

Provider Fee, Patient Days and Net Revenue Report

For Georgia Nursing Homes Not Enrolled in the Medicaid Program

Nursing Home Name: _____
City: _____

For Quarterly Period From: 07/01/26
Through: 09/30/26

Prepared by: _____
e-mail: _____

Title: _____
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	Medicare <u>Patients</u>	Medicaid <u>Patients</u>	All Other <u>Patients</u>			
	a) <u>Jul</u> <u>2026</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
	b) <u>Aug</u> <u>2026</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
	c) <u>Sep</u> <u>2026</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
	d) Total for Quarter	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
2	Provider Fee Per Patient Day			<u>\$17.10</u>			
3	Provider Fee for Quarter			<u>\$0.00</u>			
4	Provider Fee Monthly Payments						
	a) Payable by <u>October 31</u>			<u>\$0.00</u>			
	b) Payable by <u>November 30</u>			<u>\$0.00</u>			
	c) Payable by <u>December 31</u>			<u>\$0.00</u>			
5	Total Net Revenue for Patient Services						<u>\$0.00</u>

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 email to:

Nursing Home Services Unit
Georgia Department of Community Health
Division of Financial Services
2 Martin Luther King Jr. Drive SE
East Tower, 17th Floor
Atlanta, Georgia 30334
nhstaffreport@dch.ga.gov