STATE OF DELAWARE
Department of Finance
Division of Revenue
820 N. French Street
P.O. Box 2340
Wilmington, DE 19899-2340

2019 - 2020
NURSING FACILITY QUALITY ASSESSMENT REPORTING FORM

FORM LQ11_1206

Reset

Print Form

REV CODE 0028-20

1. Enter Account Number (No Dashes)

2. Business Code Group Description **408 NURSING FACILITY QUALITY ASSESSMENT FEE** ☐ **AMENDED**

3. Tax Period Ending Date **05-31-20** Due on or Before **06-15-20**

4. Facility Name

5. Facility Location Address

City

State Zip Code

6. Mailing Address if Different

City

State Zip Code

Is your nursing facility required to file this return?

A. During the entire calendar quarter, did the facility exclusively serve children?..... ☐ **YES** ☐ **NO**

B. During the entire calendar quarter, was the number of licensed nursing home beds less than 47?..... ☐ **YES** ☐ **NO**

C. If nursing services and assisted/independent living services are provided on the same campus, are the number of assisted/independent living beds at least twice (2 times) the number of nursing beds?..... ☐ **YES** ☐ **NO**

If the answer is "yes" to any of the above questions, the facility is exempt from this tax.

	Mar	Apr	May	TOTAL/AVERAGE
1. Number of annual Medicaid patient days (from most recently filed Medicaid Cost Report)				
2. Number of licensed nursing home beds (see "B" above)				0
3. Number of assisted/independent living beds on same campus (see "C" above)				0
4. Number of nursing facility resident days				0
5. Number of Medicare resident days				0
6. Number of non-Medicare resident days (Line 4 minus Line 5)				0
7. If Line 1 is less than 44,000, enter $30.15; if 44,000 or greater, enter $15.98				30.15
8. TOTAL AMOUNT DUE (Line 6 times Line 7)				$ 0.00
9. TOTAL AMOUNT REMITTED				$

Under penalties of perjury, I declare that I have examined this reporting form and that the information contained herein is true, correct, and complete.

PRINT NAME / TITLE **SIGNATURE** **DATE**

(Revised 05/2019)

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