Provider Fee, Patient Days and Net Revenue Report

For Georgia Nursing Homes Not Enrolled in the Medicaid Program

Nursing Home Name: _____ For Quarterly Period From: 04/01/14
City: _____ Through: 06/30/14

Prepared by: _____ Title: _____
e-mail: _____ telephone number: _____

		column 1	column 2	column 3	column 4	column 5	column 6
1	Patient Days Summary	Medicare Patients	Medicaid Patients	All Other Patients	Total Patient Days On-Site	Leave or Hospital Days Billed	Total Patient Days Billed
	a) Apr 2014	0	0	0	0	0	0
	b) May 2014	0	0	0	0	0	0
	c) Jun 2014	0	0	0	0	0	0
	d) Total for Quarter	0	0	0	0	0	0
2	Provider Fee Per Patient Day			$17.10			
3	Provider Fee for Quarter			$0.00			
4	Provider Fee Monthly Payments						
	a) Payable by July 31			$0.00			
	b) Payable by August 31			$0.00			
	c) Payable by September 30			$0.00			
5	Total Net Revenue for Patient Services						$0.00

I hereby certify that I am authorized to submit this form and that the information is true and accurate.

Authorized signature: _____ Signature name: _____

Date: _____ Signature title: _____

Submit completed report by mail or fax to:
Nursing Home Services Unit
Georgia Department of Community Health
Division of Financial Services
2 Peachtree Street, NW
Atlanta, Georgia 30303-3159
Fax (404) 657-4199