



TOBY DOUGLAS  
Director

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
Governor

## QUALITY ASSURANCE FEE FOR THE 2014-15 RATE YEAR

January 14, 2015

Dear Administrator:

This letter provides updated information concerning the Quality Assurance Fee (QAF) assessed for each skilled nursing facility for the rate year, August 1, 2014 to July 31, 2015. *California Health and Safety Code*, Sections 1324.20 – 1324.30 authorizes the Department of Health Care Services (DHCS) to collect a QAF from all non-exempt Freestanding Skilled Nursing Facilities (FS/NF-B), Freestanding Skilled Adult Subacute Nursing Facility Level-Bs (FS ASA/NF-B), and Freestanding Pediatric Subacute Facilities (FS PSA/NF-B). Pursuant to statutory changes (Statutes 2012), DHCS is authorized to assess a QAF on multilevel facilities (MLRCs). The purpose of this fee is to enhance federal financial participation in the Medi-Cal program, and to provide additional reimbursement and support for quality improvement efforts in licensed FS/NF-Bs that provide services for the Medi-Cal program.

Effective August 1, 2014, for the rate year 2014-15, DHCS will begin collecting the QAF authorized by the legislature on all SF/NF-Bs subject to the fee. DHCS will collect the following on a monthly basis:

- FS/NF with less than 100,000 total annual resident days – \$16.03 per resident day
- FS/NF with equal to or greater than 100,000 total annual resident days – \$15.15 per resident day

Attached to this notice are all 12 monthly payment forms with the current QAF rate, the payment due date, and the address to mail all payments and forms. Payments are due on or before the last day of the month following the month for which the fee was imposed.

Page 1 of 2

Monthly Payment Notice for the Skilled Nursing Facility Quality Assurance Fee  
Page 2

Payment Invoices are available on the DHCS Web site at:

<http://www.dhcs.ca.gov/provgovpart/Pages/SkilledNursingFacilities.aspx>

Provider bulletins and information on how the rates are set for the Quality Assurance Fee Program can be found at:

<http://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTCAB1629.aspx>

Please return the appropriate invoice with payment based on your facility's total resident days for the month to the following address:

Department of Health Care Services  
Accounting Section/Cashiers Unit  
MS 1101  
P.O. Box 997415  
Sacramento, CA 95899-7415

Please write your OSHPD and/or Medi-Cal provider number on the front of your check or money order to expedite the payment process.

Thank you for your cooperation with this program. If you have any questions please e-mail [ab1629@dhcs.ca.gov](mailto:ab1629@dhcs.ca.gov), or you may contact the FS/NF-B QAF coordinator by calling (916) 650-0583 and you will be directed to your facility's representative.

Sincerely,

John Beshara, Chief  
Quality Assurance Fee Unit

**Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Adult Subacute Nursing Facility (FS ASA/NF-B), Freestanding Pediatric Subacute, Level-B (FS PSA/NF-B)  
Quality Assurance Fee – 2014-2015 (FY)  
Payment Invoice for AUGUST 1, 2014 to AUGUST 31, 2014**

Department of Health Care Services  
Accounting Section/Cashiers Unit, Mail Stop 1101  
1501 Capitol Avenue, Suite 71.2048  
P.O. Box 997415  
Sacramento, CA 95899-7415

Office of Statewide Health Planning and  
Development Number:

\_\_\_\_\_  
National Provider Identifier:

NAME:

Due Date: MARCH 31, 2015

ADDRESS:

Amount Remitted: \$\_\_\_\_\_

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
1780	000	00	H	125600	58	84005	A14	3213

Total Resident Days \_\_\_\_\_ Multiply by \$16.03= Amount Due \_\_\_\_\_

Original Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Phone Number \_\_\_\_\_ E-Mail \_\_\_\_\_

**PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF**

**Payment Invoice Instructions:**

**Total Resident Days:** Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Medicare Advantage, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

**Amount Due:** Multiply the *Total Resident Days* by \$16.03 and enter that amount in the space provided for the *Amount Due*.

**Amount Remitted:** Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

**Original Signature:** Sign in the space provided. Please use ink.

**Date:** Enter the date you completed this payment invoice.

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**Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Adult Subacute Nursing Facility (FS ASA/NF-B), Freestanding Pediatric Subacute, Level-B (FS PSA/NF-B)  
Quality Assurance Fee – 2014-2015 (FY)  
Payment Invoice for SEPTEMBER 1, 2014 to SEPTEMBER 30, 2014**

Department of Health Care Services  
Accounting Section/Cashiers Unit, Mail Stop 1101  
1501 Capitol Avenue, Suite 71.2048  
P.O. Box 997415  
Sacramento, CA 95899-7415

Office of Statewide Health Planning and  
Development Number:

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National Provider Identifier:

NAME:

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Due Date: MARCH 31, 2015

ADDRESS:

Amount Remitted: \$ \_\_\_\_\_

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
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Payment Invoice for OCTOBER 1, 2014 to OCTOBER 31, 2014**

Department of Health Care Services  
Accounting Section/Cashiers Unit, Mail Stop 1101  
1501 Capitol Avenue, Suite 71.2048  
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Sacramento, CA 95899-7415

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National Provider Identifier:

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Due Date: MARCH 31, 2015

ADDRESS:

Amount Remitted: \$ \_\_\_\_\_

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Payment Invoice for NOVEMBER 1, 2014 to NOVEMBER 30, 2014**

Department of Health Care Services  
Accounting Section/Cashiers Unit, Mail Stop 1101  
1501 Capitol Avenue, Suite 71.2048  
P.O. Box 997415  
Sacramento, CA 95899-7415

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Due Date: MARCH 31, 2015

ADDRESS:

Amount Remitted: \$\_\_\_\_\_

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Payment Invoice for DECEMBER 1, 2014 to DECEMBER 31, 2014**

Department of Health Care Services  
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1501 Capitol Avenue, Suite 71.2048  
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Sacramento, CA 95899-7415

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Due Date: MARCH 31, 2015

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Amount Remitted: \$\_\_\_\_\_

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Payment Invoice for JANUARY 1, 2015 to JANUARY 31, 2015**

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Sacramento, CA 95899-7415

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Due Date: MARCH 31, 2015

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Quality Assurance Fee – 2014-2015(FY)  
Payment Invoice for FEBRUARY 1, 2015 to FEBRUARY 28, 2015**

Department of Health Care Services  
Accounting Section/Cashiers Unit, Mail Stop 1101  
1501 Capitol Avenue, Suite 71.2048  
P.O. Box 997415  
Sacramento, CA 95899-7415

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National Provider Identifier:

NAME:

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Due Date: MARCH 31, 2015

ADDRESS:

Amount Remitted: \$ \_\_\_\_\_

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Payment Invoice for MARCH 1, 2015 to MARCH 31, 2015**

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Sacramento, CA 95899-7415

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Due Date: APRIL 30, 2015

ADDRESS:

Amount Remitted: \$ \_\_\_\_\_

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Development Number:

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National Provider Identifier:

NAME:

\_\_\_\_\_  
Due Date: MAY 31, 2015

ADDRESS:

Amount Remitted: \$ \_\_\_\_\_

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Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

**Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Adult Subacute Nursing Facility (FS ASA/NF-B), Freestanding Pediatric Subacute, Level-B (FS PSA/NF-B)  
Quality Assurance Fee – 2014-2015 (FY)  
Payment Invoice for JUNE 1, 2015 to JUNE 30, 2015**

Department of Health Care Services  
Accounting Section/Cashiers Unit, Mail Stop 1101  
1501 Capitol Avenue, Suite 71.2048  
P.O. Box 997415  
Sacramento, CA 95899-7415

Office of Statewide Health Planning and  
Development Number:

\_\_\_\_\_  
National Provider Identifier:

NAME:

\_\_\_\_\_  
Due Date: JULY 31, 2015

ADDRESS:

Amount Remitted: \$ \_\_\_\_\_

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
1780	000	00	H	125600	58	84005	A14	3213

Total Resident Days \_\_\_\_\_ Multiply by \$16.03 = Amount Due \_\_\_\_\_

Original Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Phone Number \_\_\_\_\_ E-Mail \_\_\_\_\_

**PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF**

**Payment Invoice Instructions:**

**Total Resident Days:** Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Medicare Advantage, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

**Amount Due:** Multiply the *Total Resident Days* by \$16.03 and enter that amount in the space provided for the *Amount Due*.

**Amount Remitted:** Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

**Original Signature:** Sign in the space provided. Please use ink.

**Date:** Enter the date you completed this payment invoice.

**Phone Number/E-Mail:** Enter your area code, daytime phone number, and E-Mail address.

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**Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Adult Subacute Nursing Facility (FS ASA/NF-B), Freestanding Pediatric Subacute, Level-B (FS PSA/NF-B)  
Quality Assurance Fee – 2014-2015 (FY)  
Payment Invoice for JULY 1, 2015 to JULY 31, 2015**

Department of Health Care Services  
Accounting Section/Cashiers Unit, Mail Stop 1101  
1501 Capitol Avenue, Suite 71.2048  
P.O. Box 997415  
Sacramento, CA 95899-7415

Office of Statewide Health Planning and  
Development Number:

\_\_\_\_\_  
National Provider Identifier:

NAME:

\_\_\_\_\_  
Due Date: AUGUST 31, 2015

ADDRESS:

Amount Remitted: \$ \_\_\_\_\_

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
1780	000	00	H	125600	58	84005	A14	3213

Total Resident Days \_\_\_\_\_ Multiply by \$16.03 = Amount Due \_\_\_\_\_

Original Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Phone Number \_\_\_\_\_ E-Mail \_\_\_\_\_

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