



PROGRESSIVE PROVIDER SERVICES

Providing Medicare & Medicaid Cost Reporting Solutions

Cost Report Preparation Contract Form and Terms

Contact Name: _____

Company: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Mobile: _____ E-mail: _____

Provider Name			Provider Number		
Begin Date	End Date	Medicare /Medicaid	Type of Provider	Utilization	Price
					\$
Provider Name			Provider Number		
Begin Date	End Date	Medicare /Medicaid	Type of Provider	Utilization	Price
					\$
Provider Name			Provider Number		
Begin Date	End Date	Medicare /Medicaid	Type of Provider	Utilization	Price
					\$

Submission Methods (Check one option)

- 1) Provider will mail - PPS will send an e-mail with files and mailing instructions
- 2) Provider will file via MCR eF - PPS will send an e-mail with files and instructions for MCR eF.
- 3) PPS will file via MCR eF - \$20 charge. PPS will provide instructions.

In order to file via MCR eF, a security official needs to be set up on the IDM system at: <https://portal.cms.gov>

Cost Report Preparation Contract Form and Terms (cont.)

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 above. 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.

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.**

Medicare Cost Report for:

Skilled Nursing Facility	\$2,600	ESRD	\$1,500
Home Health Agency	\$1,800	CMHC	\$1,800
Hospice	\$2,100	Low Utilization HHA	\$500
FQHC	\$1,800	Low Utilization Hospice	\$500
FQHC Additional consolidated facilities	\$200 each	Low Utilization FQHC	\$750
RHC	\$1,500	No Utilization	\$250

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

These 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 per 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.

**Payment is due prior to receiving the final cost report files.	
<input type="checkbox"/> Please charge my credit card. Name on Card: _____	
Credit Card Number: _____ Exp Date: _____ cvv: _____	
Authorized Signature: _____	
<input type="checkbox"/> Please process ACH / Bank Transfer. Authorized Signature _____	
Bank routing number: _____ Account number: _____	

ACKNOWLEDGEMENT:

This letter correctly sets forth my understanding of this engagement.

SIGNATURE _____ NAME _____
 TITLE _____ DATE _____