Nursing Facility Quality Assessment Payment Reporting Form

Facility Days of Care for State Fiscal Quarter 1, FY12 (July 2011-September 2011)

M.A. Provider #: | | | | | | | | 0 | 0 | **(PROV NO)**

Facility Name: _____

Contact Person: _____ Phone#: _____

Total Number Licensed Beds: _____

Payer Source		**Days of Care**			
		July 2011	August 2011	September 2011	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 $5.32
PAYMENT AMOUNT					

[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 29, 2011 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