

**Center for Health Information and Analysis**  
**2 Boylston Street, Boston, MA 02116**  
**Tel (617) 988-3100 FAX (617) 727-7662 TTY (617) 988-3175**

**Nursing Facility Quarterly User Fee Assessment Form**

<b>Facility Name:</b> _____	<b>VPN:</b> _____
<b>Address:</b> _____	<b>User Fee Class</b> _____
<b>City, State, Zip:</b> _____	<b>FEIN Tax ID#:</b> _____
<b>Contact Name:</b> _____	<b>Contact Phone #:</b> _____

The purpose of this form is to gather the necessary information to calculate your facility's User Fee Assessment in accordance with regulation 114.5 CMR 12.04 (1)&(2).

If you have any questions, please call Customer Service at (617) 988-3297.

**I. Total Nursing Patient Days for Quarter Ending \_\_\_\_\_**

**Only nursing home level days should be included. Do not include resident care days.**

	1	2	3	4	5	6		7
Type	Mass. Medicaid	Non-Mass Medicaid	MA Comm for the Blind	VA/Other Public	Private	Medicare		Non-Medicare Days (Sum(1 – 5))
Total Qtr NH Patient Days								

**II. Calculation of the Nursing Facility User Fee Assessment**

Please calculate the user fee below according to your facility's class. See instructions for facility class descriptions.

	Total Qtr Non-Medicare Days (Col. 7 above)		User Fee Rate		NH User Fee
<b>Class I</b>	<b>X</b>		<b>18.41</b>	<b>=</b>	_____
<b>Class II &amp; II</b>	<b>X</b>		<b>1.84</b>	<b>=</b>	_____
<b>Class IV</b>	<b>X</b>		<b>.00</b>	<b>=</b>	_____

**III. Comments** (Attach additional pages if necessary.)

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The facility representative whose signature appears below, is acknowledging to the best of his/her knowledge, by said signature, that the information in this worksheet is true, accurate, and prepared in accordance with applicable regulations and instructions under the pains of penalties of perjury.

\_\_\_\_\_  
Signature of Owner, Partner, Officer or Administrator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of signatory above

\_\_\_\_\_  
Print Title