

Nursing Facility Quality Assessment Payment Reporting Form

Facility Days of Care for State Fiscal Quarter 3, FY12 (January 2012-March 2012)

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			
		January 2012	February 2012	March 2012	Total Quarter 3
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					

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
May 30, 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**