NMP PROFESSIONAL SERVICES, INC
Certified Public Accountants

Phone: 786-372-1155 Fax: 786-558-8461

E-mail: cruz@costreportcpa.com

Required Information to Prepare the Annual Cost Report

Facility Name					
Contact Name					
Facility Address					
City, State, Zip					
Office Phone			Office Fax		
Provider Number			Tax ID/EIN		
Cost Report Period	From		To		
Date Certified		CMS Intermediary: ☐ PALMETTO ☐ NGS ☐ CGS			
E-Mail (Print)					

New CMS updates allow now to electronically sign your cost report and E-file.

If you want us to electronically submit your Medicare cost report to CMS please add a check mark here ☐ and write below the CMS Portal (https://portal.cms.gov/) security official ID and Password. Confirmation of E-file to CMS and a copy of your cost report and other documents will be sent protected by e-mail.

CMS Portal ID:_____ **Password:** _____

If you do not want to provide your ID and password and prefer yourself electronically submit your cost report to CMS please add a check mark here ☐ and your cost report files and instructions to E-file your cost report will be sent protected by e-mail. Copy of your cost report and other documents will be sent protected in a second e-mail.

To open the protected files please type a cell phone number below to send a text message with the password and to request the security code for access to the CMS Portal if it is required.

If you want your cost report to be sent by mail with delivery confirmation please add a check mark here: ☐ The USPS tracking number will be send by e-mail after your Cost Report is sent by USPS priority mail along with a copy of your cost report and other documents.

Officer Cell Phone Number: _____

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Service Proposal for the Annual Cost Report

Dear Health Care Administrator,

Thank you for giving NMP Professional Services, Inc. the opportunity to provide you with a proposal for our cost report preparation services. Our organization has over 20 years of experience in preparing Medicare cost reports.

If your Medicare revenues for the reporting period are less than $200,000 a low utilization cost report may be filed and our regular price for a low utilization cost report preparation is $ 550. If your Medicare revenues for the reporting period are $200,000 or more only a full cost report is accepted and our regular price for a full cost report is $ 1050.

We will start working on your cost report when this proposal is received and a Pay-pal invoice will be sent by e-mail. Our preparation fees must be paid before your cost report is E-file to CMS. You may pay our invoice on-line using a debit or credit card, or by sending a check by mail.

First time customers with revenues for less than five thousand will get a twenty percent discount from our regular prices above. Additionally, our cost report services also includes, at no extra charge, preparation of your agency Projected Budgets for three years so that your agency complies with Medicare standard 484.1(i) (1).

Each HHA cost report will be completed in compliance with CMS HIM-15 and PPS rules and regulations. Our services also include Medicare settlement negotiations and answering any questions that may arise about the review of your cost report. All our services will be provided in compliance with the American Health Insurance Portability and Accountability Act (HIPAA).

When your cost report is ready a copy of your cost report, adjusted Financial Statements and projected budgets will be emailed along with confirmation that your cost report was electronically submitted to CMS.

To E-file your cost report to CMS the facility administrator name will be used to electronically sign your cost report, please write below the administrator name registered with CMS and sign this page.

I _____ have read and agree with the above statement
(Administrator Name registered with CMS) Print please

and acknowledge that it is acceptable. I hereby authorize NMP Professional Services, Inc. to prepare, electronically

sing, and e-file the cost report for the company _____

If you agree with the terms listed above, please sign below.

_____ Date: _____
(Administrator Signature registered with CMS)

The required information to prepare the annual Medicare cost report is included in the following pages. Please complete and attach all necessary documents. When it's ready, please send it by email or fax.

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Additional Required Information

☐	1	**Finacial Statements** (Profit & Loss and Balance Sheet) for the reporting period.
☐	2	Copy of **Provider Summary Reports (PS&R).** Check here ☐ if you wish us to get your PS&R from CMS and write below your user ID and Password for the CMS Portal https://portal.cms.gov/ if was not added on page 1. User ID:_____ Password: _____
☐	3	Please list the total amount paid to employees (**W2**) and contractors (**1099**). If this information is provided on your financial statements omit this step. **Total W2** _____ **Total 1099** _____
☐	4	Copy of prior cost report pages **F and F1** (If available). New clients only.
☐	5	Copy of form **1099** received from your Medicare Intermediary for the cost report period. (Palmetto GBA, NGS, CGS, Others) (If available)
☐	6	Do you contract with outside suppliers for PT? ☐ Yes ☐ No
	7	Do you contract with outside suppliers for OT? ☐ Yes ☐ No
	8	Do you contract with outside suppliers for SP? ☐ Yes ☐ No
☐	9	List Malpractice Insurance premiums and paid losses. Premiums _____ Paid Losses _____ Self-Insurance _____

Facility: _____

☐	10	**Number of unduplicated Patients and Visits by discipline for the cost reporting period**. Each patient should be counted once for each discipline. If you only provided services to Medicare patients during the last year do not complete this report.

Some billing softwares provide this information in **Census Report**, **Annual Report**, or **Visit Summary by Discipline**. If you don't know how to obtain this information you may call your billing software representative to help you get this information.

Discipline	Medicare		Medicare HMO		Non-Medicare	
	Visits	Patients	Visits	Patients	Visits	Patients
Nursing (RN/LPN)						
Physical Therapy						
Occupational Therapy						
Speech Pathology						
Medical Social Service						
Home Health Aide						

☐	11	**Gross Payments by position for the cost reporting period.** If this information is provided on your financial statements omit this step.

	Please Provide Summary by Position	**Employees -W2 Gross Payments**	**Contractors -1099 Total Payments**
1	Office Personnel (Adm and Other)		
2	Nursing (DON/RN/LPN)		
3	Physical Therapy		
4	Occupational Therapy		
5	Speech Pathology		
6	Medical Social Service		
7	Home Health Aide		
8	Spiritual Counseling (Hospice)		
9	Physician Services (Hospice)		

Facility: _____

☐	12	If you own the property please send a copy of the property ledger. Detailed property ledger / Depreciation schedule. If you rent omit this step.

☐	13	Summary of accounts payable for invoices received but not paid before the year ends and Summary of accounts receivable for services billed but not paid before the year ends. If they are already included on the financial statements omit this step.

☐	14	Square footage of your buildings broken down by department. If you only have the total square footage of your office please provide the total so we can allocate it based on your PS&R information.

Department	**Square Footage**
Administrative and General	
Skilled Nursing	
Physical Therapy	
Occupational Therapy	
Speech Pathology	
Medical Social Services	
Home Health Aide	
Spiritual Counseling (Hospice Only)	
Total	

Facility: _____

☐	15	Disclosure and facts regarding Chain Organizations.
		A Chain organization consists of a group of two or more health care facilities that are owned, leased, or, through any other device, controlled by one organization.
		If this section is applicable, please attach a list of all companies, partnerships, or proprietorships that are part of the chain.

Data required for completion of Questionnaire

☐	16	Provider Organization and Operation.

1a	Yes ☐	No ☐	The provider has changed ownership.
		If 'Yes' submit name and address of new owner, date of change, and a copy of the sales agreement or similar agreement affecting change of ownership.	

2a	Yes ☐	No ☐	The provider has terminated participation.
		If 'Yes' list date of termination and reason (voluntary/involuntary).	

3a	Yes ☐	No ☐	The Articles of Incorporation and/or Corporate by-laws of partnership agreement have changed. Example (From Corporation to Small Corp, or LLC, etc)
		If 'Yes' attach a copy and date of change.	

Facility: _____

Complete and attach all necessary documents. When it's ready, please send it by email, fax or mail. You will get a confirmation email when all the documents are received.

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