# NURSING FACILITY ENHANCED MEDICAID PAYMENT REPORT

This form should be completed by health facilities licensed under Iowa Code 135C.1 that are free-standing facilities, or are operated by a hospital licensed pursuant to Iowa Code Chapter 135B. Nursing facilities operated by the state, non-state government-owned or government-operated nursing facilities or distinct-part skilled nursing units and swing-bed units operated by a hospital do not have to complete this form.

| | | | | |
|---|---|---|---|---|
| **NPI Number** | | | | |
| **Name of Facility** | | **Employer I.D. Number** | | |
| | | | | |
| **Mailing Address** | | | | |
| **Street or P. O. Box** | | **City** | **State** | **Zip** |
| | | | | |
| **Physical Address (If Different)** | | | | |
| **Street** | | **City** | **State** | **Zip** |
| | | | | |
| **Type of Control** | ● **Proprietary** | ● **Non-Profit** | ● **Government** | |
| **Is Facility registered as a Continuing Care Retirement Community (CCRC)?** | | | ● **Yes** | ● **No** |
| **Date of Report** | Beginning | | Ending | |

| **Section 1: Reconciliation Of Quality Assurance Assessment Fee** | | |
|---|---|---|
| Statistical Information | | |
| Line No. | Type of Day | |
| 1 | Total Medicaid days | |
| 2 | Total Medicare days | |
| 3 | Hospice Days | |
| 4 | Total Other Days | |
| 5 | Total patient days | 0 |
| 6 | Licensed beds during period | |
| 7 | Total bed days during period | 0 |
| 8 | Average occupancy during period | #DIV/0! |
| 9 | Average Medicaid utilization during period | #DIV/0! |

| Quality Assurance Assessment Fee Remitted | | |
|---|---|---|
| Line No. | **Amounts reported in this section should agree with amounts from Quarterly Form 470-4836** | |
| 10 | Quality assurance assessment fee per bed day | |
| 11 | Quality assurance assessment fee paid for 1st quarter | |
| 12 | Quality assurance assessment fee paid for 2nd quarter | |
| 13 | Quality assurance assessment fee paid for 3rd quarter | |
| 14 | Quality assurance assessment fee paid for 4th quarter | |
| 15 | Total quality assurance assessment fee paid for period | $0.00 |

| Quality Assurance Assessment Pass-through and Rate Add-on Payments Received | | |
|---|---|---|
| Line No. | | |
| 16 | Quality assurance assessment payments received for 1st quarter | |
| 17 | Quality assurance assessment payments received for 2nd quarter | |
| 18 | Quality assurance assessment payments received for 3rd quarter | |
| 19 | Quality assurance assessment payments received for 4th quarter | |
| 20 | Quality assurance assessment payments received for period | $0.00 |

| Calculation of Enhanced Medicaid Payment Received and Spending Requirements | | |
|---|---|---|
| Line No. | **Enhanced Medicaid payment is the amount of payments received over amount remitted** | |
| 21 | Amount of Enhanced Medicaid Payment | $0.00 |
| 22 | Amount of Enhanced Medicaid Payment to be expended on behalf of all employees (60%) | $0.00 |
| 23 | Amount of Enhanced Medicaid Payment to be expended on behalf of CNAs (35%) | $0.00 |

**CERTIFICATION STATEMENT**

**Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and imprisonment under state or federal law.**

**I CERTIFY that I have read the above statement and that I have examined the accompanying information. To the best of my knowledge and belief, it is a true and complete statement prepared from the records of the provider in accordance with applicable instructions.**

| | | |
|---|---|---|
| **Name of Authorized Person** | **Title/Position** | **Telephone Number** |
| | | |
| **Signature of Authorized Person** | **Date** | **Address of Authorized Person** |
| | | |
| **Name of Preparer** | **Title/Position** | **Telephone Number of Preparer** |
| | | |
| **Signature of Preparer** | **Date** | **Address of Preparer** |
| | | |

**NURSING FACILITY ENHANCED MEDICAID PAYMENT REPORT**

| Facility Name: | | | Vendor No. |
|---|---|---|---|
| Period of Report | | From: | To: |

| Section 2: Demonstration of Wage and Employment Cost Change for the Period | | | | |
|---|---|---|---|---|
| **Any costs in this section MUST have a descriptive narrative in Section 3** | | | | |
| Line No. | Description | Increases for CNA wages and costs | Increases for other employee wages and costs | Total Increases for wages and costs |
| 1 | Wage increases | | | $0.00 |
| 2 | Bonuses and other wage adjustments | | | $0.00 |
| 3 | Changes to staffing patterns | | | $0.00 |
| 4 | Vacation, holiday and sick pay - PTO or leave benefits | | | $0.00 |
| 5 | Benefit programs - group health, group life, retirement | | | $0.00 |
| 6 | Education programs and advancement opportunities | | | $0.00 |
| 7 | Tuition reimbursement programs | | | $0.00 |
| 8 | Other costs | | | $0.00 |
| 9 | Total increases in wages and costs | $0.00 | $0.00 | $0.00 |

| Test of Required Increases | |
|---|---|
| CNA | |

| | | |
|---|---|---|
| Required amount to be expended on behalf of CNAs | | $0.00 |
| Actual amount expended on behalf of CNAs | | $0.00 |
| Test Met | | TRUE |

| All Employees | |
|---|---|

| | | |
|---|---|---|
| Required amount to be expended on behalf of all employees | | $0.00 |
| Actual amount expended on behalf of all employees | | $0.00 |
| Test Met | | TRUE |

| Section 3: Narrative |
|---|
| **All costs from Section 2 MUST have a descriptive narrative** |