Nursing Facility Quality Assessment Payment Reporting Form

Facility Days of Care for State Fiscal Quarter 1, FY10
(July 2009-September 2009)

Provider Number: ______________________________ (**PROV NO**)

Facility Name: ____

Total Number Licensed Beds: _____________________

Payer Source		Days of Care			
		July 2009	August 2009	September 2009	Total Quarter 1
Total Patient Days[1]	**TO**				
Less Medicare Part A days	**MCA**	( )	( )	( )	( )
Less Medicare Part C days	**MCC**	( )	( )	( )	( )
Prior Quarter Adjustments[2]	**PQ**				
Total Assessed Days = **TO - MCA - MCC +/- PQ**	**TD**				
X per diem rate		X $1.85	X $1.75	X $1.75	
subtotals					
PAYMENT AMOUNT	July 2009 + (August + September 2009)				

[1]Medicaid pending days should be included in Total Patient Days.

[2]Prior Quarter Adjustments may be additions or subtractions.

Please make check payable to: “State of Maryland”

Please send completed reporting form and payment not later than November 30, 2009 to:
Nursing Facility Quality Assessment Fund
P.O. Box 17697
Baltimore, Maryland 21297-1697
or, if sending via courier or non-USPS carrier:
SunTrust Bank
Attn: SOM/Nursing Facility Quality Assessment -17697
1000 Stewart Avenue
Glen Burnie MD 21061