

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: _____
 City: _____ Through: _____

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

	column 1	column 2	column 3	column 4	column 5	column 6
				Total Patient Days On-Site	Leave or Hospital Days Billed	Total Patient Days Billed
1 Patient Days Summary	<u>Medicare Patients</u>	<u>Medicaid Patients</u>	<u>All Other Patients</u>			
a) _____	_____	0	_____	_____	_____	_____
b) _____	_____	0	_____	_____	_____	_____
c) _____	_____	0	_____	_____	_____	_____
d) Total for Quarter	_____	0	_____	_____	_____	_____
2 Provider Fee Per Patient Day			_____			
3 Provider Fee for Quarter			_____			
4 Provider Fee Monthly Payments						
a) Payable by _____			_____			
b) Payable by _____			_____			
c) Payable by _____			_____			
5 Total Net Revenue for Patient Services						_____

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