

NEW HAMPSHIRE DEPARTMENT OF HEALTH & HUMAN SERVICES
NURSING FACILITY QUALITY ASSESSMENT CALCULATION WORKSHEET
 (603) 271-4341

Facility Name: _____ FEIN: _____ License #: _____

Assessment Period Beginning _____ and ending _____ prepared in accordance with RSA 84-C:4

Check One: January 1 - March 31 April 1 - June 30 July 1 - September 30 October 1 - December 31

2017
 2018
 Other _____

	PRIOR PERIOD ADJUSTMENTS SETTLED IN THIS PERIOD	CURRENT PERIOD	TOTAL
LINE 1 Medicaid Patient Net Revenues 1	(a)	(b)	(c)
LINE 2 Medicare Patient Net Revenue 2	(a)	(b)	(c)
LINE 3 All Other Patient Net Revenues 3	(a)	(b)	(c)
LINE 4 Total Patient Net Service Revenues 4 (Nursing Facility Beds Only)	(a)	(b)	(c)
LINE 5 Medicaid Patient Bed Days 5	(a)	(b)	(c)
LINE 6 Medicare Patient Bed Days 6	(a)	(b)	(c)
LINE 7 All Other Patient Bed Days 7	(a)	(b)	(c)
LINE 8 Total Patient Bed Days 8	(a)	(b)	(c)

Prior period adjustments are not applicable to the initial filing period. Adjustments to previously filed assessment period's revenues are to be reflected as prior period adjustment in the period the change is settled.

Line 1 Medicaid Patient Net Revenues

Enter all Medicaid Patient Net Revenues on Line 1(b) and Line 1(c), including anticipated revenue for Medicaid residents including "Medicaid Pending" residents for services rendered for the assessment period.

LINE 2 Medicare Patient Net Revenue

Enter all Medicare Patient Net Revenue including any anticipated revenue for Medicare residents for services rendered for the assessment period.

LINE 3 All Other Patient Net Revenues

Enter All Other Patient Net Revenues including all anticipated revenue for all non-Medicaid and non-Medicare residents for services rendered for the assessment period.

LINE 4 Total Patient Net Service Revenues

Enter on Line 4(a) the sum of Lines 1(a) through Line 3(a) and repeat for (b) and (c). Enter all Total Patient Net Service Revenues for Nursing Facility Beds Only. Enter the amount from Line 4(c) NH Dept. of Revenue Form DP-156, Nursing Facility Assessment Return, Line 1.

LINE 5 Medicaid Patient Bed Days

Enter the actual occupied bed days of Medicaid residents including "Medicaid Pending" residents for services rendered during the assessment period.

LINE 6 Medicare Patient Bed Days

Enter the actual occupied bed days of Medicare residents for services rendered during the assessment period.

LINE 7 All Other Patient Bed Days

Enter the actual occupied bed days of all non-Medicaid and non-Medicare residents for services rendered during the assessment period.

LINE 8 Total patient Bed Days

Enter on Line 8(a) the sum of Lines 5 (a) through Line 7(a); Enter on Line 8(b) the sum of Lines 5(b) through 7(b); and Enter on Line 8(c) the sum of Lines 5(c) through 7(c). If zero, enter 0.

WHEN TO FILE

This calculation worksheet and a copy of the completed DP-156 shall be filed with Health and Human Services on or before the 10th day of the month following the close of the assessment period.

Mail This Worksheet To:	NH DEPT OF HEALTH & HUMAN SERVICES BUREAU OF ELDERLY & ADULT SERVICES RATE SETTING & AUDIT UNIT 129 PLEASANT STREET CONCORD NH 03301-3857
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