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# Medicare

## Provider Reimbursement Manual

### Part 2, Provider Cost Reporting Forms and Instructions, Chapter 11, Form CMS-339

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Department of Health &  
Human Services (DHHS)  
Centers for Medicare &  
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**HEADER SECTION NUMBERS**

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Sections 1100-1102.1(cont.)

11-3 (1 p.)

11-3 (1 p.)

**REVISED MATERIAL--*EFFECTIVE DATE:***

Section 1100 is being revised to identify providers that must continue to complete Form CMS-339 -- namely: Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), and Organ Procurement Organizations (OPOs).

**DISCLAIMER:** The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged.

CMS-Pub. 15-2-11

CHAPTER 11  
PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE  
FORM CMS-339

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## 1100. GENERAL

Form CMS-339 must be completed by all *Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), and Organ Procurement Organizations (OPOs)* submitting cost reports to the Medicare Administrative Contractor (MAC) under Title XVIII of the Social Security Act (hereafter referred to as "the Act"). Its purpose is to assist you in preparing an acceptable cost report and to minimize the need for direct contact between you and your MAC. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

To the degree that the information in the Form CMS-339 constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the MAC should consult with the CMS Regional Office.

**1100.1 Filing Requirements of Provider Cost Report Reimbursement Questionnaire.**--Providers receiving payments and filing a cost report are required to maintain sufficient financial records and statistical data for the MAC to use for the proper determination of costs payable under the Medicare program. The Medicare regulations at 42 CFR 413.20 and the related policies issued by CMS in the Provider Reimbursement Manual set forth the criteria for fulfilling these requirements. The questionnaire is designed to facilitate this process and must be completed and submitted with each full cost report. Submit the questionnaire as required by §§ 1815(a) and 1833(e) of the Act to assure proper payments by Medicare. Failure to submit this questionnaire and the supporting documents will result in suspension of payments to you and may result in a determination that all interim payments made since the beginning of the cost reporting period are overpayments.

Instructions

1102. INSTRUCTIONS FOR FORM CMS-339 (PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE)

These instructions are furnished to assist you in determining the type of information required by the questionnaire. Mark as "N/A" those statements in Exhibit 1 sections you are required to complete that are not applicable to your situation or circumstances. Mark as either "YES" or "NO" those statements which reflect situations or circumstances applicable to you and submit the necessary information referred to after each question.

The questionnaire requests providers to submit various listing and summary schedules in lieu of detailed, and potentially voluminous, supporting documentation. This is done to ease the providers' filing burden. However, the MAC maintains the right to request, and the provider must submit, additional detailed supporting documentation as deemed necessary. Requests for additional information are not intended to be routine. The MAC should request this information only if necessary to perform a complete review of the provider filing.

**1102.1 Exhibit 1 - General Provider Information.**--This information identifies the provider and the cost report with which the questionnaire is to be associated.

Enter your name and CMS certification number (CCN). Information on individual providers in a chain organization or complex common to all providers reporting to the same MAC can be handled through one submittal. Indicate those areas of information that are common to all providers and handled under a single submission.

The reporting period covered by the information furnished through the questionnaire must be consistent with the period covered by the cost report.

1102.2 Certification by Officer or Administrator of Provider.--Sign and date this certification after the questionnaire is completed and specify the title of the signer.

Also enter the name and telephone number of the person that your MAC may contact for additional information in the designated space provided on Exhibit 1.

1102.3 Reimbursement Information.--Furnish the information in this section as a means of expediting review and settlement of cost reports. CMS has established a process whereby the MAC's field audit effort at your site can be streamlined through completion of a preliminary cost report review as part of the desk review at the MAC's facilities. The information required by the questionnaire is readily available since it is the basic type of documentation necessary to fulfill program recordkeeping requirements. Furnish the information in a single submission with the cost report rather than sporadically throughout the desk review and field audit process. Complete the questionnaire annually.

A. Provider Organization and Operation.--The information gathered through these questions is designed to alert the MAC of pertinent organizational and/or personnel changes. It will be used to assess potential effects upon the cost report. The information pertaining to you and your personnel relationships within your organization and with outside organizations is essential to the MAC's evaluation of information obtained through other sections of the questionnaire. The following instructions will assist you in determining the type of information being solicited.

- When a change of ownership occurs, the information requested in question 1.a enables the MAC to determine the party responsible for the cost report.
- Describe the information on relationships with outside entities requested in question 2 to enable the MAC to assess whether associated costs are properly handled in the cost report. This information should generally be available from employment disclosure statements.

A related organization transaction described in question 2 occurs when services, facilities or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See Provider Reimbursement Manual, Part 1 (PRM-1), chapter 10 and 42 CFR 413.17.)

Management contracts and services under arrangements with the provider described in question 2 pertain to those business transactions where services are performed by the owner or corporation (shareholders) who has common ownership or control over the provider.

B. Financial Data and Reports.--The recordkeeping capabilities and system of internal control is most appropriately expressed through the financial statements. The financial statements, when prepared in accordance with the standards promulgated by the American Institute of Certified Public Accountants, can establish your ability to meet the general requirements for proper cost reporting.

The reliability of the information contained in the cost report can be established, in part, through financial statement disclosures and the opinion expressed by the independent public accountant.

Submit copies of financial statements that are compiled, reviewed or audited by the independent public accountant together with the independent public accountant's opinion and footnotes. If the audited financial statements are not available for submission with this questionnaire, indicate when the MAC can expect to receive them.

Where you do not engage public accountants for this type of service, submit a copy of the financial statements prepared by you and written statements of significant accounting policy and procedure changes affecting reimbursement which occurred during the cost reporting period.

This may be accomplished by submitting changes to your accounting or administrative procedures manual.

Only consolidated statements and not financial statements may be available for individual providers in a chain organization or complex. In these circumstances, submit the consolidated statements.

Where the provider's cost report year end and the year end of the audited financial statements differ, submit the following:

- o The audited financial statements; and
- o Working trial balance and financial statements that were used to prepare the cost report.

If the response to question 2 is "Yes", submit revenue and expense reconciliations to expedite completion of the MAC's desk review process.

C. Approved Educational Activities.--Disclose information, as directed, pertaining to nursing school and allied health/paramedical education programs as well as graduate medical education programs for which you are claiming reimbursement. Disclose the title and nature of each educational activity, and where applicable, the costs involved. The listings of educational programs may be maintained by deleting discontinued activities and adding new ones. Furnish copies of approvals and renewals for activities requiring certification.

For the purpose of Question 1, the provider is the legal operator of a nursing school or allied health program if it meets the criteria in 42 CFR 413.85(f)(1) or (f)(2).

D. Bad Debts.--A provider's bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries are considered in the program's calculation of reimbursement to the provider if they meet the criteria specified in 42 CFR 413.80ff and PRM-1, chapter 3, §§ 306-324.

A provider whose Medicare bad debts meet the above criteria should complete Exhibit 2 or submit internal schedules duplicating the documentation requested on Exhibit 2 to support bad debts claimed. If the provider claims bad debts for inpatient and outpatient services, complete a separate Exhibit 2 or internal schedules for each category.

Exhibit 2 of Form CMS-339 which can be used to list the bad debts claimed contains much of the information the MAC will need in order to determine the allowability of the bad debts. The submission of this listing may possibly provide the MAC with sufficient information upon which to base its acceptance of the bad debts claimed on the hospital's cost report without the necessity of an on-site visit.

Exhibit 2 requires the following documentation:

Columns 1, 2, 3 - Patient Names, HIC NO., Dates of Service (From - To).--The documentation requested for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number (social security number) and dates of service that correlate to the filed bad debt. (See PRM-1, §314 and 42 CFR 413.80.)

Column 4 - Indigency/Welfare Recipient.--If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column 1 has a valid Medicaid number, also include this number in this column. See the criteria in PRM-1, chapter 3, §§312 and 322 and 42 CFR 413.80 for guidance on the billing requirements for indigent and welfare recipients.

Columns 5 & 6 - Date First Bill Sent to Beneficiary – Date Collection Efforts Ceased.--This information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, and 3 of this exhibit. The date in Column 6 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(f) and PRM-1, chapter 3, §§308, 310, and 314.)

Column 7 – Medicare Remittance Advice Dates.--Enter in this column the remittance advice dates that correlate with the beneficiary name and date of service shown in columns 1, 2, and 3 of this exhibit. This will enable the MAC to verify the authenticity of the Medicare patient and the related deductible and coinsurance amounts.

Columns 8 & 9 - Deductible - Coinsurance.--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services as instructed in this exhibit.

Column 10 - Total Medicare Bad Debts.—Enter on each line of this column the sum of the amounts in columns 8 and 9. Calculate the total bad debts by summing up the amounts on all lines of Column 10. This “total” should agree with the bad debts claimed in the cost report. Attach additional supporting schedules, if necessary, for recoveries of bad debts reimbursed in prior cost reporting period(s).

E. Medicare Settlement Data (PS&R DATA).--The PS&R system generates several reports which provide apportionment, statistical, settlement and reimbursement data that can be used in filing the cost report.

In some cases, the provider may have independent record keeping capabilities which provide them with the capacity to generate the appropriate cost report data consistent with that contained in the PS&R. The provider's record keeping capability, relative to cost report preparation, will vary by provider type and the scope of the services rendered. A provider's system, in order to be effective, requires all necessary updating of PRICER information, fees, prevailing charges, and other regulatory changes impacting the resultant PS&R, as well as adjustment claims. This is an ongoing process that does not end with the filing of the cost report, but continues through final settlement.

The revenue codes on the Form CMS-1450 have been standardized for Medicare billing purposes without regard to providers' actual revenue and expense accounting process. In many cases, therefore, there will be differences between the classifications of revenues in the PS&R and the general ledger classifications that can affect Medicare reimbursement. Providers must evaluate the impact of these classification differences and maintain accurate Medicare logs which collect charge data consistent with the general ledger classifications of revenues and expenses, if they are not using the PS&R in its entirety.

Several actions are required for providers in filing the cost report, whether they use the PS&R for the source document or internal log records. Providers must include the summary of their "unpaid" log as support for any claims not included on the PS&R. The summary should include totals consistent with the breakdowns on the PS&R. This report should be generated to reflect claims paid that are unprocessed or unpaid as of the cutoff date of the PS&R. The cut-off date equates to the paid date reflected on the PS&R.

**Using PS&R only** - Providers are required to develop a table, where applicable, for inclusion with the filed cost report which provides a crosswalk between the revenue codes and charges, patient days, visits, etc. found on the PS&R to the cost center groupings found on the cost report. This crosswalk reflects a one-on-one match, cost center to revenue code. No overlap is permitted in this example. Unpaid claims will be added to the PS&R totals, following the same revenue crosswalk.

**Using PS&R for totals, provider records for allocation** – Providers are required to develop and submit with the cost report a table which provides a detailed crosswalk showing in which cost centers on the cost report the charges, patient days, visits, and any other utilization statistics (as applicable) identified by various revenue codes on the PS&R were included. In this instance, there is no requirement for a one on one match for “charges”, but providers must show total dollars by cost center and the range of revenue codes within each cost center. The total charges must match those found on the PS&R, plus any claims reflected on the unpaid log. Supporting working papers must be maintained by the provider to identify the source of their data in order to attest to its accuracy.

If the MAC finds that the working papers do not provide sufficient documentation and validation of the provider's records, the PS&R will be used in its entirety. It is the responsibility of the provider to maintain, furnish, and reasonably demonstrate that its internal records provide a more accurate allocation for cost report settlement purposes than the PS&R.

**Using provider records only** - Providers who use their internal records for filing the cost report, without reference or cross-reference to the PS&R, are required to provide the MAC audit staff with detailed documentation of their system flow in order to validate their data. Documentation of systems flow, at a minimum, should include:

- o Copies of input tables, calculations, or charts supporting data elements
- o Log summaries and log detail supporting program utilization statistics, charges, and payment information broken into each Medicare bill type in a manner consistent with the PS&R; and
- o Reconciliation of remittance totals to the provider consolidated log totals.

The provider may supplement this information with a narrative, internal flow charts, or outside vendor informational material to further describe and validate the reliability of their system. It is the responsibility of the provider to furnish and maintain reasonable documentation supporting the accuracy of their data in lieu of the PS&R. In the event the MAC determines that supporting documentation is insufficient, the MAC must furnish written discussion detailing weaknesses in the provider's documented system flow prior to



either a partial or complete disallowance of the provider's records. It is not necessary for the provider to develop a reconciliation to the PS&R if the work flow demonstrates that the provider has consistently reconciled their logs to the remittance advices received from the MAC, either claim by claim or in total. No crosswalk is required for this example, merely documentation of system flow. Providers will include an unpaid log summary for review by the MAC, using the date of the last remittance advice posted to the provider log as the cut-off date.

**EXHIBIT 1**  
FORM APPROVED  
OMB NO. 0938-0301

This questionnaire is required under the authority of sections 1815(a) and 1833(e) of the Social Security Act. Failure to submit this questionnaire will result in suspension of Medicare payments.

To the degree that the information in CMS-339: 1) constitutes commercial or financial information which is confidential, and/or 2) is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act.

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 0938-0301. The time required to complete this information collection is estimated to average 4 hours and 22 minutes 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: CMS, 7500 Security Boulevard, Attn: PRA Reports 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.**

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE  
(You MUST USE Instructions for Completing This Form  
Located In PRM-2, §§1100ff.)

Provider Name: \_\_\_\_\_

CCN(s): \_\_\_\_\_

Filed with Form CMS- 2088 222 216 (Other - Specify)

Period: From \_\_\_\_\_  
To \_\_\_\_\_

**INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW**

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying information prepared by \_\_\_\_\_ (Provider 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 a true, correct and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

(Signed)

\_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name and Telephone Number of Person to Contact for More Information

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>NOTE: 42 CFR 413.20 and instructions contained in the PRM-1 require that the provider maintain adequate financial and statistical data necessary for the MAC to use for a proper determination of costs payable under the program. Providers are, therefore, required to maintain and have available for audit all records necessary to verify the amounts and allowability of costs included in the filed cost report. Failure to have such records available for review by MACs acting under the authority of the Secretary of the Department of Health and Human Services will render the amount claimed in the cost report unallowable.</p> <p>A. <u>Provider Organization and Operation</u></p> <p>1. The provider has:</p> <p>a. Changed ownership. If "yes", submit name and address of new owner, date of change, copy of sales agreement, or any similar agreement affecting change of ownership.</p> <p>b. Terminated participation. If "yes", list date of termination, and reason (Voluntary/Involuntary).</p> <p>2. The provider is involved in business transactions, including management contracts and services under arrangements, with individuals or entities (e.g., chain home offices, drug or medical supply companies, etc.) that are 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.</p> <p>If "yes" attach a list of the individuals, the organizations involved, and description of the transactions.</p> <p>B. <u>Financial Data and Reports</u></p> <p>1. During this cost reporting period, the financial statements are prepared by Certified Public Accountants or Public Accountants (submit complete copy or indicate available date) and are:</p> <p>a. Audited;</p> <p>b. Compiled; and</p> <p>c. Reviewed.</p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>NOTE: Where there is no affirmative response to the above described financial statements, attach a copy of the financial statements prepared by you and a description of the changes in accounting policies and practices if not mentioned in those statements.</p> <p>2. Cost report total expenses and total revenues differ from those on the filed financial statement. If "yes", submit reconciliation.</p> <p>C. <u>Approved Educational Activities</u></p> <p>1. Costs were claimed for Nursing School and Allied Health Programs. If "yes", attach list of the programs and annotate for each whether the provider is the legal operator of the program.</p> <p>2. Approvals and/or renewals were obtained during this cost reporting period for Nursing School and/or Allied Health Programs. If "yes", submit copies.</p> <p>3. Costs were claimed for Interns and Residents in approved graduate medical education programs on the current cost report.  If "yes" attach a list of the programs and the approval for each program.</p> <p>D. <u>Bad Debts</u></p> <p>1. The provider seeks Medicare reimbursement for bad debts. If "yes", complete Exhibit 2 or submit internal schedules duplicating documentation required on Exhibit 2 to support bad debts claimed. (see instructions)</p> <p>2. The provider's bad debt collection policy changed during the cost reporting period. If "yes", submit copy.</p> <p>3. The provider waives patient deductibles and/or copayments. If yes, insure that they are not included on Exhibit 2.</p> <p>E. <u>PS&amp;R Data</u></p> <p>1. The cost report was prepared using the PS&amp;R only? If "yes", attach, where applicable, a crosswalk between revenue codes and charges found on the PS&amp;R to the cost center groupings</p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>on the cost report. This crosswalk will reflect a cost center to revenue code match only.</p> <p>2. The cost report was prepared using the PS&amp;R for totals and the provider records for allocation.</p> <p>If yes, include, where applicable, a detailed crosswalk between revenue codes, departments and charges on the PS&amp;R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting working papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.</p> <p>Include working papers supporting the allocation of charges, patient days, visits, etc. into the various cost centers. If internal records are used for these allocations, the source of this information must be included in the documentation.</p> <p>3. Provider records only were used to complete the cost report?</p> <p>If yes, attach detailed documentation of the system used to support the data reported on the cost report. <u>If the detail documentation was previously supplied, submit only necessary updated documentation.</u></p> <p>The minimum requirements are:</p> <ul style="list-style-type: none"> <li>- Copies of input tables, calculations, or charts supporting data elements and other claims PRICING information.</li> <li>- Log summaries and log detail supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&amp;R.</li> <li>- Reconciliation of remittance totals to the provider consolidated log totals.</li> </ul> <p>Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material.</p> <p>Include the name of the system used and indicate how the</p>			

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE			
	YES	NO	N/A
<p>system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.</p> <p>4. If yes to questions 1 or 2 above, were any of the following adjustments made to the Part A PS&amp;R data?</p> <p>a) Addition of claims billed but not on PS&amp;R? Indicate the paid claims through date from the PS&amp;R used and the final pay date of the claims that supplement the original PS&amp;R. Also indicate the total charges for the claims added to the PS&amp;R. Include a summary of the unpaid claims log.</p> <p>b) Correction of other PS&amp;R information?</p> <p>c) Late charges?</p> <p>d) Other (describe)?</p> <p>Attach documentation which provides an audit trail from the PS&amp;R to the cost report. The documentation should include the details of the PS&amp;R, reclassifications, adjustments, and groupings necessary to trace to the cost center totals.</p>			

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER \_\_\_\_\_

PREPARED BY \_\_\_\_\_

NUMBER \_\_\_\_\_

DATE PREPARED \_\_\_\_\_

FYE \_\_\_\_\_

INPATIENT \_\_\_\_\_ OUTPATIENT \_\_\_\_\_

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) DATE COLLECTION EFFORT CEASED	(7) MEDICARE REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

\* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT.  
SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION