

# 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	<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 email to:  
 Nursing Home Services Unit  
 Georgia Department of Community Health  
 Division of Financial Services  
 2 Martin Luther King Jr. Drive SE  
 East Tower, 17<sup>th</sup> Floor  
 Atlanta, Georgia 30334  
[nhstaffreport@dch.ga.gov](mailto:nhstaffreport@dch.ga.gov)