



North Carolina Department of Health and Human Services
 Division of Medical Assistance
 Finance Management

Michael F. Easley, Governor
 Carmen Hooker Odom, Secretary

Gary Fuquay, Director

STATEMENT DUE DATE:
Monthly Assessment Fee Statement

Nursing Facility Name: (1) _____
 Provider Number: (2) _____
 Federal Tax ID Number (3) _____

Please complete and return this form along with your monthly fee payment to the address below. It is imperative that you complete all data fields on this statement. Failure to submit the completed provider fee report and full payment by the due date shall result in penalties and interest as stated in the North Carolina Provider Agreement and Controller Cash Management Plan. Retain the bottom (canary) copy for your records. If you should have any questions regarding this form or the reporting requirements, please contact DMA Nursing Home Rate Setting staff at (919) 857-4015.

Please Make Check Payable to:
 DHHS Accounts Receivable

Mailing Address:
 DHHS Accounts Receivable
 2022 Mail Service Center
 Raleigh, NC 27699-2022

**indicate
 "Nursing Facility Assessment Fee"
 on the memo line of the check

Provider Assessment Worksheet -

	Current Month Ended Total	Documented Prior Period Adjustments	Adjusted Monthly Total	Year to Date Cumulative
A Total Medicaid Patient Days	(4)	(9)	(14)	(21)
B Total Private / Other Non Medicare Days	(5)	(10)	(15)	(22)
C Total Non - Medicare Days (A+B)	(6)	(11)	(16)	(23)
D Provider Assessment Daily Rate			*(17)	
E Monthly Provider Fee Due (C*D)			(18)	
F Total Medicare Patient Days	(7)	(12)	(19)	(24)
G Total Patient Days (C + F)	(8)	(13)	(20)	(25)

Signed By: (26) _____, Title (27) _____
 (Must Be Owner, Partner, Officer or Administrator)

Print Name: (28) _____, Telephone/Email (29) _____

White - Financial Management Copy * Do not remove
 Green - Controller's Office Copy * Do not remove
 Canary -- Provider's Copy * Retain Before Sending