

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: _____
 Through: _____

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) _____	_____	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 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