PROGRESSIVE PROVIDER SERVICES

Providing Medicare & Medicaid Cost Reporting Solutions

Cost Report Preparation Contract Form

Contact Name:_____ Company: _____

Billing Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Mobile: _____ E-mail: _____

For multiple facilities, use additional space on page three.

Provider Name: _____ Provider Number: _____

Cost Report Begin Date: _____ Cost Report End Date: _____ □ Medicare □ Medicaid

Facility type: Utilization: Price: $_____ Filing Fee: $_____

Please choose a submission option below:

□ Provider will mail - PPS will send an e-mail with files and mailing instructions.

□ Provider will file via MCReF - PPS will send an e-mail with files and instructions for MCReF.

□ PPS will file via MCReF - **$20 charge per report**. PPS will provide instructions. (IDM Security Official required for this option.)

Full Medicare Cost Report:		**Low/No Utilization Reports**		**State Cost Reports:**	
□Skilled Nursing Facility	$2,600	□FQHC Low Utilization	$1,000	□MassHealth SNF	$4,500
□Home Health Agency	$1,800	□Hospital Low Utilization	$1,500	□MassHealth NSCR ADH	$1,800
□Hospice	$2,100	□SNF Low Utilization	$500	□MassHealth GAFC/AFC	$1,250
□Home Office Cost Statement	$1,800	□HHA Low Utilization	$500	□Colorado SNF Med-13	$3,300
□Hospital	$5,000	□Hospice Low Utilization	$500	□Indiana HHA Medicaid	$1,250
□FQHC	$2,500	□RHC Low Utilization	$500	□Pennsylvania Medicaid	$3,500
□RHC	$1,500	□No Utilization	$250	□UDS for FQHC	$1,000
□Consolidated FQHC/RHC each	$200			□Arizona Hospice UAR	$750
				□Arizona SNF DHS	$2,000

Payment is due prior to receiving the final cost report files.

Total Charge Amount $_____ (From provider above and any subsequent providers from page 3.)

Please select a payment option below:

☐ Please charge my credit card. Name on Card: _____

Credit Card Number: _____ Exp Date: _____ CVV: _____

☐ Please process ACH / Bank Transfer

Bank routing number: _____Account number: _____

ACKNOWLEDGEMENT: This letter correctly sets forth my understanding of this engagement.

Signature: _____ Name: _____Date: _____

To submit contract, upload to secure Dropbox link. To obtain link contact blimi@ppsassistant.com or call (248)968-4100.

Cost Report Preparation Contract Terms

OBJECTIVES AND NATURE OF CONSULTING SERVICES

We will compile and prepare, from the information provided to us, the Medicare and/or Medicaid cost report pertaining to the reporting period indicated. Included with the cost report that we prepare, we will provide you with a package that includes all supplementary cost report worksheets and electronic files as applicable.

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.

PPS is not responsible for any variations in reimbursement amounts calculated by the Medicare Administrative Contractor based on, or that differ from, the cost report calculations.

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. If sending patient specific information, a separate signed Business Associate Agreement will be required.

FEES

Payment is due prior to receiving the final cost report files.

Fees include direct out-of-pocket expenses. The preparation fees do not include additional time we may incur in connection with the audit or desk review of the cost report. Additionally, preparation fees assume compliance with all checklist requests. If there are files which require extensive time to render them usable including, but not limited to, creating Excel spreadsheets out of pdf or scanned files or otherwise converting files from unusable formats to usable formats, there will be an hourly charge of $150 per hour to perform this service.

It is imperative that all information provided be carefully analyzed before sending to PPS. We will consider all information as final. If there are adjustments made that require extensive redo of already prepared information, there will be additional charges assessed at a rate of $150/hour. Provider should recognize that such changes will impact cost and delivery time. Cancellation fee will be charged at hourly rate of $150/ hour that was spent on the cost report prior to your written cancellation notice.

PLEASE NOTE: In order to guarantee on-time preparation, please submit all information three weeks in advance of your due date.

Please feel free to contact us with questions at 248 968-4100 or (800) 447-2540.

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Please fill out one box below per additional facility:

Contact Name: ______________________________ Company: ________________________________ Date: ____________

Provider Name: ____ Provider Number: ____________

Cost Report Begin Date: ____________ Cost Report End Date: ____________ □ Medicare □ Medicaid

Facility type: Utilization: Price: $____________ Filing Fee: $ ____________

Provider Name: ____ Provider Number: ____________

Cost Report Begin Date: ____________ Cost Report End Date: ____________ □ Medicare □ Medicaid

Facility type: Utilization: Price: $____________ Filing Fee: $____________

Provider Name: ____ Provider Number: ____________

Cost Report Begin Date: ____________ Cost Report End Date: ____________ □ Medicare □ Medicaid

Facility type: Utilization: Price: $____________ Filing Fee: $____________

Provider Name: ____ Provider Number: ____________

Cost Report Begin Date: ____________ Cost Report End Date: ____________ □ Medicare □ Medicaid

Facility type: Utilization: Price: $____________ Filing Fee: $____________

Provider Name: ____ Provider Number: ____________

Cost Report Begin Date: ____________ Cost Report End Date: ____________ □ Medicare □ Medicaid

Facility type: Utilization: Price: $____________ Filing Fee: $____________

Provider Name: ____ Provider Number: ____________

Cost Report Begin Date: ____________ Cost Report End Date: ____________ □ Medicare □ Medicaid

Facility type: Utilization: Price: $____________ Filing Fee: $____________

Total Price: $_____________________________

Please complete the payment information on page one and submit.

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