

**4047. ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS**

This worksheet provides for the analysis of the direct and indirect expenses related to the renal dialysis cost centers, allocation of cost between inpatient and outpatient renal dialysis services where separate cost centers are not maintained, and the allocation of the cost to the various modes of outpatient dialysis treatment. The ancillary renal dialysis cost center is serviced by the general cost centers and includes all reimbursable cost centers within the provider organization which provide services to the renal dialysis department. The cost used in the analysis for the renal dialysis department is obtained, in part, from Worksheets A; B, Part I; and C. Complete a separate Worksheet I series for lines 74 and 94 of Worksheet A. In other words, complete one Worksheet I series for line 74 and one for line 94, if appropriate.

**4048. WORKSHEET I-1 - ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS**

This part provides for recording the direct salaries and other direct expenses applicable to the total inpatient and outpatient renal dialysis cost center or outpatient renal dialysis cost center where you maintain a separate and distinct outpatient renal dialysis cost center. If you have more than one renal dialysis department, and/or more than one home dialysis department, submit one Worksheet I series combining the renal dialysis departments and a separate Worksheet I series combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I series for each renal dialysis department and for each home dialysis department along with the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, §2720. Do not combine the cost of the renal dialysis with home program dialysis reported separately on Worksheet A, lines 74 and 94.

This worksheet also provides for recording the indirect expenses applicable to the total renal or outpatient renal dialysis department obtained from Worksheet B, Part I, columns 1 through 23, line 74 as adjusted for post stepdown adjustments, if any. When completing a separate Worksheet I for home program dialysis, transfer the direct expenses from Worksheet B, Part I, columns 1 through 23, line 94. Do not combine the cost of the renal department with home program dialysis. These costs are listed separately on Worksheet A, lines 74 and 94, respectively.

**Column Descriptions**

**Column 1**--Enter on lines 1 through 8 the amounts included from Worksheet A, column 7 for salaries only. Enter on lines 10 through 16 and 18 through 26 the amounts from Worksheet B, Part I, all columns for lines 74 and 94. The subtotal on Worksheet I-1, line 27 agrees with the sum of Worksheet B, Part I, column 26, line 74 or line 94 if a home dialysis cost center was established and used on Worksheet A.

**Column 2**--This column lists the statistical bases for allocating costs on Worksheet I-3.

**Column 3**--Enter paid hours per type of staff listed on lines 1 through 6.

**Column 4**--Enter full time equivalents by dividing column 3 by 2080 hours.

**Line Descriptions**

**Lines 1 - 6**--Enter on these lines the direct patient care salaries after adjustments and reclassification that you reported in column 7 of Worksheet A. Direct patient care salary includes only the salary of staff providing direct patient care services. Also include fee paid to non-employees providing direct patient care services. Time spent furnishing administrative or management services by direct patient care personnel is reported on line 8, non-patient care salary.

Line 7--Include on this line amounts paid to physicians for their administrative services of managing the renal department. These payments are subject to the limitation contained in §2723.3 of CMS Pub. 15-1. Also include payments to physicians for their medical services if the box on line 21 of Worksheet S-5 is marked the initial method. A complete description of the initial method is in CMS Pub. 15-1, §2715. For a renal provider to be paid under the initial method, all renal physicians at the provider must elect the initial method. Under the initial method, renal physicians are paid by the provider for their routine renal medical services and the provider's composite payment rate is increased according to 42 CFR 414.313. No payment to physicians for patient medical services should appear on this line if the monthly capitation payment (MCP) box is marked on Worksheet S-5. Under the MCP, contractors pay physicians directly for their medical services.

Line 8--Enter the amount of salaries paid non-patient care personnel after reclassifications and adjustments that you report in column 7 of Worksheet A.

Lines 10 through 16--Include on the appropriate lines costs directly charged to the renal department after reclassifications and adjustments. Report other direct costs on line 16 that cannot be specifically identified on lines 11 through 15.

Lines 17--Add lines 9 through 16. The total in column 1 must agree with the total on Worksheet A, column 7 for line 74 or line 94, as appropriate.

Lines 18 through 26--Enter the allocated general service costs from Worksheet B, Part I, lines 74 or 94 as listed in the chart below.

**NOTE:** Line 25 should exclude the costs of EPO and Aranesp administered to ESRD patients in the renal department and home program identified on Worksheet B-2, lines 1, 2, 3 or 4.

Worksheet I-1, Part I, Column 1, <u>Line Number</u>	<u>General Service Cost Centers</u>	Worksheet B, Part I, Lines 74 or 94, Columns
18	Capital-Related Costs- Buildings and Fixtures	1
19	Capital-Related Costs- Moveable Equipment	2
20	Employee Benefits	4
21	Administrative and General	5
22	Maintenance & Repairs, Operation of Plant and Housekeeping	Sum of 6, 7, and 9
23	Medical Education Programs	Sum of 20, 21, 22, 23, and 25 (medical education only)

24	Central Services & Supplies	14
25	Pharmacy	15
26	Other Allocated Costs	Sum of 8, 10, 11, 12, 13, 16, 17, 18, and 19

Line 27--Add lines 18 through 26. This total must agree with the total on Worksheet B, column 26, line 74 or line 94 if a home dialysis cost center was established, less the adjustments for EPO and Aranesp reported on Worksheet B-2, lines 1, 2, 3, or 4 as appropriate.

Lines 28, 29, and 30--These lines provide for the allocation of costs associated with routine dialysis services furnished to renal patients from other ancillary departments. Enter the cost to charge ratio from Worksheet C, Part I, column 9. Payment for routine laboratory services, as defined in the Medicare Benefit Policy Manual (100-02 IOM), chapter 11 (ESRD), §30.2, is paid for under the composite payment rate. No separate payment is made for routine laboratory tests. The costs of these services are allocated to the renal department based on the provider's laboratory cost to charge ratio from Worksheet C, Part I, column 9, line 60. Providers must maintain a log of routine laboratory charges for allocating routine laboratory costs to the renal department. The lab charges reported on Worksheet C do not include the lab charges for ESRD therefore those charges must be grossed up in accordance with Pub. 15-1, § 2314. The cost to charge ratio must be recalculated and applied against the charges reported in column 3 of this worksheet. Do not gross up ESRD charges. Instead, the cost to charge ratio for lab charges reported on Worksheet C will be used.

Line 31--Enter the sum lines 27 through 30.

4049. **WORKSHEET I-2 - ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES**

The purpose of this schedule is to allocate costs to the different services furnished in the renal department. Line 1 combines the costs reported on Worksheet I-1 for allocating costs to the different services furnished in the renal department.

Line 1--Add the costs from Worksheet I-1, and transfer these amounts to line 1 in the following manner:

<u>Worksheet I-2</u>	<u>Worksheet I-2 Column</u>	<u>Worksheet I-1</u>
Capital & Main Building Costs	1	Sum of lines 11, 18, and 22
Capital, Machine & Repair Costs	2	Sum of lines 12, 13, and 19
Registered Nurses Direct Patient Care Salary	3	Line 1
Other Direct Patient Care Salary	4	Sum of lines 2, 3, 4, 5, and 6
Employee Benefits	5	Sum of lines 10 and 20
Drugs	6	Sum of lines 15 and 25
Medical Supplies	7	Sum of lines 14 and 24
Routine Ancillary Services	8	Sum of lines 28, 29, and 30
Subtotal	9	Not applicable
Overhead	10	Sum of lines 7, 8, 16, 21, and 26

Complete columns 1 through 8 and 10 in conjunction with Worksheet I-3, which contains the statistical bases for allocating costs to the proper lines. For each line item in columns 1 through 8 and 10, multiply the statistic entered in the corresponding line and column of Worksheet I-3 by the unit cost multiplier on line 18.

Lines 2 through 11--These lines identify the type of dialysis treatments that are paid for under the composite payment rate system. The total costs (column 11) for these individual dialysis services are transferred to Worksheet I-4.

Transfer the total on Worksheet I-2, column 11 to Worksheet I-4 per the following instructions.

<u>From Worksheet I-2, Column 11</u>	<u>To Worksheet I-4, Column 2</u>
Line 2	Line 1
Line 3	Line 2
Line 4	Line 3
Line 5	Line 4
Line 6	Line 5
Line 7	Line 6
Line 8	Line 7
Line 9	Line 8
Line 10	Line 9
Line 11	Line 10

If you complete a Worksheet I-2 for the renal department and the home program dialysis department, complete a separate Worksheet I-4.

Lines 12 through 16--These services are not paid for under the composite payment rate system. Therefore, the costs of these services are not transferred to Worksheet I-4. Exclude these costs in the calculation of reimbursement composite payment rate bad debts. (See 42 CFR 413.178(d).)

Line 12--Report inpatient costs. Inpatient dialysis services are paid under the DRG system for Medicare patients.

Line 13--Report the costs of support services furnished to Method II home patients. Payment for Method II home patient dialysis services are subject to the rules in 42 CFR 414.330. Under Method II, a renal provider is only allowed to bill for support services and not dialysis equipment or supplies. Payment for support services is limited to the lower of the provider's reasonable cost or the payment limit as defined in the regulation, which is \$121.15 per patient per month. This amount includes payment for support services and routine laboratory tests furnished to home patients.

Line 14--Report the direct costs of EPO net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter EPO amount for informational purposes only. This amount is not included in the total on line 17.

Line 15--Report the direct costs of Aranesp net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter Aranesp amount for informational purposes only. This amount is not included in the total on line 17.

Line 16--Report the costs of other services furnished and billed in the renal department that are paid for outside the composite payment rate.

Line 17--Add columns and enter totals. Since lines 14 and 15, column 9 are shaded, no costs for EPO and Aranesp are included in the total for line 17, column 9 and column 6, lines 14 and 15 should be excluded from total.

Line 18--Enter the amount of medical educational program costs from Worksheet I-1, line 23. Payment for medical educational program costs allocated to the renal department is not included in the composite payment rate.

Line 19--Add lines 17 and 18. This total agrees with the sum of Worksheet I-1, column 1, line 31.

#### Column Description

Columns 1 through 8--For each line, multiply the unit cost multiplier on Worksheet I-3, line 18 by the statistical base, and enter the result on the corresponding line and column on Worksheet I-2.

Column 9--Add columns 1 through 8 for each line, except lines 14 (EPO) and 15 (Aranesp), and enter the total.

Column 10--Multiply the unit cost multiplier on Worksheet I-3, column 10, line 18 by the line amounts in column 9 of Worksheet I-2, and enter the amount in column 10.

Column 11--Add columns 9 and 10 for each line, and enter the result.

4050. WORKSHEET I-3 - DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

To accomplish the allocation of your direct and indirect costs reported on Worksheet I-1 to the different services provided in the department, you must maintain renal department statistics. To facilitate the allocation process, the format of Worksheets I-2 and I-3 is identical.

Line 1--Transfer the amounts on Worksheet I-2, line 1, columns 1 through 10 to Worksheet I-3, line 1, columns 1 through 10.

Lines 2 through 16--Enter on these lines and in the appropriate columns, the statistic for allocating costs to the appropriate line item. The statistical basis used in each column is defined in the column heading and on Worksheet I-1.

**NOTE:** If you wish to change your allocation basis for a particular general cost center, you must receive written approval from your contractor before the start of your cost reporting period for which the alternative method is used. (See §4017 for Worksheets B and B-1.)

Line 12--Enter, in the area provided, the number of inpatient dialysis treatments furnished during the cost reporting period.

Line 17--Add the statistical basis for each column, except columns 9 and 10.

Line 18--Calculate the unit cost multiplier by dividing the amount on line 1 by the total statistical basis on line 17 for each column. Multiply the unit cost multiplier by the statistical base, and enter the cost on the appropriate line and column number on Worksheet I-2.

Column Descriptions

Column 1--Use the square footage of the renal department to allocate capital and maintenance building costs.

Column 2--Use percentage of time to allocate capital and maintenance equipment costs.

Columns 3 and 4--Use paid hours to allocate registered nurses and direct patient care salary.

Column 5--Use total direct patient care salaries in columns 4 and 5 of Worksheet I-2 to allocate employee benefits.

Columns 6 and 7--Use cost of requisitions to allocate drug and medical supply costs.

Column 8--Use routine laboratory charges to allocate laboratory costs.

Column 10--Use subtotal costs in column 9, Worksheet I-2 to allocate overhead cost. To compute the unit cost multiplier, transfer the amount from Worksheet I-2, line 17, column 9 to Worksheet I-3, line 17, column 10. Do not allocate overhead costs to lines 14 (EPO) or 15 (Aranesp).

**4051. WORKSHEET I-4 - COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS**

This worksheet records the apportionment of total outpatient cost to the types of dialysis treatment furnished by you and shows the computation of expenses of dialysis items and services that you furnished to Medicare dialysis patients. This information is used for overall program evaluation, determining the appropriateness of program reimbursement rates, and meeting statutory requirements for determining the cost of ESRD care.

Complete separate worksheets to report the costs of the renal dialysis department and the home program dialysis department.

If you have more than one renal dialysis and/or home dialysis department, submit one Worksheet I-4 combining the renal dialysis departments and/or one Worksheet I-4 combining the home dialysis departments as only one average composite rate will apply to each modality. Enter on the combined Worksheet I-4 each provider's satellite number if you are separately certified as a satellite facility.

In accordance with section 1881(b)(12)(A) of the Act, as added by section 623(d)(1) of MMA 2003, the ESRD payment is replaced by a calculated ESRD composite rate.

Section 153(b) of MIPPA amended section 1881(b) of the Act to require the implementation of an ESRD bundled payments system effective January 1, 2011.

For cost reporting periods that straddle January 1, 2011, report the rates for each modality on Worksheet I-4 as follows: For the portion of the cost reporting period prior to January 1, 2011, enter the average composite rate for each modality in column 7. For the portion of the cost reporting period on and after January 1, 2011, enter the average ESRD PPS payment rate for each modality in column 7.02. For cost reporting periods that straddle January 1, 2012, January 1, 2013, and January 1, 2014, report the average ESRD PPS payment rate for each modality on Worksheet I-4 as follows: For the portion of the cost reporting period prior to January 1, enter the average ESRD PPS payment rate for each modality in column 7.01. For the portion of the cost reporting period on and after January 1, enter the average ESRD PPS payment rate for each modality in column 7.02.

Columns 1 through 3 refer to total outpatient statistics, i.e., to all outpatient dialysis services furnished, whether reimbursed directly by the program or not.

Column 1--Enter on the appropriate lines the total number of outpatient treatments by type for all renal dialysis patients from your records. These statistics include all treatments furnished to all patients in the outpatient renal department, both Medicare and non-Medicare.

Column 2--Enter on the appropriate lines the total cost transferred from Worksheet I-2, columns 11, lines as appropriate.

Column 3--Determine the amounts entered on the appropriate lines by dividing the cost entered on each line in column 2 by the number of treatments entered on each line in column 1.

Line 9--Report continuous ambulatory peritoneal dialysis (CAPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home using CAPD.

Line 10--Report continuous cycling peritoneal dialysis (CCPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home by CCPD.

### Medicare Treatments

Columns 4 through 7 refer only to treatments furnished to Medicare beneficiaries that were billed to the facility and reimbursed by the program directly. (Amounts entered in these columns are reconcilable to your records.)

Column 4--Enter on the appropriate lines the number of treatments billed to the Medicare program directly. Obtain this information from your records and/or the PS&R. For cost reporting periods that straddle January 1, 2011, enter on column 4 the total number of treatments or patient weeks billed to Medicare for services rendered prior to January 1, 2011.

Column 4.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013 or January 1, 2014, enter the total number of treatments or patient weeks billed to Medicare for services rendered prior to January 1.

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

For cost reporting periods beginning on or after January 1, 2014, enter the number of ESRD PPS treatments billed to Medicare in column 4 and eliminate columns 4.01 and 4.02.

Column 5--Determine the amounts entered on the appropriate lines by multiplying the number of treatments entered on each line in column 4 by the average cost per treatment entered on the corresponding line in column 3. For cost reporting periods that straddle or begin on or after January 1, 2011, enter total expenses determined by multiplying the sum of columns 4, 4.01, and 4.02 by the average cost per treatment entered on each corresponding line in column 3. Transfer the total expenses from this column, line 11 to Worksheet I-5, line 1. If you complete a Worksheet I-4 for renal dialysis and a Worksheet I-4 for home dialysis, add the sum of the cost from this column, line 11, and transfer the total to Worksheet I-5, line 1.

Column 6--Total Program Payment--Enter the total program payment by the type of treatment for the reporting period. Since this amount is calculated on a patient basis and is case mix adjusted, the total program payment will be provider specific for each modality. For cost reporting periods that straddle January 1, 2011, enter in column 6 the total program payment by the type of treatment for services rendered prior to January 1, 2011. For cost reporting periods beginning on or after January 1, 2014, enter the total program payment by the type of treatment. Obtain this from the PS&R. Transfer the total from column 6, line 11, to Worksheet I-5, line 2, column 1.

Column 6.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013 or January 1, 2014, enter the total program payment by the type of treatment for Medicare for services rendered prior to January 1. Obtain this from the PS&R. Transfer the total from column 6.01, line 11, to Worksheet I-5, line 2.01, column 1.

Column 6.02--For cost reporting periods that straddle or begin January 1, 2011, January 1, 2012, or January 1, 2013, enter the total program payment by the type of treatment for Medicare for services rendered on and after January 1. For cost reporting periods that straddle January 1, 2014, enter the total program payment by the type of treatment for services rendered on and after January 1. Obtain this from the PS&R. Transfer the total from column 6.02, line 11, to Worksheet I-5, line 2.02, column 1.

For cost reporting periods beginning on or after January 1, 2014, enter the total program payment by the type of treatment in column 6 and eliminate columns 6.01 and 6.02.

The ESRD Medicare payment rate is an average payment calculated based on the total Medicare payments by type of treatment divided by the total ESRD Medicare treatments.

Column 7--Average Payment Rate--For cost reporting periods that straddle January 1, 2011, for the portion of the cost reporting period prior to January 1, 2011, enter the total average payment rate by the type of treatment for the reporting period. Determine the amounts entered on the appropriate lines by dividing the total payments on each corresponding line in column 6 by the number of treatments entered on each line in column 4.

Column 7.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013, or January 1, 2014, report the average ESRD PPS payment rate for each modality in column 7.01 for the portion of the cost reporting period prior to January 1 by entering the result of column 6.01 divided by column 4.01.

Column 7.02--For cost reporting periods that straddle or begin January 1, 2011, January 1, 2012, or January 1, 2013, report the average ESRD PPS payment rate for each modality in column 7.02 for the portion of the cost reporting period on and after January 1 by entering the result of column 6.02 divided by column 4.02. For cost reporting periods that straddle January 1, 2014 report the average ESRD PPS payment rate for each modality in column 7.02 for the portion of the cost reporting period on and after January 1.

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

For cost reporting periods beginning on or after January 1, 2014, enter all ESRD PPS payment rates in column 7, and eliminate columns 7.01 and 7.02 and.

Line 11--Enter in columns 1 and 4 the sum total of lines 1 through 8. Enter in columns 2, 5, and 6 the sum total of lines 1 through 10.

Line 12--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 9 and 10 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 11, column 1.

**4052. WORKSHEET I-5 - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B**

This worksheet provides for the calculation of reimbursable Part B bad debts relating to outpatient renal dialysis treatments. If you have completed more than one Worksheet I-2 (i.e., one for renal dialysis department and one for home program dialysis), make a consolidated bad debt computation.

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 and 413.178 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 ESRD services rendered on and after January 1, 2011, by a facility 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 amount from Worksheet I-4, column 5, line 11. The amount reported is reflective of the provider's calculated basic composite rate payment cost.

Line 2--Enter the amount from Worksheet I-4, column 6, line 11. For cost reporting periods that overlap January 1, 2011, enter in column 1 the amount from Worksheet I-4, column 6, line 11. 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 I-4, column 6, line 11. Enter in column 2 the amount reported in column 1 times the facility specific composite cost ratio from, line 14. 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 I-4, column 6.01, line 11. 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 line 14. 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 I-4, column 6.02, line 11. 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 line 14. 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 2.04--Enter the amount for outlier payments applicable to Medicare (Part B) patients from your records. (Informational only)

Line 3--Enter the amount shown in your records for deductibles billed to Medicare (Part B) for dialysis treatments. For cost reporting periods that overlap January 1, 2011, enter in column 1 the amount shown in your records for deductibles billed to Medicare (Part B) patients for dialysis treatments. Include only deductible 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 billed to Medicare (Part B) patients. Enter in column 2 the amount reported in column 1 times the facility specific composite cost ratio from line 14.

For cost reporting periods beginning on or after January 1, 2014, do not complete lines 3.01 and 3.02.

Line 3.01--Enter in column 1 the amount shown in your records for deductibles billed to Medicare (Part B) patients. Include only deductible 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 line 14. Add to this amount the composite cost portion of the payment.

Line 3.02--Enter in column 1 the amount shown in your records for deductibles billed to Medicare (Part B) patients. Include only deductible 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 line 14. Add to this amount the composite cost portion of the payment.

Line 3.03--Enter the sum of lines 3, 3.01 and 3.02, columns 1 and 2 respectively.

Line 4--Enter the amount shown in your records for coinsurance billed to Medicare (Part B) for dialysis treatments. For cost reporting periods that overlap January 1, 2011, enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients for dialysis treatments. Include only 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 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 line 14.

For cost reporting periods beginning on or after January 1, 2014, do not complete lines 4.01 and 4.02.

Line 4.01--Enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Include only 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 line 14. Add to this amount the composite cost portion of the payment.

Line 4.02--Enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Include only 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 line 14. Add to this amount the composite cost portion of the payment.

Line 4.03--Enter the sum of lines 4, 4.01 and 4.02, columns 1 and 2 respectively.

Line 5--Enter the uncollectible portion of the amounts entered on lines 3 and 4 reduced by any amount recovered during the cost reporting period. For cost reporting periods that overlap or begin on or after January 1, 2011, 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 5.01--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 line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.02--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 line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.03--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 line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.04--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 line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, DO NOT complete lines 5.01, 5.02 or 5.03, 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 line 14.

Line 5.05--Enter in column 1 the sum of lines 5 through 5.04, column 1. This amount must reconcile to the provider's bad debt listing(s). Enter in column 2, the sum of lines 5 through 5.04, column 2.

Line 6--Enter the result of line 5.05, column 2 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 7--Enter the gross allowable 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 5.05, column 1, i.e., line 7 is a subset of line 5.05, column 1.

Line 8--Enter the sum of lines 3 and 4, less line 5, in column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 2, the sum of lines 3.03, column 2 and 4.03 column 2, less line 5.05, column 2.

Line 9--Subtract line 3 from line 2, and enter 80 percent of the difference in column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, subtract line 3.03, column 2 from line 2.03, column 2, and enter 80 percent of the difference in column 2.

Line 10--Enter the result of line 1 minus the sum of lines 8 and 9, in column 1. If the result is negative, enter zero and do not complete line 11. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 2, the result of line 1 minus the sum of lines 8 and 9, column 2. For cost reporting periods beginning on or after January 1, 2013, do not complete this line.

Line 11--Enter in column 1, the lesser of line 5 or line 10, column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 1, the lesser of line 5.05, column 2 or line 10, column 2. For cost reporting periods that begin on or after October 1, 2012, enter in column 1, the lesser of line 6, column *1*, or line 10, column 2. For cost reporting periods beginning on or after January 1, 2013, enter in column 1, the result of line 6, column *1*. Transfer the amount on this line to Worksheet E, Part B, line 33.

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 12--For cost reporting periods that overlap or begin on or after January 1, 2011, enter the total allowable expenses from Worksheet I-4, column 2, line 11, plus Worksheet B-2, sum of the absolute values of lines 1 through 6, column 4.

Line 13--Enter total base composite rate costs from Worksheet I-4, column 2, line 11.

Line 14--Compute the facility specific composite cost percentage (line 13 divided by line 12).