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 copy of your cost report, e-file confirmation, adjusted financial statements and budgets will be sent for your records.

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 copy of your cost report, adjusted financial statements, and budgets will be sent for your records.

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 by USPS priority mail. The USPS tracking number will be sent to your e-mail and you will also get a confirmation by e-mail when your cost report is delivered. A copy of your cost report, mail confirmation, adjusted financial statements and budgets will be sent for your records.

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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 is accepted by CMS; our 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 by CMS; our price for a **full cost report is $1050**.

Once this proposal is received by fax or e-mail a invoice will be sent by e-mail. **Our invoice must be paid before we start working on your cost report**, you can pay our bill using a debit or credit card from our web site, from the e-mail sent, or by sending a check by mail.

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 is required. Please write below the officer name and sign this page.

I _____ , _____ have read and agree with the above statement
(**Officer Name** on CMS records) **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 or mail to CMS the cost report for the company: _____

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

_____ Date: _____
(**Officer Signature**)

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 that we get your PS&R and please write below your user ID and Password. ID:_____ Password:_____
☐	3	Please list the total amount paid to employees (**W2**) and contractors (**1099**). **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	**Home Health unduplicated Patients and Visits by discipline for the cost reporting period**. Each patient should be counted once for each discipline.

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	**Home Health gross payments by position for the cost reporting period.** If this information is provided on your financial statements omit this step.

	Payment Summary by Position	**Employees -W2 Gross Payments**	**Contractors -1099 Total Payments**
1	Office Personnel (A&G)		
2	Nursing (DON/RN/LPN)		
3	Physical Therapy		
4	Occupational Therapy		
5	Speech Pathology		
6	Medical Social Service		
7	Home Health Aide		

Complete this page for Home Health Only

Facility: _____

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

	Payment Summary by Position	**Employees -W2 Gross Payments**	**Contractors -1099 Total Payments**
1	Office Personnel (A&G)		
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		
9	Physician Services		

☐	13	**Hospice revenue break down for the cost reporting period.** If this information is provided on your financial statements omit this step.

		Medicare	**Medicaid**	**Other**
1	Continuous Home Care			
2	Routing Home Care			
3	Impatient Respite Care			
4	General Impatient Care			
	Unduplicated Days			

Complete this page for Hospice Only

Hospice Facility Name: _____

☐	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.
		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 the name of new owner: _____, date of change _____, and add here _____ the percent of ownership.

2a	Yes ☐	No ☐	The provider has terminated participation. If yes add the 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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