

Nursing Facility Quality Assessment Payment Reporting Form

Facility Days of Care for State Fiscal Quarter 2, FY12 (October 2011-December 2011)

M.A. Provider #:

										0	0
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 (PROV NO)

Facility Name: _____

Contact Person: _____ Phone#: _____

Total Number Licensed Beds: _____

Payer Source		Days of Care			
		October 2011	November 2011	December 2011	Total Quarter 2
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 \$19.94
PAYMENT AMOUNT					

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

²Prior 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
February 29, 2012 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**