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
Expires 10/31/2025

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

PART I - COST REPORT STATUS

| | | | |
|---|---|---|---|
| Provider use only | 1. [ ] Electronically prepared cost report | Date (mm/dd/yyyy): _____ | Time: _____ |
| | 2. [ ] Manually prepared cost report | | |
| | 3. If this is an amended report enter the number of times the provider resubmitted this cost report. _____ | | |
| Contractor use only | 4. [ ] Cost Report Status<br>(1) As Submitted<br>(2) Settled without Audit<br>(3) Settled with Audit<br>(4) Reopened<br>(5) Amended | 5. Date Received: _____<br>6. Contractor No._____<br>7. [ ] First Cost Report for this Provider CCN<br>8. [ ] Last Cost Report for this Provider CCN<br>9. NPR Date: _____ | 10. If line 4, column 1 is "4", enter number of times reopened _____<br>11. Contractor Vendor Code _____<br>12. Medicare Utilization _____ |

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 |
| 10.01 | Is this facility reporting no Medicare utilization for the cost reporting period? Enter "Y" for yes or "N" for no. | | | | | 10.01 |
| 10.02 | Is this facility reporting low Medicare utilization for the cost reporting period? Enter "Y" for yes or "N" for no. | | | | | 10.02 |
| 11 | Type of physicians' reimbursement (see instructions) | | | | | 11 |
| 12 | Was this facility previously certified as a hospital-based unit? Enter "Y" for yes or "N" for no. | | | | | 12 |
| 13 | Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (see instructions.) | | | | | 13 |
| 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? See instructions. | | | | | 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ {Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, 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.

| | SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR | | CHECKBOX | ELECTRONIC SIGNATURE STATEMENT | |
|---|---|---|---|---|---|
| | 1 | | 2 | | |
| 1 | | | | I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature. | 1 |
| 2 | Signatory Printed Name | | | | 2 |
| 3 | Signatory Title | | | | 3 |
| 4 | Signature date | | | | 4 |

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 to average *66* 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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

RENAL DIALYSIS STATISTICS

| | | OUTPATIENT | | TRAINING | | |
|---|---|---|---|---|---|---|
| | | HEMODIALYSIS | PERITONEAL DIALYSIS | HEMODIALYSIS | PERITONEAL DIALYSIS | |
| | | 1 | 2 | 3 | 4 | |
| 1 | Number of treatments not billed to Medicare and furnished directly | | | | | 1 |
| 2 | Number of treatments not billed to Medicare and furnished under arrangements | | | | | 2 |
| 3 | Number of patients currently in dialysis program | | | | | 3 |
| 4 | Average times per week patient receives dialysis | | | | | 4 |
| 5 | Number of days in an average week for patient dialysis treatments | | | | | 5 |
| 6 | Average time of patient dialysis treatment including set up time | | | | | 6 |
| 7 | Number of machines regularly available for use | | | | | 7 |
| 8 | Number of standby machines | | | | | 8 |
| 9 | Number of shifts in typical week during regular reporting period | | | | | 9 |
| 10 | Hours per shift in typical week during regular reporting period | | | | | 10 |
| 10.01 | First shift | | | | | 10.01 |
| 10.02 | Second Shift | | | | | 10.02 |
| 10.03 | Third shift | | | | | 10.03 |
| 11 | Number of treatments provided | | | | | 11 |
| 11.01 | One (1) time per week | | | | | 11.01 |
| 11.02 | Two (2) times per week | | | | | 11.02 |
| 11.03 | Three (3) times per week | | | | | 11.03 |
| 11.04 | More than three (3) times per week | | | | | 11.04 |
| 11.05 | Total | | | | | 11.05 |

| | | Type of Dialyzers | Dialyzer Reuse Count | Other Dialyzers | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 12 | Column 1: Type of dialyzers used (see instructions)<br>Column 2: Number of times dialyzers are reused (see instructions)<br>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)<br>Column 2: Number of times dialyzers were reused (see instructions)<br>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 |
| 32 | Child Life/Other Specialists for Pediatric Patients | | | | 32 |
| 33 | Registered Nurses - Pediatric | | | | 33 |
| 34 | Nutritionists and Dieticians - Pediatric | | | | 34 |
| 35 | Pediatric Unit Staff | | | | 35 |

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

| | PROVIDER ORGANIZATION AND OPERATION | Y/N 1 | DATE 2 | V/I 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 1 | A/C/R 2 | DATE 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 coinsurance waived? Enter "Y" for yes or "N" for no. If yes, see instructions. | | 8 |

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

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

| | | FACILITY HEALTH CARE COSTS | SALARIES | | OTHER | TOTAL ( col. 1 through col. 3 ) | RECLASS. TO EXPENSES ( from Wkst. A-1 ) | RECLASSIFIED TRIAL BALANCE ( col 4. +/- col. 5 ) | ADJUSTMENTS TO EXPENSES ( from Wkst. A-2 ) | NET EXPENSES FOR COST ALLOCATION ( col. 6+/-col. 7 ) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | PHYSICIAN COMPENSATION | OTHER | | | | | | | |
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| | | COST CENTERS | | | | | | | | | |
| 1 | 0100 | Cap Rel Costs-Bldg & Fixt | | | | | | | | | 1 |
| 2 | 0200 | Cap Rel Costs-Mvble Equip | | | | | | | | | 2 |
| 3 | 0300 | Operation & Maintenance of Plant | | | | | | | | | 3 |
| 4 | 0400 | Housekeeping | | | | | | | | | 4 |
| 5 | | Subtotal (sum of lines 1 through 4)* | | | | | | | | | 5 |
| 6 | 0600 | Cap Rel Costs-Renal Dialysis Equip* | | | | | | | | | 6 |
| 7 | 0700 | Salaries for Direct Patient Care* | | | | | | | | | 7 |
| 8 | 0800 | EH&W Benefits for Direct Pt. Care | | | | | | | | | 8 |
| 9 | 0900 | Supplies* | | | | | | | | | 9 |
| 9.01 | 0901 | Supplies-Pediatric* | | | | | | | | | 9.01 |
| 10 | 1000 | Laboratory* | | | | | | | | | 10 |
| 11 | 1100 | Administrative & General | | | | | | | | | 11 |
| 12 | 1200 | Drugs* | | | | | | | | | 12 |
| 13 | 1300 | Interest Expense | | | | | | | | | 13 |
| 14 | 1400 | Laundry and Linen | | | | | | | | | 14 |
| 15 | 1500 | Medical Records | | | | | | | | | 15 |
| 16 | 1600 | Phy Rout Prof Svcs-Initial Method | | | | | | | | | 16 |
| 17 | 1700 | Other (Specify) | | | | | | | | | 17 |
| 18 | | Subtotal (sum of line 11 plus lines 13 through 17)* | | | | | | | | | 18 |
| 19 | 1900 | Phy Rout Prof Svcs-MCP Method | | | | | | | | | 19 |
| 20 | 2000 | Whole Blood & Packed Red Blood Cells* | | | | | | | | | 20 |
| 21 | 2100 | Vaccines* | | | | | | | | | 21 |
| | | NONREIMBURSABLE COSTS CENTERS | | | | | | | | | |
| 22 | 2200 | Physicians Private Offices* | | | | | | | | | 22 |
| 23 | 2300 | ESAs (prior to January 1, 2011) | | | | | | | | | 23 |
| 24 | 2400 | Method II Patients (prior to January 1, 2011) | | | | | | | | | 24 |
| 25 | 2500 | Other Nonreimbursable (specify)* | | | | | | | | | 25 |
| 26 | 2600 | Other Nonreimbursable (specify)* | | | | | | | | | 26 |
| 27 | | Total | | | | | | | | | 27 |

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

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

| | EXPLANATION OF ENTRY | CODE (1) | INCREASE | | | DECREASE | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | COST CENTER | LINE NO. | AMOUNT (2) | COST CENTER | LINE NO. | AMOUNT (2) | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 1 | | | | | | | | | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 11 | | | | | | | | | 11 |
| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
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| 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:<br>From:<br>To: | WORKSHEET A-2 |
|---|---|---|---|

| | DESCRIPTION (1) | BASIS FOR ADJUSTMENT (2) | AMOUNT | Expense classification on Worksheet A from which amount is to be deducted or to which the amount is to be added | | |
|---|---|---|---|---|---|---|
| | | | | COST CENTER | LINE NO. | |
| | | 1 | 2 | 3 | 4 | |
| 1 | Investment income on commingled restricted and unrestricted funds (Chapter 2) | | | | | 1 |
| 2 | Trade, quantity and time discounts on purchases (Chapter 8) | | | | | 2 |
| 3 | Rebates and refunds of expenses (Chapter 8) | | | | | 3 |
| 4 | Rental of building or office space to others | | | | | 4 |
| 5 | Physician non-routine professional patient care services | | | | | 5 |
| 6 | Home office costs (Chapter 21) | | | | | 6 |
| 7 | Adjustment resulting from transactions with related organizations (Chapter 10) | From Wkst. A-3 | | | | 7 |
| 8 | Vending machines | | | | | 8 |
| 9 | Meals served to patients | | | | | 9 |
| 10 | Physicians' professional services--MCP Method | A | | Physicians' professional services--MCP 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 |
|---|---|---|---|

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 a 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 ADJUST-MENT (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)<br>(Transfer col. 6, lines 1 through 4, to Wkst. A, col. 7, as appropriate)<br>(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.

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

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

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

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

PART I - STATEMENT OF TOTAL COMPENSATION TO OWNERS
(Include compensation of employees related to owners)

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

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

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

(A) Function or job description of each owner. If employee is related to owner, cite relationship.
(B) Compensation as used in this worksheet has the same definition as 42 CFR 413.102

| RECONCILIATION OF CAPITAL COSTS CENTERS | PROVIDER CCN: | PERIOD: From: To: | WORKSHEET A-7, PARTS I & II |
|---|---|---|---|

PART I - ANALYSIS OF CAPITAL COSTS FROM WORKSHEET A, LINES 1 AND 2

| | | SUMMARY OF CAPITAL | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DEPRE-CIATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CRC | TOTAL | | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | | | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | | 2 |
| 3 | Total (sum of lines 1 and 2) | | | | | | | | | | 3 |

PART II - ANALYSIS OF RENAL DIALYSIS EQUIPMENT COSTS FROM WORKSHEET A, LINE 6

| | | DEPRECIATION | | | | CAPITAL LEASE | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HEMO-DIALYSIS MACHINES | PERITONEAL DIALYSIS MACHINES | WATER PUR-IFICATION EQUIPMENT | TOTAL DEPRE-CIATION | HEMO-DIALYSIS MACHINES | PERITONEAL DIALYSIS MACHINES | WATER PUR-IFICATION EQUIPMENT | TOTAL CAPITAL LEASE | TOTAL | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| 1 | Capital Related Costs-Renal Dialysis Equipment - In-Facility | | | | | | | | | | 1 |
| 2 | Capital Related Costs-Renal Dialysis Equipment - In-Home | | | | | | | | | | 2 |
| 3 | Total (sum of lines 1 and 2) | | | | | | | | | | 3 |

This page reserved for future use.

| 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 | CAP REL REN DIAL EQUIP | SALARIES FOR DIR PT CARE | EH&W BENE FOR DIR PT CARE | SUPPLIES | SUPPLIES-PEDIATRIC | LABORATORY | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 7.01 | 8 | |
| 1 | COSTS TO BE ALLOCATED | | | | | | | | | | 1 |
| 2 | Drugs Included in Composite Rate | | | | | | | | | | 2 |
| 3 | ESAs | | | | | | | | | | 3 |
| 4 | ESRD Related Other Drugs | | | | | | | | | | 4 |
| 4.01 | AKI Related Other Drugs | | | | | | | | | | 4.01 |
| 5 | Non-ESRD Related Drugs, Supplies & Lab | | | | | | | | | | 5 |
| 5.01 | AKI Non-Renal Related Drugs, Supplies & Lab | | | | | | | | | | 5.01 |
| 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 |
| 8.03 | AKI-Hemodialysis | | | | | | | | | | 8.03 |
| 9 | Maintenance-IPD | | | | | | | | | | 9 |
| 9.01 | Maintenance-IPD Adult | | | | | | | | | | 9.01 |
| 9.02 | Maintenance-IPD Pediatric | | | | | | | | | | 9.02 |
| 9.03 | AKI-IPD | | | | | | | | | | 9.03 |
| 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 |

*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.

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 | CAP REL REN DIAL EQUIP | SALARIES FOR DIR PT CARE | EH&W BENE FOR DIR PT CARE | SUPPLIES | SUPPLIES-PEDIATRIC | LABORATORY | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 7.01 | 8 | |
| 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 through 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.

| 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 INCLUD. IN COMP RATE | SUBTOTAL ( see instructions ) | ESA'S | ESRD REL. AND AKI REL. 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 |
| 4.01 | AKI Related Other Drugs | | | | | | | | | | 4.01 |
| 5 | Non-ESRD Related Drugs, Supplies & Lab | | | | | | | | | | 5 |
| 5.01 | AKI Non-Renal Related Drugs, Supplies & Lab | | | | | | | | | | 5.01 |
| 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 |
| 8.03 | AKI-Hemodialysis | | | | | | | | | | 8.03 |
| 9 | Maintenance -IPD | | | | | | | | | | 9 |
| 9.01 | Maintenance-IPD Adult | | | | | | | | | | 9.01 |
| 9.02 | Maintenance-IPD Pediatric | | | | | | | | | | 9.02 |
| 9.03 | AKI-IPD | | | | | | | | | | 9.03 |
| 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 |

*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.

| 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 INCLUD. IN COMP RATE | SUBTOTAL ( see instructions ) | ESA'S | ESRD REL. AND AKI REL. DRUGS | TOTAL EXPENSES ALL PAT. SVCS. ( cols. 11A-13 ) | | |
| | | 8A | 9 | 10 | 11 | 11A | 12 | 13 | 13A | | |
| 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 through 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.

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN | PERIOD: From: To: | WORKSHEET B-1

| | | NET EXPENSES FOR COST ALLOC. | CAP REL OP & MAINT & HOUSE ( SQUARE FEET )[1] | STEP DOWN OF COL. 2 ( # TREAT MENTS )[3] | CAP REL REN DIAL EQUIP ( % TIME )[3] | SALARIES FOR DIR PT CARE ( HRS OF SERVICE )[3] | EH&W BENE FOR DIR PT CARE ( GROSS SALARIES )[3] | SUPPLIES ( CHARGES )[3] | SUPPLIES-PEDIATRIC ( CHARGES )[3] | LABORATORY ( CHARGES )[3] | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 7.01 | 8 | |
| 1 | COSTS TO BE ALLOCATED | | | | | | | | | | 1 |
| 2 | Drugs Included in Composite Rate | | | | | | | | | | 2 |
| 3 | ESAs | | | | | | | | | | 3 |
| 4 | ESRD Related Other Drugs | | | | | | | | | | 4 |
| 4.01 | AKI Related Other Drugs | | | | | | | | | | 4.01 |
| 5 | Non-ESRD Related Drugs, Supplies & Lab | | | | | | | | | | 5 |
| 5.01 | AKI Non-Renal Related Drugs, Supplies & Lab | | | | | | | | | | 5.01 |
| 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 |
| 8.03 | AKI-Hemodialysis | | | | | | | | | | 8.03 |
| 9 | Maintenance -IPD | | | | | | | | | | 9 |
| 9.01 | Maintenance-IPD Adult | | | | | | | | | | 9.01 |
| 9.02 | Maintenance-IPD Pediatric | | | | | | | | | | 9.02 |
| 9.03 | AKI-IPD | | | | | | | | | | 9.03 |
| 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 |

| COST ALLOCATION - STATISTICAL BASIS | | | | | | | | PROVIDER CCN | PERIOD: From: To: | WORKSHEET B-1 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | NET EXPENSES FOR COST ALLOC. | CAP REL OP & MAINT & HOUSE ( SQUARE FEET )[1] | STEP DOWN OF COL. 2 ( # TREAT MENTS )[3] | CAP REL REN DIAL EQUIP ( % TIME )[3] | SALARIES FOR DIR PT CARE ( HRS OF SERVICE )[3] | EH&W BENE FOR DIR PT CARE ( GROSS SALARIES )[3] | SUPPLIES ( CHARGES )[3] | *SUPPLIES-PEDIATRIC ( CHARGES )*[3] | LABORATORY ( CHARGES )[3] | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | *7.01* | 8 | |
| 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 through 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 | Total (see instructions) | | | | | | | | | | 23 |
| 24 | Total Costs to be Allocated | | | | | | | | | | 24 |
| 25 | Unit Cost Multiplier (line 24 divided by line 23) | | | | | | | | | | 25 |

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN | PERIOD: From: To: | WORKSHEET B-1

| | | SUBTOTAL | UNIT COST MULTIPLIER COMPUTATION | DRUGS ( CHARGES ) (3) | DRUGS INCLD IN COMP RATE ( CHARGES ) (3) | SUBTOTAL | ESA'S ( CHARGES ) (3) | ESRD REL. AND AKI REL. DRUGS ( CHARGES ) (3) | TOTAL EXPENSES ALL PATIENT SERVICES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 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 |
| 4.01 | AKI Related Other Drugs | | | | | | | | | | 4.01 |
| 5 | Non-ESRD Related Drugs, Supplies & Lab | | | | | | | | | | 5 |
| 5.01 | AKI Non-Renal Related Drugs, Supplies & Lab | | | | | | | | | | 5.01 |
| 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 |
| 8.03 | AKI-Hemodialysis | | | | | | | | | | 8.03 |
| 9 | Maintenance -IPD | | | | | | | | | | 9 |
| 9.01 | Maintenance-IPD Adult | | | | | | | | | | 9.01 |
| 9.02 | Maintenance-IPD Pediatric | | | | | | | | | | 9.02 |
| 9.03 | AKI-IPD | | | | | | | | | | 9.03 |
| 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 |

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN | PERIOD: From: To: | WORKSHEET B-1

| | | SUBTOTAL | UNIT COST MULTIPLIER COMPUTATION | DRUGS ( CHARGES ) (3) | DRUGS INCLD IN COMP RATE ( CHARGES ) (3) | SUBTOTAL | ESA'S ( CHARGES ) (3) | ESRD REL. AND AKI REL. DRUGS ( CHARGES ) (3) | TOTAL EXPENSES ALL PATIENT SERVICES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 8A | 9 | 10 | 11 | 11A | 12 | 13 | 13A | | |
| 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 through 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 | Total (see instructions) | | | | | | | | | | 23 |
| 24 | Total Costs to be Allocated | | | | | | | | | | 24 |
| 25 | Unit Cost Multiplier (line 24 divided by line 23) | | | | | | | | | | 25 |

This page is reserved for future use.

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

| | | TOTAL | | | |
|---|---|---|---|---|---|
| | | NUMBER OF TREATMENTS | COSTS ( Transferred from Wkst. B, col. 13A ) | AVERAGE COST PER TREATMENT ( col. 2 divided by col. 1 ) | |
| | | 1 | 2 | 3 | |
| 8.01 | Maintenance-Hemo Adult | | | | 8.01 |
| 8.02 | Maintenance-Hemo Pediatric | | | | 8.02 |
| 8.03 | AKI-Hemo | | | | 8.03 |
| 9.01 | Maintenance-IPD Adult | | | | 9.01 |
| 9.02 | Maintenance-IPD Pediatric | | | | 9.02 |
| 9.03 | AKI-IPD | | | | 9.03 |
| 10.01 | Training-Hemo Adult | | | | 10.01 |
| 10.02 | Training-Hemo Pediatric | | | | 10.02 |
| 11.01 | Training-IPD Adult | | | | 11.01 |
| 11.02 | Training-IPD Pediatric | | | | 11.02 |
| 12.01 | Training-CAPD Adult | | | | 12.01 |
| 12.02 | Training-CAPD Pediatric | | | | 12.02 |
| 13.01 | Training-CCPD Adult | | | | 13.01 |
| 13.02 | Training-CCPD Pediatric | | | | 13.02 |
| 14.01 | Home Program-Hemodialysis Adult | | | | 14.01 |
| 14.02 | Home Program-Hemodialysis Pediatric | | | | 14.02 |
| 15.01 | Home Program-IPD Adult | | | | 15.01 |
| 15.02 | Home Program-IPD Pediatric | | | | 15.02 |
| 16.01 | Home Program-CAPD Adult | Patient Weeks | | | 16.01 |
| 16.02 | Home Program-CAPD Pediatric | Patient Weeks | | | 16.02 |
| 17.01 | Home Program-CCPD Adult | Patient Weeks | | | 17.01 |
| 17.02 | Home Program-CCPD Pediatric | Patient Weeks | | | 17.02 |
| 18 | Totals (Column 1 - sum of lines 8.01 through 15.02) (Column 2 - sum of lines 8.01 through 17.02) | | | | 18 |
| 19 | Total provider treatments (informational only) | | | | 19 |

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

| | | TOTAL | | | MEDICARE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL NUMBER OF TREAT-MENTS | COSTS ( transfer from Wkst. B, col. 11A ) | AVERAGE COST OF TREAT-MENT ( col 2 / col. 1 | NUMBER OF TREAT-MENTS ( see instructions ) | NUMBER OF TREAT-MENTS ( see instructions ) | NUMBER OF TREAT-MENTS ( see instructions ) | TOTAL EXPENSES ( see instructions ) | AVERAGE PAYMENT RATE ( see instructions ) | AVERAGE PAYMENT RATE ( see instructions ) | AVERAGE PAYMENT RATE ( see instructions ) | TOTAL PAYMENT DUE ( col. 4 x col. 6 ) | TOTAL PAYMENT DUE ( col. 4.01 x col. 6.01 ) | TOTAL PAYMENT DUE ( col. 4.02 x col. 6.02 ) | TOTAL PAYMENT DUE | |
| | | 1 | 2 | 3 | 4 | 4.01 | 4.02 | 5 | 6 | 6.01 | 6.02 | 7 | 7.01 | 7.02 | 8 | |
| 1 | Maintenance-Hemodialysis | | (line 8.01, 8.02, and 8.03) | | | | | | | | | | | | | 1 |
| 2 | Maintenance-IPD | | (line 9.01, 9.02, and 9.03) | | | | | | | | | | | | | 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 | | (line 15.01 and line 15.02) | | | | | | | | | | | | | 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: To: | WORKSHEET E, PARTS I & II |
|---|---|---|---|

PART I - CALCULATION OF REIMBURSABLE BAD DEBTS TITLE XVIII - PART B

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

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

PART I - TO BE COMPLETED BY CONTRACTOR

| | Description | | | Part B mm/dd/yyyy 1 | Part B Amount 2 | |
|---|---|---|---|---|---|---|
| 1 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero. (1) | Program to Provider | .01 | | | 1.01 |
| | | | .02 | | | 1.02 |
| | | | .03 | | | 1.03 |
| | | Provider to Program | .50 | | | 1.50 |
| | | | .51 | | | 1.51 |
| | | | .52 | | | 1.52 |
| | SUBTOTAL (sum of lines 1.01 through 1.49 minus sum of lines 1.50 through 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 | | NPR Date (mm/dd/yyyy) | | 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 |
| 5 | TDAPA | | 5 |
| 6 | TPNIES | | 6 |
| 7 | CRA TPNIES | | 7 |
| 8 | HDPA | | 8 |
| 9 | PPA | | 9 |

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

| | ASSETS (omit cents) | | |
|---|---|---|---|
| | CURRENT ASSETS | Amount | |
| 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 |
|---|---|---|---|

| | | Amount | Amount | |
|---|---|---|---|---|
| 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 |
| 31.50 | COVID-19 PHE funding | | | 31.50 |
| 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 |

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