is 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. 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 CMS Pub. 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 CMS Pub. 100-04, Chapter 8, §50.2). In addition to drugs included in the composite rate, this cost center includes separately billable injectable drugs provided to the facility's patients. Effective for claims with dates of service on or after January 1, 2011, ESRD-related injectable drugs and biologicals and oral equivalents of those injectable drugs and biologicals are included and are no longer separately billable. Report all drugs, ESRD related and non-ESRD related (including approved ESAs), on this line (see CMS Pub. 100-04, chapter 8, §50.2). Do not include on this line any ESA drug cost for dates of service prior to January 1, 2011, as these costs must be reported on line 23.

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 that 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.

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, etc. and (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement. (See CMS Pub. 15-1, chapter 23, §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. *Do not use for purchases on or after January 1, 2012; use line 20.01.*

Line 20.--Enter rebates taken on aranesp purchases on or after January 1, 2011. *Do not use for purchases on or after January 1, 2012; use line 20.01.*

Line 20.01.--Enter rebates taken on ESA drug purchases on or after January 1, 2012.

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.

4210. WORKSHEET A-4 - STATEMENT OF COMPENSATION

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 performed more than one duty, the person's combined percentage may not total over 100 percent. For example, if one person was both an administrator and a medical director, and spent 60 percent the workweek as an administrator, then a maximum of 40 percent can be reported as time spent as the medical director. Use a separate line per person per function. When one person performed 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 that 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 rendered 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 *that* the owner received from the institution; and deferred compensation.

4210.2 Part II – Statement of Total Compensation to Administrators, Assistant Administrators, and/or 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 who performed 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 *that* 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 for columns 1 through 8. The column and line numbers for columns 1 through 8 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

Columns 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 multiplied by the costs allocated on the respective lines on Worksheet B, column 2.

Columns 7 and 8.--These columns allocate supplies and laboratory services, (i.e., ESRD related and Non-ESRD related) provided to both Medicare and non-Medicare patients, *that* were furnished by, billed by, and reimbursed to your facility. Do not include any items and services that were billed by physicians as such costs are not part of your facility's costs. To determine the costs allocated to the various cost centers, report 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 *CMS Pub.* 100-04, Chapter 8, §50.1.)

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 each result 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 *amounts greater than zero* in column 8A of Worksheet B. *Exclude any cost centers with negative amounts in column 8A of Worksheet B as the negative amounts will cause an improper distribution of this overhead cost center.* 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>Lines</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:

From Worksheet B	To
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 amounts for the reimbursable cost centers are transferred to Worksheet C.

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

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.--Enter the average cost *per* treatment 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.--Report "total provider treatments" on this line. 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.

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.

4214. WORKSHEET E - CALCULATION OF BAD **DEBT REIMBURSEMENT**

4214.1 Part I – Calculation of Reimbursable Bad Debts Title XVIII – Part B.--Under the composite rate payment system for services prior to January 1, 2011, the contractor pays the facility its allowable ESRD bad debts, up to the facility's unreimbursed 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 for allowable ESRD bad debts, up to the facility's unreimbursed 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.

Determination of bad debt amounts for the basic case-mix adjusted composite rate payment portion of the ESRD PPS payment, is based on the percentage of basic composite rate payment costs to total costs on a facility specific basis. The facility specific composite rate percentage is applied to the facility's total bad debt amounts associated with the ESRD PPS payment. The resulting bad debt amount is used to determine the allowable Medicare bad debt payment in accordance with 42 CFR §413.89 of the regulations. During the transition periods, apply the facility specific composite cost percentage to the bad debt amounts associated with 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 percent 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 percent composite rate and 25 percent ESRD PPS payment rate. The facility specific composite cost percentage will be applied to 25 percent of the bad debts and the resulting bad debt amount will be added to the transitional 75 percent 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 percent 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 is 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 the sum of the amount from Worksheet D, column 5, line 11. The amount reported is reflective of the provider's calculated basic composite rate payment cost.

Line 2.--*For cost reporting periods that straddle January 1, 2011, 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 for outlier payments applicable to Medicare (Part B) patients from your records. (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. Include only deductibles and coinsurance amounts that are related 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. Include only deductibles and coinsurance amounts that are related 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.

Line 7.02.--Enter in column 1, the amount shown in your records for deductibles and coinsurance billed to Medicare (Part B) patients. Include only deductibles and coinsurance amounts that are related 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.

Line 7.03--Enter the sum of column 2, lines 7, 7.01 and 7.02. If that sum is less than 20 percent of the amount reported on line 2.03, column 2, enter 20 percent of the amount reported 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 percent of the amount in column 1, plus 25 percent 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 percent PPS, do not complete this line but 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 percent of the amount in column 1, plus 50 percent 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 percent PPS, do not complete this line but 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 percent of the amount in column 1, plus 75 percent 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 percent PPS, do not complete this line but 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 percent 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 percent 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 percent 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 result. If the amount on line 14 exceeds the amount on line 6, do not complete line 16. For cost reporting periods beginning on or after January 1, 2013, do not complete this line.

Line 16--For cost reporting periods ending on or before September 30, 2012, enter the lesser of the amount on line 13, column 2, or the amount on line 15. For cost reporting periods beginning on or after October 1, 2012, enter the lesser of the amount on line 13, column 2 times 88 percent, or the amount on line 15. For cost reporting periods beginning on or after January 1, 2013, enter the amount on line 13, column 2 times 88 percent. For cost reporting periods beginning on or after October 1, 2013, enter the amount on line 13, column 2 times 76 percent. For cost reporting periods beginning on or after October 1, 2014, enter the amount on line 13, column 2 times 65 percent.

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 13, i.e., line 17 is a subset of line 13.

Line 18.--Your contractor will enter the Part A tentative adjustments from Worksheet E-1, column 2, line 1.99.

Line 19.--Enter the sequestration adjustment amount. For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period), rounded to four decimal places) times line 16]. *If line 16 is less than zero, do not calculate the sequestration adjustment.*

Line 20.--Enter the net of the amount on line 16 minus lines 18 and 19. Enter a negative amount in parentheses ().

4214.2 Part II – Calculation of Facility Specific Composite Cost Percentage.--A facility specific composite cost percentage is 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 dividing your facility's basic composite rate costs by your total allowable expenses.

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 PROVIDER FOR SERVICES RENDERED

4215.1 Part I – For Contractor Use Only

Line 1.--List the date and amount of each tentative settlement payment for this cost reporting period.

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.--For cost reporting periods that begin or overlap January 1, 2012, if your response on Worksheet S, Part II, line 10 is "Y", enter the amount of your low volume payments.

4216. WORKSHEETS F - BALANCE SHEET and WORKSHEET F-1 - STATEMENT OF REVENUES AND EXPENSES.

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 that do not include the "F" series worksheets are considered incomplete and unacceptable.

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
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report Date (mm/dd/yyyy): _____ Time: _____ 2. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> 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. (If certified on/after 1/1/2011, see instructions.)				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 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

I HEREBY CERTIFY that I have read the above *certification* 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 Provider CCN(s)} for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and 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, *and that the services* identified in this cost report were provided in compliance with such laws and regulations.

OFFICER OR ADMINISTRATOR OF PROVIDER

Printed Name _____ Signed _____
 Title _____ Date _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0236. The time required to complete this information collection is estimated 65 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-265-11 (06/2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4204, 4204.1 AND 4204.2)

INDEPENDENT RENAL DIALYSIS FACILITY STATISTICAL DATA	PROVIDER CCN:	PERIOD: From: To:	WORKSHEET S-1
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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
				1	2	
15.01	ESA and units furnished to patients during the cost reporting period (see instructions)					15.01

TRANSPLANT STATISTICS

16	Number of patients awaiting transplants					16
17	Number of patients who received transplants					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 were 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
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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 similar 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		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 1	OTHER 2						OTHER 3
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
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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	
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:	WORKSHEET A-2	
			To:		
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		LINE NO.
	1		2	COST CENTER 3	
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 M	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 (see instructions)			Epoetin	12 19
20	Rebates on Aranesp on or after January 1, 2011 (see instructions)			Aranesp	12 20
20.01	Rebates on ESA drugs on or after January 1, 2012			Drugs	12 20.01
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. 15-1
- (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
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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 to organizations furnishing services, facilities, or supplies:

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 provide 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.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S)			
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
1	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)

	TITLE	FUNCTION (A)	SOLE PROPRIETORSHIPS	PARTNERS		CORPORATION OWNERS		TOTAL COMPENSATION INCLUDED IN ALLOWABLE COSTS FOR THE PERIOD (B)	
			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		
	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 EXPENSE FOR COST ALLOC. (from Wkst. A, col. 8)	CAP REL OP & MAINT & HOUSE	STEP DOWN OF OF COL. 2	MACH CAP REL OR <i>REN</i> & MAINT	SALARIES FOR DIR PT CARE	EH&W BENE FOR DIR PT CARE	SUPPLIES	LABORATORY	
	1	2	3	4	5	6	7	8	
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 2-17.02)								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	Totals (see instructions)								23

*Transfer the amounts to Wkst. C, col. 2, as appropriate

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

FORM CMS-265-11 (06/2013) (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			
		SUBTOTAL (col. 1 through col. 8)	A & G & OTHER COST CENTERS	DRUGS	DRUGS INCL. IN COMP RATE	SUBTOTAL (see instructions)	ESA'S	ESRD RELATED DRUGS	TOTAL EXPENSES ALL PAT. SVCS. (cols. 11A-13)	
		8A	9	10	11	11A	12	13	13A	
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 2-17.02)									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	Totals (see instructions)									23

*Transfer the amounts to Wkst. C, col. 2, as appropriate

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

FORM CMS-265-11 (12/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4211)

COST ALLOCATION - STATISTICAL BASIS				PROVIDER CCN:		PERIOD: From: To:		WORKSHEET B-1		
		<i>NET EXPENSES FOR COST ALLOC.</i>	CAP REL OP & MAINT & HOUSE (SQUARE FEET) (1)	STEP DOWN OF COL. 2 (# TREAT MENTS) (3)	MACH CAP REL OR RENT & MAINT (% TIME) (3)	SALARIES FOR DIR PT CARE (HRS OF SERVICE) (3)	EH&W BENE FOR DIR PT CARE (GROSS SALARIES) (3)	SUPPLIES (CHARGES) (3)	LABORATORY (CHARGES) (3)	
		1	2	3	4	5	6	7	8	
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

COST ALLOCATION - STATISTICAL BASIS				PROVIDER CCN:		PERIOD: From: To:		WORKSHEET B-1	
		UNIT COST MULTIPLIER	DRUGS (CHARGES)	DRUGS INCLD IN COMP RATE (CHARGES)		ESA'S (CHARGES)	ESRD REL DRUGS (CHARGES)	TOTAL EXPENSES ALL PATIENT SERVICES	
	<i>8A</i>	COMPUTATION 9	(3)	(3)	<i>11A</i>	(3)	(3)	13A	
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

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COMPUTATION OF AVERAGE COST PER TREATMENT ESRD PPS BUNDLED PAYMENT		PROVIDER CCN:	PERIOD: From: To:	WORKSHEET C
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		TOTAL			
		NUMBER OF TREATMENTS	COSTS (Transferred from Wkst. B, col. 13A)	AVERAGE COST <i>PER</i> TREATMENT (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 /ines 8.01 through 15.02) (Column 2 - sum of /ines 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
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		TOTAL			MEDICARE											
		TOTAL NUMBER OF TREATMENTS	COSTS (transfer from Wkst. B, col. 11A)	AVERAGE COST OF TREATMENT (col 2 / col. 1)	NUMBER OF TREATMENTS (see instructions)	NUMBER OF TREATMENTS (see instructions)	NUMBER OF TREATMENTS (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)													2
3	Training-Hemodialysis		(line 10.01 and line 10.02)													3
4	Training-IPD		(line 11.01 and line 11.02)													4
5	Training-CAPD		(line 12.01 and line 12.02)													5
6	Training-CCPD		(line 13.01 and line 13.02)													6
7	Home Program-Hemodialysis		(line 14.01 and line 14.02)													7
8	Home Program-IPD		<i>(line 15.01 and line 15.02)</i>													8
9	Home Program-CAPD	Patient Weeks	(line 16.01 and line 16.02)													9
10	Home Program-CCPD	Patient Weeks	(line 17.01 and line 17.02)													10
11	Total (see instructions)															11

CALCULATION OF BAD DEBT REIMBURSEMENT		PROVIDER CCN:	PERIOD: From:	WORKSHEET E, PARTS I & II
			To:	
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 <i>instructions</i>)			2.01
2.02	Total payment due net of Part B deductibles (from Wkst. D, col. 7.02, line 11) (see <i>instructions</i>)			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
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
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 (see <i>instructions</i>)			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 (see <i>instructions</i>)			16
17	Reimbursable bad debts for dual eligible beneficiaries (see instructions--informational only)			17
18	Tentative adjustment			18
19	Sequestration adjustment amount			19
20	Balance due provider/program (line 16 minus lines 18 and 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
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PART I - TO BE COMPLETED BY CONTRACTOR

Description	Part B		Amount
	mm/dd/yyyy		
	1		
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	.01	1.01
	Provider	.02	1.02
	Provider to	.03	1.03
	Program	.50	1.50
		.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 line 2.50, 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
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ASSETS (omit cents)		
CURRENT ASSETS		
		<i>Amount</i>
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 47)	48
49	TOTAL LIABILITIES (Sum of lines 42 and 48)	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
		<i>Amount</i>	<i>Amount</i>	
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 6, 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 through 16)			17
18	Net income from services 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 through 31)			32
33	Net Income or Loss for the period (Line 18 plus line 32)			33

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-11
TABLE OF CONTENTS

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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting. Each electronic cost report submission (file) has four types of records. The first group (type 1 records) contains information for identifying, processing, and resolving problems. The text used throughout the cost report for variable line labels (e.g., Worksheet A) and variable column headers (Worksheet B-1) is included in the type 2 records. Refer to Table 5 for cost center coding. The data detailed in Table 3 are identified as type 3 records. The encryption coding at the end of the file, records 1, 1.01, and 1.02, are type 4 records.

The medium for transferring cost reports submitted electronically to contractors is *compact disc (CD), flash drive, or other means (such as electronic mail or a secured website) as approved by the provider's contractor*. The *file* must be in IBM format *and* the character set must be ASCII. *A provider* must seek approval from *their* contractor regarding alternate methods of submission to ensure that the method of transmission is acceptable. *The ECR and PI files sent via electronic mail or uploaded to a secured website must be compressed or self-extracting files.*

The following are requirements for all records:

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

Below is an example of a Type 1 record with a narrative description of its meaning.

1	2	3	4	5	6
123456789012345678901234567890123456789012345678901234567890					
1	1	272599201100120113656A99P00120121362011001			

Record #1: This is a cost report file submitted by Provider CCN 272599 for the period from January 1, 2011, (2011001) through December 31, 2011, (2011365). It is filed on Form CMS-265-11. It is prepared with vendor number A99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is an alpha character. Positions 39 and 40 remain constant for approvals issued after the first test case. This file is prepared by the ESRD facility on May 15, 2012 (2012136). The electronic cost report specification dated January 1, 2011, (2011001), is used to prepare this file.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
TABLE 1 - RECORD SPECIFICATIONS (Cont.)

FILE NAMING CONVENTION

Name each cost report ECR file in the following manner:
RDNNNNNN.YYL, where

1. RD (ESRD Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit CMS Certification Number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A through Z) to enable separate identification of files from ESRD facilities with two or more cost reporting periods ending in the same calendar year.

Name each cost report PI file in the following manner: PINNNNNN.YYL, where

1. PI (Print Image) is constant;
2. NNNNNN is the 6 digit CMS Certification Number,
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A through Z) to enable separate identification of files from ESRD facilities with two or more cost reporting periods ending in the same calendar year.

RECORD NAME: Type 1 Records - Record Number 1

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remark</u>
1. Record Type	1	X	1	Constant "1"
2. For Future Use	10	9	2-11	Numeric only
3. Spaces	1	X	12	
4. Record Number	1	X	13	Constant "1"
5. Spaces	3	X	14-16	
6. ESRD Provider CCN	6	9	17-22	Field must have 6 numeric characters.
7. Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8. Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9. MCR Version	1	X	37	Constant "6" (for FORM CMS-265-11)
10. Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 42-502.
11. Vendor Equipment	1	X	41	P = PC; M = Main Frame

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-11
TABLE 1 - RECORD SPECIFICATIONS (Cont.)

RECORD NAME: Type 1 Records - Record Number 1 (Cont.)

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remark</u>
12.. Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13. Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14. ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods <i>ending</i> on or after 2014090 (March 31, 2014). <i>Prior approvals 2012275 for cost reports beginning on or after October 1, 2013, and 2011001 for cost reporting periods ending on or after January 1, 2011.</i>

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

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remark</u>
1. Record Type	1	9	1	Constant "1"
2. Spaces	10	X	2-11	
3. Record Number	2	9	12-13	#2 - Reserved for future use. #3 - Vendor information; optional; left justified in positions 21 through 60. #4 - The time that the cost report is created. This is represented in military time as alpha numeric. Use positions 21 through 25. Example 2:30 pm is expressed as 14:30. #5 through 99 - Reserved for future use.
4. Spaces	7	X	14-20	Spaces (optional)
5. ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remark</u>
1. Record Type	1	9	1	Constant "2"
2. Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3. Spaces	2	X	9-10	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-11
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S				
<u>Part I: Cost report Status</u>				
Provider Use Only				
Electronically filed cost report	1	1	1	X
Manually submitted cost report	2	1	1	X
If this is an amended cost report enter the number of times the provider resubmitted this cost report = (0-9)	3	1	1	9
Creation Date (MM/DD/YYYY)	3	2	10	X
Creation Time (XX:XX:XX XX)	3	3	11	X
Contractor Use Only				
Cost Report Status	4	1	1	X
Date Received	5	1	10	X
Contractor Number	6	1	5	X
First Cost Report for Provider CCN	7	1	1	X
Last Cost Report for Provider CCN	8	1	1	X
NPR Date: (MM/DD/YYYY)	9	1	10	X
If line 4, column 1 is "4", enter number of times reopened = (0-9)	10	1	1	9
Enter the Contractor's vendor code	11	1	3	X
<u>Part II: General</u>				
Name	1	1	36	X
Street	2	1	36	X
P.O. Box	2	2	9	X
City	3	1	36	X
State	3	2	2	X
ZIP Code	3	3	10	X
County	4	1	36	X
CBSA Code (XXXXXX)	4	2	5	X
Provider CCN (XXXXXXX)	5	1	6	X
Date Certified (MM/DD/YYYY)	6	1	10	X
Contact Person Name	7	1	36	X
Phone number (XXX-XXX-XXXX)	7	2	12	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-11
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
 DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S (Cont.)				
Cost reporting period beginning date (MM/DD/YYYY)	8	1	10	X
Cost reporting period ending date (MM/DD/YYYY)	8	2	10	X
Type of control: (See Table 3B)	9	1	2	9
Other(Specify)	9	2	36	X
Is this facility approved as a low-volume facility for this cost reporting period? (Y/N)	10	1	1	X
Type of physicians' reimbursement: (See Table 3B)	11	1	1	9
Date of election of initial method (MM/DD/YYYY)	11	2	10	X
Was this facility previously certified as a hospital-based unit? (Y/N)	12	1	1	X
Did your facility elect 100 percent PPS effective January 1, 2011? (Y/N)	13	1	1	X
If you responded "N" to line 13, enter in col. 1 the year of transition for periods prior to January 1	14	1	1	X
And enter in col. 2 the year of transition for periods after December 31	14	2	1	X
Malpractice premiums	15	1	9	-9
Malpractice paid losses	16	1	9	-9
Malpractice self insurance	17	1	9	-9
Are malpractice premiums and/or paid losses reported in other than the A&G cost center? (Y/N)	18	1	1	X
If you are part of a chain organization enter "Y" for yes or "N" for no.	19	1	1	X
If line 19 is "Y" enter the Name:	20	1	36	X
Street	21	1	36	X
P.O. Box	21	2	9	X
City	22	1	36	X
State	22	2	2	X
<i>ZIP</i> code of the organization	22	3	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET B				
Costs after cost finding by department	5-7, 8.01-8.02, 9.01-9.02, 10.01-10.02, 11.01-11.02, 12.01-12.02, 13.01-13.02, 14.01-14.02, 15.01-15.02, 16.01-16.02, 17.01-17.02, 19-22	13A	9	-9
Total costs after cost finding	23	13A	9	9
WORKSHEET B-1				
All cost allocation statistics	2-22	2-8, 10-13	9	9
WORKSHEET C				
Total number of treatments	8.01-15.02, 18	1	11	9
Total CAPD patient weeks	16.01-16.02	1	11	9
Total CCPD patient weeks	17.01-17.02	1	11	9
Total provider treatments (informational only)	19	1	11	9
WORKSHEET D				
Total number of treatments	1-8,11	1	11	9
Total CAPD patient weeks	9	1	11	9
Total CCPD patient weeks	10	1	11	9
Number of treatments-Medicare	1-8,11	4, 4.01 & 4.02	11	9
CAPD patient weeks-Medicare	9	4, 4.01 & 4.02	11	9
CCPD patient weeks-Medicare	10	4, 4.01 & 4.02	11	9
Average Payment Rates	1-10	6, 6.01 & 6.02	6	9(3).99
Total Payment Due	1-10	7, 7.01, 7.02 & 8	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
 DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET E, Part I				
Part I – Calculation of Reimbursable Bad Debts Title XVIII – Part B				
Total expenses related to care of Medicare beneficiaries	1	1	11	9
Total payment due net of Part B deductibles	2-2.03	1 & 2	11	9
Outlier payments	3	1	11	9
Program payments (80 percent of line 2.03, column 2)	5	1	11	9
Amount of cost to be recovered from Medicare patients (line 1 minus line 5)	6	1	11	9
Deductibles & coinsurance billed to Medicare Part B patients	7 - 7.02	1 & 2	11	9
Total deductibles & coinsurance billed to Medicare Part B patients for comparison	7.03	1	11	9
Bad debts for deductibles & coinsurance net of bad debt recoveries for services rendered prior to 1/1/2011	8	1 & 2	11	-9
Transition period 1 (75-25 percent) bad debts for deductibles & coinsurance net of bad debt recoveries for services on or after 1/1/2011 but before 1/1/2012	9	1 & 2	11	-9
Transition period 2 (50-50 percent) bad debts for deductibles & coinsurance net of bad debt recoveries for services on or after 1/1/2012 but before 1/1/2013	10	1 & 2	11	-9
Transition period 3 (25-75 percent) bad debts for deductibles & coinsurance net of bad debt recoveries for services on or after 1/1/2013 but before 1/1/2014	11	1 & 2	11	-9
100 percent PPS bad debts for deductibles & coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	12	1 & 2	11	-9
Total bad debts (sum of lines 8 through 12)	13	1 & 2	11	-9
Net deductibles and coinsurance billed to Unrecovered from Medicare Part B patients	14	1	11	9
	15	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-11
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET E, Part I (Cont.)				
Reimbursable bad debts	16	1	11	-9
Reimbursable bad debts for dual eligible beneficiaries	17	1	11	9
Sequestration adjustment amount	19	1	11	9
Balance due provider/(program)	20	1	11	-9
WORKSHEET E, Part II				
Part II - Calculation of Facility Specific Composite Cost Percentage				
Total allowable expenses	1	1	9	9
Total composite costs	2	1	9	9
Facility specific composite cost percentage	3	1	9	9.9(6)
WORKSHEET E-1 Part I				
Part I – TO BE COMPLETED BY CONTRACTOR				
Enter the date of the tentative payment from program to provider (mm/dd/yyyy)	1.01 - 1.49	1	10	X
Enter the amount of the tentative payment from program to provider	1.01 - 1.49	2	9	-9
Enter the date of the tentative payment from provider to program (mm/dd/yyyy)	1.50 - 1.98	1	10	X
Enter the amount of the tentative payment from provider to program	1.50 - 1.98	2	9	-9
Name of contractor	3	0	39	X
Contractor number	3	1	5	X
WORKSHEET E-1 Part II				
Part II - TO BE COMPLETED BY PROVIDER				
Low volume payment amount	4	1	9	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-11
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET F				
For all ESRD (end stage renal disease) facilities (see note):				
Balance sheet account balances	1 - 10, 12 - 26, 28 - 31, 34 - 41, 43 - 47, 50, 51	1	9	-9
Other (specify)	47	0	36	X

NOTE: For contra accounts (reported on lines 6, 14, 16, 18, 20, 22, and 24), the usage is -9.

WORKSHEET F-1

Total patient revenues	1	1	9	9
Allowances and discounts on patients' accounts	2	1	9	9
Blank lines (specify)	5 - 10, 11 - 16	0	36	X
Increases to operating expenses reported on Worksheet A	5 - 10	1	9	9
Decreases to operating expenses reported on Worksheet A	11 - 16	1	9	9
Other revenues	19 - 31	1	9	9
Blank lines (specify)	27 - 31	0	36	X
Net income or (loss) for the period	33	2	9	-9

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet B

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
TABLE 6 - EDITS

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

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

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

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

I. Level I Edits (Minimum File Requirements)

<u>Reject Code</u>	<u>Condition</u>
1000	The first digit of every record must be either 1, 2, 3, or 4 (encryption code only). [1/1/2011]
1005	No record may exceed 60 characters. [1/1/2011]
1010	All alpha characters must be in upper case. This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [1/1/2011]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [1/1/2011]
1020	The independent renal dialysis facility provider number (record #1, positions 17 through 22) must be valid and numeric. [1/1/2011]
1025	All dates (record #1, positions 23 through 29, 30 through 36, 45 through 51, and 52 through 58) must be in Julian format and legitimate. [1/1/2011]
1030	The fiscal year beginning date (record #1, positions 23 through 29) must be less than the fiscal year ending date (record #1, positions 30-36). [1/1/2011]
1035	The vendor code (record #1, positions 38 through 40) must be a valid code. [1/1/2011]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements) (Cont.)

<u>Reject Code</u>	<u>Condition</u>
1050	The type 1 record #1 must be correct and the first record in the file. [1/1/2011]
1055	All record identifiers (positions 1 through 20) must be unique. [1/1/2011]
1060	Only a Y or N is valid for fields <i>that</i> require a Yes/No response. [1/1/2011]
1075	Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [1/1/2011]
1080	For every line used on Worksheets A, there must be a corresponding type 2 record. [1/1/2011]
1090	Fields requiring numeric data (charges, treatments, costs, FTEs, etc.) may not contain any alpha character. [1/1/2011]
1100	In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [1/1/2011]
1005S	The cost reporting <i>period</i> ending date (Worksheet S, Part II, column 2, line 8) must be on or after January 1, 2011. [1/1/2011]
1010S	The cost reporting <i>period</i> beginning date (Worksheet S, Part II, column 1, line 8) must precede the cost reporting <i>period</i> ending date (Worksheet S, Part II, column 2, line 8). [1/1/2011]
1015S	The independent renal dialysis facility name, address, city, State, ZIP code, provider CCN, and certification date (Worksheet S, Part II, line 1, column 1; line 2, column 1; line 3, columns 1, 2, & 3; lines 5 and 6, column 1) must be present and valid. [1/1/2011]
1020S	The type of control (Worksheet S, Part II, line 9, column 1) must be present and a valid code of 1 <i>through</i> 11. If code 2, 6, or 11 is entered, there must be an entry in column 2. [1/1/2011]
<i>1022S</i>	<i>If Worksheet S-1, column 1, line 14 or 15, or column 2, line 15.01 (including all subscripted lines of line 15.01), is greater than zero, then Worksheet A, column 8, line 12 must be greater than zero. [1/1/2011]</i>
1025S	The independent renal dialysis total number of hours per work week must be greater than zero (0) (Worksheet S-1, line 21, column 1). [1/1/2011]
1030S	The total number FTEs for Social Workers must be greater than zero (0) (Worksheet S-1, line 27, sum of columns 1 and 2). [1/1/2011]
1000A	All amounts reported on Worksheet A, columns 1 <i>through</i> 3, line 27, must be greater than or equal to zero. [1/1/2011]
<i>1005A</i>	<i>For cost reporting periods beginning on or after January 1, 2011, Worksheet A, column 8, line 23 must be zero. [1/1/2011b]</i>
1020A	For reclassifications reported on Worksheet A-1 the sum of all increases (column 4) must equal the sum of all decreases (column 7). [1/1/2011]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements) (Cont.)

<u>Reject Code</u>	<u>Condition</u>																						
1025A	For each line on Worksheet A-1, if there is an entry in columns 3, 4, 6, or 7, there must be an entry in column 1. There must be an entry on each line of column 4 for each entry in column 3 (and vice versa), and there must be an entry on each line of column 7 for each entry in column 6 (and vice versa). [1/1/2011]																						
1040A	For Worksheet A-2 adjustments on lines 1 through 6, and 8 through 21, if there is an amount in column 2, there must be an entry in columns 1 and 4, and if any of lines 22 through 99 and subscripts has an entry in column 2, then all columns 0, 1, 2, and 4 must have entries. Only valid line numbers may be used in column 4. [1/1/2011]																						
1045A	If there are any transactions with related organizations or home offices as defined in CMS Pub. 15-1, chapter 10 (Worksheet A-3, Part A, column 1, line 1 is "Y"), Worksheet A-3, Part B, columns 4 or 5, sum of lines 1 through 4 must be greater than zero; and Part C, column 1, any one of lines 1 through 4 must contain any one of alpha characters A through G. Conversely, if Worksheet A-3, Part A, column 1, line 1 is "N", Worksheet A-3, Parts B and C must not be completed. [1/1/2011]																						
1000B	On Worksheet B-1, all statistical amounts must be greater than or equal to zero. [4/1/2005]																						
1005B	For each overhead cost center with a net expense for cost allocation greater than zero (Worksheet A, column 8, lines 1 through 4 and 6 through 12,), the corresponding total cost allocation statistics (Worksheet B-1, columns 2 through 13, sum of lines 2 through 22) must also be greater than zero. Exclude from this edit any column that uses accumulated cost as its basis for allocation and any reconciliation column. [1/1/2011]																						
1010B	Worksheet B, columns 11A and 13A, line 23 must be greater than zero. [1/1/2011]																						
<i>1000C</i>	<i>For each line on Worksheet C (lines 8.01 through 17.02), if column 1 is greater than zero, then Worksheet C, column 2 for that line must also be greater than zero, and vice versa. [1/1/2011]</i>																						
<i>1010C</i>	<i>Total treatments on Worksheet C, column 1 must equal total treatments on Worksheet D, column 1 as noted below. [1/1/2011]</i>																						
	<table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Worksheet C</u></th> <th style="text-align: left;"><u>Worksheet D</u></th> </tr> </thead> <tbody> <tr> <td><i>Line 8.01 plus line 8.02</i></td> <td><i>Line 1</i></td> </tr> <tr> <td><i>Line 9.01 plus line 9.02</i></td> <td><i>Line 2</i></td> </tr> <tr> <td><i>Line 10.01 plus line 10.02</i></td> <td><i>Line 3</i></td> </tr> <tr> <td><i>Line 11.01 plus line 11.02</i></td> <td><i>Line 4</i></td> </tr> <tr> <td><i>Line 12.01 plus line 12.02</i></td> <td><i>Line 5</i></td> </tr> <tr> <td><i>Line 13.01 plus line 13.02</i></td> <td><i>Line 6</i></td> </tr> <tr> <td><i>Line 14.01 plus line 14.02</i></td> <td><i>Line 7</i></td> </tr> <tr> <td><i>Line 15.01 plus line 15.02</i></td> <td><i>Line 8</i></td> </tr> <tr> <td><i>Line 16.01 plus line 16.02</i></td> <td><i>Line 9</i></td> </tr> <tr> <td><i>Line 17.01 plus line 17.02</i></td> <td><i>Line 10</i></td> </tr> </tbody> </table>	<u>Worksheet C</u>	<u>Worksheet D</u>	<i>Line 8.01 plus line 8.02</i>	<i>Line 1</i>	<i>Line 9.01 plus line 9.02</i>	<i>Line 2</i>	<i>Line 10.01 plus line 10.02</i>	<i>Line 3</i>	<i>Line 11.01 plus line 11.02</i>	<i>Line 4</i>	<i>Line 12.01 plus line 12.02</i>	<i>Line 5</i>	<i>Line 13.01 plus line 13.02</i>	<i>Line 6</i>	<i>Line 14.01 plus line 14.02</i>	<i>Line 7</i>	<i>Line 15.01 plus line 15.02</i>	<i>Line 8</i>	<i>Line 16.01 plus line 16.02</i>	<i>Line 9</i>	<i>Line 17.01 plus line 17.02</i>	<i>Line 10</i>
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements) (Cont.)

<u>Reject Code</u>	<u>Condition</u>
1000D	Worksheet D, column 1, <i>lines 9, 10, or 11</i> must be greater than zero. [1/1/2011]
<i>1010D</i>	<i>For each line on Worksheet D, the sum of columns 4, 4.01, and 4.02 must be less than or equal to the total in column 1 for the same line. [1/1/2011]</i>
1000E	Worksheet E, Part I, line 1 must be greater than zero when the sum of Worksheet D, line 11, columns 4, 4.01 and 4.02 <i>is</i> greater than 0. [1/1/2011]
<i>1010E</i>	<i>For Worksheet E, Part I, column 1, line 2.03 must be greater than zero and less than or equal to Worksheet D, column 8, line 11. [1/1/2011]</i>

II. Level II Edits (Potential Rejection Errors)

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

<u>Edit</u>	<u>Condition</u>
2000	All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts). [1/1/2011]
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file. [1/1/2011]
2010	The cost center codes (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique. [1/1/2011]
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code. [1/1/2011]
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [1/1/2011]
2025	Only nonstandard cost center codes within a cost center category may be placed on standard cost center lines of that cost center category. [1/1/2011]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
TABLE 6 - EDITS

II. Level II Edits (Potential Rejection Errors) (Cont.)

<u>Edit</u>	<u>Condition</u>																																																																		
2030	The standard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [1/1/2011]																																																																		
	<table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>Cost Center</u></th> <th style="text-align: center;"><u>Line</u></th> <th style="text-align: center;"><u>Code</u></th> </tr> </thead> <tbody> <tr> <td>Cap Rel-Bldg & Fixt.</td> <td style="text-align: center;">1</td> <td style="text-align: center;">0100</td> </tr> <tr> <td>Cap Rel-Mvble Equip</td> <td style="text-align: center;">2</td> <td style="text-align: center;">0200</td> </tr> <tr> <td>Operation & Maintenance of Plant</td> <td style="text-align: center;">3</td> <td style="text-align: center;">0300</td> </tr> <tr> <td>Housekeeping</td> <td style="text-align: center;">4</td> <td style="text-align: center;">0400</td> </tr> <tr> <td>Machine Cap-Rel or Rental & Maint.</td> <td style="text-align: center;">6</td> <td style="text-align: center;">0600</td> </tr> <tr> <td>Salaries for Direct Patient Care</td> <td style="text-align: center;">7</td> <td style="text-align: center;">0700</td> </tr> <tr> <td>EH&W Benefits for Direct Pt. Care</td> <td style="text-align: center;">8</td> <td style="text-align: center;">0800</td> </tr> <tr> <td>Supplies</td> <td style="text-align: center;">9</td> <td style="text-align: center;">0900</td> </tr> <tr> <td>Laboratory</td> <td style="text-align: center;">10</td> <td style="text-align: center;">1000</td> </tr> <tr> <td>Administrative and General</td> <td style="text-align: center;">11</td> <td style="text-align: center;">1100</td> </tr> <tr> <td>Drugs</td> <td style="text-align: center;">12</td> <td style="text-align: center;">1200</td> </tr> <tr> <td>Interest Expense</td> <td style="text-align: center;">13</td> <td style="text-align: center;">1300</td> </tr> <tr> <td>Laundry and Linen</td> <td style="text-align: center;">14</td> <td style="text-align: center;">1400</td> </tr> <tr> <td>Medical Records</td> <td style="text-align: center;">15</td> <td style="text-align: center;">1500</td> </tr> <tr> <td>Phy Routine Prof Services-Initial Method</td> <td style="text-align: center;">16</td> <td style="text-align: center;">1600</td> </tr> <tr> <td>Phy Routine Prof Services-MCP Method</td> <td style="text-align: center;">19</td> <td style="text-align: center;">1900</td> </tr> <tr> <td>Whole Blood & Packed Red Blood Cells</td> <td style="text-align: center;">20</td> <td style="text-align: center;">2000</td> </tr> <tr> <td>Vaccines</td> <td style="text-align: center;">21</td> <td style="text-align: center;">2100</td> </tr> <tr> <td>Physicians' Private Offices</td> <td style="text-align: center;">22</td> <td style="text-align: center;">2200</td> </tr> <tr> <td>ESAs</td> <td style="text-align: center;">23</td> <td style="text-align: center;">2300</td> </tr> <tr> <td>Method II Patients (Direct Dealing)</td> <td style="text-align: center;">24</td> <td style="text-align: center;">2400</td> </tr> </tbody> </table>	<u>Cost Center</u>	<u>Line</u>	<u>Code</u>	Cap Rel-Bldg & Fixt.	1	0100	Cap Rel-Mvble Equip	2	0200	Operation & Maintenance of Plant	3	0300	Housekeeping	4	0400	Machine Cap-Rel or Rental & Maint.	6	0600	Salaries for Direct Patient Care	7	0700	EH&W Benefits for Direct Pt. Care	8	0800	Supplies	9	0900	Laboratory	10	1000	Administrative and General	11	1100	Drugs	12	1200	Interest Expense	13	1300	Laundry and Linen	14	1400	Medical Records	15	1500	Phy Routine Prof Services-Initial Method	16	1600	Phy Routine Prof Services-MCP Method	19	1900	Whole Blood & Packed Red Blood Cells	20	2000	Vaccines	21	2100	Physicians' Private Offices	22	2200	ESAs	23	2300	Method II Patients (Direct Dealing)	24	2400
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-11
TABLE 6 - EDITS

II. Level II Edits (Potential Rejection Errors) (Cont.)

<u>Edit</u>	<u>Condition</u>
2035	The administrative and general standard cost center code (1100) may appear only on line 11. [1/1/2011]
2040	All calendar format dates must be edited for 10 character format, e.g., 01/01/2011 (MM/DD/YYYY). [1/1/2011]
2045	All dates must be possible, e.g., no "00", no "30" or "31" in February. [1/1/2011]
2005S	If the response on Worksheet S, Part II, line 10 is "Y", the total treatments on Worksheet C, column 1, line 19 must be less than 4000. [1/1/2011]
2010S	If the response on Worksheet S, Part II, line 10 is "Y", effective for cost reporting periods that overlap 1/1/2012, there should be an amount on Worksheet E-1, Part II, line 4 and vice versa. [1/1/2012s].
2015S	The independent renal dialysis facility certification date (Worksheet S, column 1, line 3) should be on or before the cost report beginning date (Worksheet S, column 1, line 5). [1/1/2011]
2020S	The length of the cost reporting period should be greater than 27 days and less than 459 days. [1/1/2011]
2100S	The following statistics from Worksheet S-1, should be greater than zero: a. Total treatments for the independent renal dialysis facility (columns 1 through 4, line 11.05) [1/1/2011]
2000A	Worksheet A-1, column 1 (reclassification code) must be alpha characters. [1/1/2011]
2020A	Worksheet A-3, Part A, must contain a "Y" or "N" response. [1/1/2011]
2000B	At least one cost center description (lines 1 through 3), at least one statistical basis label (lines 4 through 5), and one statistical basis code (line 6) must be present for each general service cost center. This edit applies to all general service cost centers required and/or listed. [1/1/2011]
2005B	The column numbering among these worksheets must be consistent. For example, data in capital related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [1/1/2011]
2000F	Total assets on Worksheet F (line 33) must equal total liabilities and fund balances (line 51). [01/01/2013b]
2010F	Net income or loss (Worksheet F-1, column 2, line 33) should not equal zero. [01/01/2013b]

NOTE: CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet user requirements.