

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 to electronically sign your cost report and E-file.

If you prefer that we 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. A protected copy of your cost report for your records, e-file confirmation, adjusted financial statements and budgets will be sent to your e-mail.

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

If you prefer not to provide your ID and password and rather electronically submit your cost report to CMS yourself please add a check mark here. Your cost report files and instructions on how to electronically submit your cost report will be sent by e-mail. A protected copy of your cost report for your records, e-file confirmation, adjusted financial statements and budgets will be sent to your e-mail.

To open the protected files please type here _____ your cell phone number to send you a text message with the password.

If you prefer that we send your cost report by mail with delivery confirmation please add a check mark here. Because your cost report is electronically signed we can send it directly to CMS at no additional charges. The USPS priority mail tracking number will be sent to your e-mail so you may know when your cost report is delivered. A protected copy of your cost report for your records, mail confirmation, adjusted financial statements and budgets will be sent to your e-mail.



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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 25 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 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 our invoice will be sent by e-mail. You may pay our invoice with a debit or credit card from our web site, using the invoice sent by e-mail, or by sending a check by mail. **Our invoice must be paid before your cost report is sent electronically or by mail to CMS.**

First time customers with revenues less than five hundred thousand will get a twenty percent discount from our regular prices above. Additionally, our cost report services also include, 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 finished a copy will be sent by e-mail along with a copy of adjusted financial statements, projected budgets, and a confirmation that your cost report was electronically submitted to CMS.

To comply with new CMS regulations and electronically sign your cost report, authorization of a facility officer registered on CMS records is required. Please write below the officer name and sign this page.

I _____, _____ have read and agree with the above statement
(Officer Name registered with CMS) Please Print Title (Presd, Adm, DON)

and acknowledge that it is reasonable. I hereby authorize NMP Professional Services, Inc. to prepare, electronically sign, and E-file the cost report for the company: _____

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

_____ Date: _____
(Officer 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

<input type="checkbox"/>	1	Financial Statements (Profit & Loss and Balance Sheet) for the reporting period.
<input type="checkbox"/>	2	Copy of Provider Summary Reports (PS&R) . Check here <input type="checkbox"/> if you wish that we get your PS&R and please write below your user ID and Password. ID: _____ Password: _____
<input type="checkbox"/>	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 _____
<input type="checkbox"/>	4	Copy of prior cost report pages F and F1 (If available). New clients only.
<input type="checkbox"/>	5	Copy of form 1099 received from your Medicare Intermediary for the cost report period. (Palmetto GBA, NGS, CGS, Others) (If available)
<input type="checkbox"/>	6	Do you contract with outside suppliers for PT? <input type="checkbox"/> Yes <input type="checkbox"/> No
	7	Do you contract with outside suppliers for OT? <input type="checkbox"/> Yes <input type="checkbox"/> No
	8	Do you contract with outside suppliers for SP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	9	List Malpractice Insurance premiums and paid losses. Premiums _____ Paid Losses _____ Self-Insurance _____

Facility: _____

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<input type="checkbox"/>	10	<p>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.</p>					
<p>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.</p>							
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							

<input type="checkbox"/>	11	<p>Gross Payments by position for the cost reporting period. If this information is provided on your financial statements omit this step.</p>		
		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)		

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<input type="checkbox"/>	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.
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<input type="checkbox"/>	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.
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<input type="checkbox"/>	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.
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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: _____

<input type="checkbox"/>	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.		
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

<input type="checkbox"/>	16	Provider Organization and Operation.
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1a	Yes <input type="checkbox"/>	No <input type="checkbox"/>	The provider has changed ownership.
If 'Yes' submit the name of new owner: _____, date of change _____, and add here _____ the percent of ownership.			

2a	Yes <input type="checkbox"/>	No <input type="checkbox"/>	The provider has terminated participation. If yes add the date of termination _____ and reason: Voluntary Involuntary
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3a	Yes <input type="checkbox"/>	No <input type="checkbox"/>	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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