Medicare
Provider Reimbursement Manual
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 34, Form CMS-265-94

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

Transmittal 6 **Date: APRIL 2002**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal is for the cost reporting periods ending on or after April 30, 2002.

Section 3490, Cost Report Forms Exhibit 1 - Form CMS-265-94, this transmittal adds the cost reporting forms to the manual.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

CHAPTER 34

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

Section

General

EXHIBIT 1- Form CMS-265-94

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

This worksheet is required by law (section 1833(e)) of the Social Security Act and 42 CFR 413.20 and CFR 413.24. Failure to report can result in all payments made since the beginning of the cost report period being deemed as overpayments.

Form Approved
OMB NO. 0938-0236

INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT CERTIFICATION	INTERMEDIARY USE ONLY		WORKSHEET S
	[ ] AUDITED [ ] DESK REVIEW	INTERMEDIARY NUMBER	DATE RECEIVED

PART 1- GENERAL

1	NAME AND ADDRESS	2. FACILITY NUMBER	3. DATE CERTIFIED
4	NAME AND PHONE NUMBER		
5	COST REPORTING PERIOD FROM TO		

6 TYPE OF CONTROL

a. [ ] SOLE PROPRIETARY
b. [ ] PARTNERSHIP
c. [ ] CORPORATION
d. [ ] NON-PROFIT
e. [ ] OTHER (SPECIFY)

7 TYPE OF PHYSICIANS' REIMBURSEMENT

a. [ ] INITIAL METHOD Date of Election of initial method _____
b. [ ] MCP METHOD

8 Was this facility previously certified as a hospital-based unit?

[ ] Yes (see instructions) [ ] No

9 If your are part of a chain organization check " YES" and enter the name and address of the home office, otherwise check "NO".

Chain Organization ?
YES [ ] NO [ ]

_____
Name of Home Office

_____
Address of Home Office

_____

PART II - CERTIFICATION BY OFFICER OR ADMINISTRATOR OF FACILITY

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by _____ _____(Facility's name(s) and number(s)) for the cost report period beginning_____ and ending _____,and that to the best of my knowledge and belief, it is true, correct and complete statement prepared from the books and records of the facility in accordance with applicable instructions, except as noted.

(Signed) _____
Officer or Director of the Facility(s)

_____
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 to average 196 hours per response, including the time to review instructions, search existing data resources , gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form please write to: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

FORM CMS-265-94 (8/95) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3404, 3401.1, AND 3404.2)

INDEPENDENT RENAL DIALYSIS FACILITY STATISTICAL DATA	PROVIDER NO.:	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
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
12	Type of dialyzers used. If dialyzers are reused, indicate the number of times 1 [ ] Hollow Fiber _____ times 3 [ ] Coil _____times 2 [ ] Parallel Plate _____times 4 [ ] Other _____times					12
13	Number of back-up sessions furnished to home patients 1. CAPD _____			2. OTHER _____		13
14	Number of units of epoetin furnished during cost reporting period					14

TRANSPLANT STATISTICS

15	Number of patients who are awaiting transplants		15
16	Number of patients who received transplants during this period		16

HOME PROGRAM

17	Number of patients commencing home dialysis training during this period		17
18	Number of patients currently in home program		18
19	Type of dialyzers used. If dialyzers are reused, indicate number of times 1 [ ] Hollow Fiber _____times 3 [ ] Coil _____times 2 [ ] Parallel Plate _____times 4 [ ] Other _____times		19

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

	Enter the number of hours in your normal work week _____	Staff	Contract	Total	
		1	2	3	
20	Physicians				20
21	Registered Nurses				21
22	Licensed Practical Nurses				22
23	Nurses Aides				23
24	Technicians				24
25	Social Workers				25
26	Dieticians				26
27	Administrative				27
28	Management				28
29	Other (Specify)				29

FORM CMS 265-94 (8/95) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II SECTION 3405

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | FACILITY NO.: _____ | REPORTING PERIOD FROM:_____ TO:_____ | WORKSHEET A

	FACILITY HEALTH CARE COSTS	SALARIES								
		PHYSICIAN COMPENSATION	OTHER	OTHER	TOTAL (COL.1-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)	
		1	2	3	4	5	6	7	8	
	COST CENTERS									
1	Capital-Related--Buildings and Fixtures									1
2	Capital-Related--Moveable Equipment									2
3	Operation and Maintenance of Plant									3
4	Housekeeping									4
5*	Subtotal (sum of lines 1-4)									5*
6*	Machine Capital-Related or Rental and Maintenance									6*
7*	Salaries for Direct Patient Care									7*
8*	Emp. Health & Welfare Benefits for Direct Patient Care									8*
9*	Drugs									9*
10*	Supplies									10*
11*	Laboratory									11*
12	Administrative and General									12
13	Interest Expense								-0-	13
14	Laundry and Linen									14
15	Medical Records									15
16	Physicians' Routine Professional Services-Initial Method									16
17										17
18*	Subtotal(sum of lines 12-17)									18*
19	Physicians' Routine Professional Services-MCP Method							( )	-0-	19
20*	Whole Blood and Packed Red Blood Cells									20*
21*	Hepatitis B Vaccine									21*
	NONREIMBURSABLE COSTS CENTERS									
22*	Physicians' Private Offices									22*
23	Epoetin								-0-	23
24*	Method II Patients (Direct Dealing)									24*
25*										25*
26*										26*
27	Total					-0-				27

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

RECLASSIFICATIONS	FACILITY NO.:	REPORTING PERIOD: FROM:_____ TO:_____	WORKSHEET A-1

	EXPLANATION OF ENTRY	CODE (1)	INCREASE			DECREASE			
			COST CENTER	LINE NO.	AMOUNT (2)	COST CENTER	LINE NO.	AMOUNT (2)	
		1	2	3	4	5	6	7	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36	TOTAL RECLASSIFICATIONS (Sum of Column 4 must equal sum of Column 7)								36

(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	FACILITY NO.:	REPORTING PERIOD: FROM:_____ TO:_____	WORKSHEET A-2

	Description (1)	Basis for Adjustment (2)	Amount	Expense Classification on Worksheet A from which amount is to be deducted or to which the amount is to be added: Cost Center	Line No.	
		1	2	3	4	
1	Investment Income on Commingled Restricted and Unrestricted Funds (chapter 2)					1
2	Trade, Quantity and Time Discounts on Purchases (chapter 8)	B		Administrative & General	12	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				19	10
11	Services Under Arrangement					11
12	Provision for Doubtful Accounts					12
13	Capital Related -Buildings & Fixtures			Capital-Related	1	13
14	Capital Related -Moveable Equipment			Capital-Related	2	14
15	Rebates on Epoetin			Epoetin	23	15
16	Epoetin			Epoetin	23	16
17	Other (Specify)					17
18	Other (Specify)					18
19	Other (Specify)					19
20	Other (Specify)					20
21	Total Transfer to Wkst. A col.7, line 27					21

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

(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	FACILITY NO.: _____	REPORTING 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 the Provider Reimbursement Manual, Part I, Chapter 10?
[ ] Yes [ ] No (If "Yes", complete Parts II and III)

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

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

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

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

This information will be used by the Centers for Medicare and Medicaid Services and its intermediaries 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 section 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 _____

PART 1. STATEMENT OF TOTAL COMPENSATION TO OWNERS. (INCLUDE COMPENSATION OF EMPLOYEES RELATED TO OWNER)

FACILITY NO.: _____

REPORTING PERIOD: FROM_____ TO_____

WORKSHEET A-4

	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	PERCENT 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

(A) Fully describe function or job description of each owner on reverse side of this page or a separate page (If employee is related to owner, site relationship.)

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

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 FOR THE PERIOD	
1				1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10

COST ALLOCATION-GENERAL SERVICE COSTS | FACILITY NO.: | REPORTING PERIOD FROM TO | WORKSHEET B

		NET EXPENSES FOR COST ALLOCATION (FROM WKST. A, COL.8)	CAP. RELATED OPERATION AND MAINT. OF PLANT AND HOUSE KEEPING	MACHINE CAP. RELATED OR RENTAL AND MAINT.	SALARIES FOR DIRECT PATIENT CARE	EMPLOYEE HEALTH & WELFARE BENEFITS FOR DIRECT PATIENT CARE	DRUGS	SUPPLIES	LABORATORY	SUBTOTAL (COLS.1-8)	A & G & OTHER COST CENTERS	TOTAL EXPENSES ALL PATIENT SERVICES (COLS. 9 & 10)	
		1	2	3	4	5	6	7	8	9	10	11	
1	COSTS TO BE ALLOCATED												1
2	Separately Billable Drugs												2
3	Separately Billable Supplies												3
4	Separately Billable Laboratory Services												4
5	Whole Blood and Packed Red Blood Cells												5
6	Hepatitis B Vaccine												6
	REIMBURSABLE COST CENTERS												
7*	Maintenance-Hemodialysis												7*
8*	Maintenance Peritoneal Dialysis												8*
9*	Training-Hemodialysis												9*
10*	Training-Peritoneal Dialysis												10*
11*	Training-CAPD												11*
12*	Training-CCPD												12*
13*	Home Program-Hemodialysis												13*
14*	Home Program-Peritoneal Dialysis												14*
15*	Home Program-CAPD												15*
16*	Home Program-CCPD												16*
16.01	Subtotal (sum oflines 1-16)												16.01
	NONREIMBURSABLE COST CENTERS												
17	Physicians' Private Offices												17
18	Method II Patients												18
19													19
20													20
21	Totals (see instructions)												21

*Transfer the amounts to Worksheet C, column 2, as appropriate
The total of column 1, line 21 must equal the amount on Worksheet A, column 8, line 27.

FORM CMS-265-94 (2/95) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3411)

COST ALLOCATION-STATISTICAL BASIS | FACILITY NO.: | REPORTING PERIOD: FROM_____ TO_____ | WORKSHEET B-1

	COST CENTERS		CAP. RELATED OPERATION AND MAINT. OF PLANT AND HOUSE (SQ. FEET)	MACHINE CAP. RELATED OR RENTAL AND MAINT. (% OF TIME SPENT)	SALARIES FOR DIRECT PATIENT CARE (HRS. OF SERVICE)	EMPLOYEE HEALTH & WELFARE BENEFITS FOR DIRECT PATIENT (GROSS SALARIES)	DRUGS (CHARGES)	SUPPLIES (CHARGES)	LABORATORY (CHARGES)		UNIT COST MULTIPLIER COMPUTATION		
		1	2	3	4	5	6	7	8	9	10	11	
1	COSTS TO BE ALLOCATED												1
2	Separately Billable Drugs												2
3	Separately Billable Supplies												3
4	Separately Billable Laboratory Services												4
5	Whole Blood and Packed Red Blood Cells												5
6	Hepatitis B Vaccine												6
	REIMBURSABLE COST CENTERS												
7	Maintenance-Hemodialysis												7
8	Maintenance Peritoneal Dialysis												8
9	Training-Hemodialysis												9
10	Training-Peritoneal Dialysis												10
11	Training-CAPD												11
12	Training-CCPD												12
13	Home Program-Hemodialysis												13
14	Home Program-Peritoneal Dialysis												14
15	Home Program-CAPD												15
16	Home Program-CCPD												16
	NONREIMBURSABLE COST CENTERS												
17	Physicians' Private Offices												17
18	Method II Patients												18
19													19
20													20
21	Total (SEE INSTRUCTIONS)												21
22	Total Costs to be Allocated												22
23	Unit Cost Multiplier (22/21)												23

COMPUTATION OF AVERAGE COST PER TREATMENT	FACILITY NO.: _____	REPORTING PERIOD FROM_____ TO_____	WORKSHEET C

		TOTAL			MEDICARE				
		NUMBER OF TREATMENTS	COSTS (TRANSFERRED FROM WKST. B., COL.11)	AVERAGE COST OF TREATMENTS (COL.2/COL.1)	NUMBER OF TREATMENTS	TOTAL EXPENSES (COL.4 x COL.3)	PAYMENT RATE	TOTAL PAYMENT DUE (COL.4 x COL.6)	
		1	2	3	4	5	6	7	
1	Maintenance-Hemodialysis		Line 7						1
2	Maintenance-Peritoneal Dialysis		Line 8						2
3	Training-Hemodialysis		Line 9						3
4	Training-Peritoneal Dialysis		Line 10						4
5	Training-CAPD		Line 11						5
6	Training-CCPD		Line 12						6
7	Home Program-Hemodialysis		Line 13						7
8	Home Program-Peritoneal Dialysis		Line 14						8
9	Home Program-CAPD	Patient Wks	Line 15						9
10	Home Program-CCPD	Patient Wks	Line 16						10
11	Totals Sum of Lines 1-8 (Cols. 1 & 4) Sum of Lines 1-10 (Cols. 2,5, & 7)								11

CALCULATION OF REIMBURSABLE BAD DEBTS TITLE XVIII-PART B	FACILITY NO.	PERIOD: FROM:_____ TO:_____	WORKSHEET D

1	Total Expenses Related to Care of Medicare Beneficiaries (From Worksheet C, Column 5, line 11)	$	1
2	Total Payment Due (Net of Part B Deductibles) (From Worksheet C, Column 7, line 11)		2
3	Program Payments(80% of Line 2)		3
4	Amount of Cost To Be Recovered From Medicare Patients (Line 1 Minus Line 3)		4
5	Deductibles and Coinsurance Billed to Medicare (Part B) Patients		5
6	Bad Debts for Deductibles and Coinsurance, Net of Bad Debt Recoveries		6
7	Net Deductibles and Coinsurance Billed to Medicare (Part B) Patients (Line 5 Minus Line 6)		7
8	Unrecovered From Medicare (Part B) Patients (Line 4 Minus Line 7)(If Line 7 Exceeds Line 4, Do Not Complete Line 9)		8
9	Reimbursable Bad Debts(Lessor of Line 6 or Line 8)		9