

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 Medicare cost reports.

If your facility Medicare revenues for the cost reporting period are under \$200,000, a low utilization cost report is accepted by CMS. For revenues of \$200,000 or more, only a full cost report is accepted. Our price for a **Low cost report** is _____ and for a **Full cost report** is _____.

Once this proposal is received an invoice will be sent by email. Our invoice must be paid before we start working on your Medicare cost report.

Additionally, our cost report services also include, at no extra charge, preparation of 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 for your records will be sent by email along with a copy of financial statements, projected budgets, and depending on your selection below, we will also send:

1. Instructions for E-file and cost report files that you must send electronically to CMS.
2. Confirmation of cost report electronic submission to CMS.
3. USPS tracking number as confirmation that the cost report was sent by Priority Mail.

To begin working on your cost report, the authorization of a facility official registered with CMS is required. Please write the officer's name below and sign this page.

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

acknowledge that it is reasonable. I authorize NMP Professional Services, Inc to prepare and according to the option selected above send the cost report for: _____ Provider Nro: _____
(Company Name)

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

(Officer Signature)

Date: _____

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.

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) on the reporting period: Total W2 _____ Total 1099 _____
<input type="checkbox"/>	4	Copy of prior cost report (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: _____

Complete this page for Home Health Only

<input type="checkbox"/>	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							

<input type="checkbox"/>	11	Home Health gross payments by position for the cost reporting period. If this information is provided in the 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		

Facility: _____

NMP PROFESSIONAL SERVICES, INC
Phone: 786-372-1155 Fax: 786-558-8461

Complete this page for Hospice Only

<input type="checkbox"/>	12	Hospice Gross Payments by position for the cost reporting period. If this information is provided in the 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		

<input type="checkbox"/>	13	Hospice revenue break down for the cost reporting period. If this information is provided in the financial statements, omit this step.			
			Medicare	Medicaid	Other
	1	Continuous Home Care			
	2	Routing Home Care			
	3	Inpatient Respite Care			
	4	General Inpatient Care			
		Unduplicated Days			

Facility Name: _____

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<input type="checkbox"/>	12	If you own the property please send Detailed property ledger / Depreciation schedule. If you rent, omit this step.
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<input type="checkbox"/>	13	Summary of Accounts Payable and Accounts Receivable for the reporting period. If they are already included in 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 _____ 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"/>	Is the provider seeking reimbursement for bad depts?
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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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 Certified Public Accounting Firm
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