NMP PROFESSIONAL SERVICES, INC
Certified Public Accounting Firm
Phone: 786-372-1155 Fax: 786-558-8461 Email:
cruz@costreportcpa.com

Required Information to Prepare the Medicare 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)				
Medicare Revenues for the Cost R. Period Reported in form 1099:				

Please select one of the following options:

1. ☐ Select here if you prefer yourself to electronically submit your cost report to CMS via MCReF. When your cost report is ready, the cost report files and instructions on how to electronically submit your cost report will be sent by email. A copy of the cost report, financial statements, and budgets will be sent for your records.

2. ☐ Select here if you prefer that we electronically submit your Medicare cost report and write below the CMS Portal (https://portal.cms.gov/) user ID and Password necessary to submit your cost report to CMS. A copy of the cost report, e-file confirmation, financial statements and budgets will be sent for your records.

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

3. ☐ Select here if you prefer that we send your cost report by priority mail with delivery confirmation. The USPS tracking number will be sent to your email. A copy of the cost report, financial statements and budgets will be sent for your records. Please note that sending the cost report by mail takes longer to process and increases the risk of being rejected due to improper handling of the CD containing the cost report files, therefore, we recommend to send your cost report electronically via MCReF.

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Service Proposal for the Medicare 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 Medicare revenues of $200,000 or more, only a full cost report is accepted.

Our price for a low-cost report is **$550** and for a full cost report of **$1050**. 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, you may pay online with a debit or credit card using our invoice or by sending a check by mail.

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 will be sent for your records along with a copy of financial statements, projected budgets, and depending on your selection on page 1, we will also send:

1. ☐ Cost report files that you must send electronically to CMS and instructions will be sent by email.
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**) **Please Print** **Title** (CEO, ADM, DON)

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

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**) on the reporting period: **Total W2** _____ **Total 1099** _____
☐	4	Copy of prior cost report (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: _____

Complete this page for Home Health Only

☐	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 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: _____

Complete this page for Hospice Only

☐	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		

☐	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	Impatient Respite Care			
4	General Impatient Care			
	Unduplicated Days			

Facility Name: _____

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

☐	13	Summary of Accounts Payable and Accounts Receivable for the reporting period. If they are already included in 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 _____ 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 ☐	Is the provider seeking reimbursement for bad depts?

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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