Nursing Facility Quality Assessment Payment Reporting Form

Facility Days of Care for State Fiscal Quarter ____, FY 12
(_____ 20__--_____ 20__)

M.A. Provider #: | | | | | | | | 0 | 0 | **(PROV NO)**

Facility Name: _____

Contact Person: _____ Phone#: _____

Total Number Licensed Beds: _____

Payer Source		**Days of Care**			
		_____ 20____	_____ 20____	_____ 20____	Total Quarter____
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					

[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 _____, _____ 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