



Charlie Crist
GOVERNOR

Holly Benson
SECRETARY

Monthly Quality Assessment Fee Remittance Form

Please make checks payable to:

Agency for Health Care Administration
2727 Mahan Drive, MS # 14
Tallahassee, FL 32308
Finance & Accounting - NFGAF
Memo: Nursing Facility Quality Assessment Fee

Reference ID: 1108-0007
Creation Date: 7/12/2009
Report Month/Year: NOVEMBER 2009
Facility Name: Palm Gardens
Facility Address: 21251 E. ...
NORTH ...

The Federal NPI number has been removed.

Perm ID 976
Medicaid Number 025749400
Medicare Number 105610

The **Current Amount** field has been added in place of Previous Remittance Charge and Balance Due. Since the invoice only gives a current charge amount for each submission, facility's must calculate the Balance Due if a resubmission is made.

Please submit your remittance and monthly fee payment to the address above. Failure to do so by the due date shall result in penalties and interest as stated in Section 409.9082 Florida Statute. If you have any questions regarding this form or reporting requirements, please contact Finance & Accounting at 850/488-5869.

Total Non-Medicare Days 20,000,000
Provider Assessment Rate (X) \$3.00
Current Amount \$60,000,000.00

Payments are due by the 15th of the following reporting month.

Print Name of Owner, Partner, Officer or Administrator Title

Signature of Owner, Partner, Officer or Administrator Date

Telephone/Email of Owner, Partner, Officer or Administrator

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Tallahassee, Florida 32308



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