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: 07/01/14
City: _____ Through: 09/30/14

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) Jul 2014	0	0	0	0	0	0
	b) Aug 2014	0	0	0	0	0	0
	c) Sep 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 October 31 $0.00
- b) Payable by November 30 $0.00
- c) Payable by December 31 $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