

Nursing Facility Quality Assessment Payment Reporting Form

Facility Days of Care for State Fiscal Quarter __, FY10
(_____ 20__ - _____ 20__)

Provider Number: _____ (PROV NO)

Facility Name: _____

Total Number Licensed Beds: _____

Payer Source		Days of Care			
		_____	_____	_____	Total Quarter _
		200_	200_	200_	
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 \$6.62
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
_____, 20__ 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