PPS

PROGRESSIVE PROVIDER SERVICES of COLORADO

Building Your PPS Team

Provider of Accounting and Reimbursement Services for the Long Term Care Industry

Cost Report Preparation Form and Terms

Contact Name: _____

Company: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Mobile: (optional) _____E-mail: _____

Provider Name:_____

Medicare Provider Number: _____

Cost Report dates: _____ to _____

Type of Provider: (please circle) SNF / HHA / Hospice / RHC

Total Number of Cost Reports: _____(attach additional forms if needed)

Total Price: _____

☐ Please charge my credit card ☐ Check is enclosed / will be mailed ☐ Please bill me

Name on Card: _____

Credit Card Number: _____Exp Date: _____ cvv:_____

Authorized Signature: _____

☐ Please e-mail the completed cost report files to: _____

☐ Please mail the cost report files to: (additional $15 Shipping & Handling fee per report)

_____

Please fax this completed form to (888) 405-4162 or mail together with a check to:

Progressive Provider Services LLC
245 S. Benton Street, Suite 300
Lakewood, CO 80226
www.ppsassistant.com

For more information, please contact: *Blimi Schwartz (800) 447-2540* *blimi@ppsassistant.com*

OBJECTIVES AND NATURE OF CONSULTING SERVICES

We will compile and prepare, from the information provided to us, the Medicare cost report pertaining to the reporting period indicated above. Included with the cost report we prepare, we will provide you with a report that includes the following materials:

- *Completed supplementary cost report information, i.e., required electronic file, questionnaire, etc.*

We will not, however, audit the cost report or its supplementary information, and accordingly, will not express an opinion or any other form of assurance on them. In addition, our engagement cannot be relied upon to discover errors and irregularities, including fraud or defalcations that may exist. However, we will inform you of irregularities that come to our attention, unless they are inconsequential.

CONFIDENTIALITY

We will maintain as confidential all data, inclusive of, but not limited to, resident records which your facility provides to us in connection with our work on this engagement and will not disclose any such information to others, except as is required by law, without your approval

FEES

Medicare Cost Report for:	
Skilled Nursing Facility	**$2,400**
Home Health Agency	**$1,800**
Hospice	**$2,000**
FQHC	**$1,800 (includes up to 2 consolidated facilities)**
FQHC Additional consolidated facilities	**$200 each**
RHC	**$1,500**
Low Utilization	**$500**
Low Utilization FQHC	**$750**

Discounts are available for preparation of multiple cost reports. Please contact our office for details.

These fees include direct out-of-pocket expenses, such as copies, facsimiles, long distance telephone calls etc. The preparation fees do not include additional time we may incur in connection with the audit or desk review of the cost report.

Cancellation fee will be charged at hourly rate of $150 per hour that was spent on the cost report prior to your written cancellation notice.

We would be pleased to further discuss or clarify any of the information contained within this agreement. We can be reached at 303-233-5143 or (800) 447-2540.

ACKNOWLEDGEMENT*:*

This letter correctly sets forth my understanding of this engagement.

SIGNATURE _____

TITLE _____

DATE _____