

**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**

Facility Information:	Payment Details:
Facility Name:	Rate Year:
Address:	Full Year Reconciliation: Yes No
NPI:	Month Reporting:
OSHPD:	Amount Due: \$
Phone:	Due Date:

Fiscal Year	Reporting Structure	Account	App Ref	Service Location
	4260KB0B	4129200	980	84005
Activity	Program	Alt Account	Fund	Project
	9990	4129200015	3213	

Resident days are the number of days in which a patient resides at the SNF.

This includes, **but is not limited to:** bed hold days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, private pay, other insurance, charity, and hospice. **The QAF Rate for Rate Year is \$ for less than 100,000 resident days, and \$ for 100,000 or more resident days.**

Amount Due:	
Total # of Resident Days:	
QAF Rate:	
Amount Due = Total # of Resident Days x QAF Rate:	

Payment Instructions:

Please visit <http://dhcs.ca.gov/epay> and use invoice number **SNF12345678** to pay via EFT, the preferred method of payment. To pay by mail, please submit payment and form to: 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.

Submitter Information:

Name:	Email:
Original Signature:	Date:
I am an administrator, officer, or other individual duly authorized and designated to make this certification on behalf of the above named facility. I declare under penalty of perjury under the laws of the State of California that the foregoing information is <i>true, correct, and complete</i> .	