

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 \$6.70	X \$6.62	X \$6.62	
subtotals					
PAYMENT AMOUNT	July 2009 + (August + September 2009)				

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
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**