# 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 | **(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 $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 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**