NURSING FACILITY QUALITY ASSURANCE ASSESSMENT
CALCULATION WORKSHEET

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**	
Did facility status as a CCRC change since the last quarter?				**Yes**		**No**	
If Yes: Effective date facility became registered:			**Effective date facility registration terminated:**				
Is Payment for a Month or Quarter?	**Month**		**Quarter**				

Month of Report							
		Year					
January		April		July		October	
February		May		August		November	
March		June		September		December	

Quarter of Report					
January 1 - March 31		**Year**		July 1 - September 30	
April 1 - June 30				October 1 - December 31	

Statistical Data

Beds at Beginning of Period		Beds at End of Period	

If there was a change in the number of beds, please submit documentation with the completed form to the address identified below.

	Current Period	Prior Period Adjustment	Total
A.1 - Total Medicaid Days for Reporting Period - Fee For Service			0
A.2 - Total Medicaid Days for Reporting Period - Wellpoint in Iowa			0
A.3 - Total Medicaid Days for Reporting Period - Iowa Total Care			0
A.4 - Total Medicaid Days for Reporting Period - Molina			0
A. Total Medicaid Days for Reporting Period	0	0	0
B. Total Medicare Days for Reporting Period - Part A and Part C			0
C. Hospice Days (Medicare, Medicaid, Private Pay)			0
D. Total Other Days for Reporting Period - Private Pay, Insurance, VA, & HMO			0
E. Total Leave Days (Paid or Unpaid)			0
F. Excluded Days			0
G. Total Resident Days for reporting Period (Paid or Unpaid)	0	0	0

Calculation of Quality Assurance Assessment Amount

H. Patient days used for calculation (A and D from above)	0
I. Quality assurance assessment fee per bed day (See Instructions)	
J. Total quality assurance assessment owed to Iowa Medicaid (F* G)	$ -

This Form and Check are due no later than 30 Days after the quarter end

Make Check Payable and Mail to:
Iowa Medicaid
PO Box 850280
Minneapolis, MN 55485-0285

CERTIFICATION STATEMENT

This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, complete, and related to nursing facility patient care. I understand that this information is submitted for the purpose of calculating the quality assessment under SF 476, and the ultimate collection of the quality assessment will be based upon the information contained herein. The provider certifies that they have not imposed rate increases due to the quality assurance assessment fee for non-Medicaid payors as a component of the routine service charges for those payors. I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge.

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**

State of Iowa
Iowa Department of Health and Human Services
Division of Medical Services

Instructions for the Nursing Facility Quality Assurance Assessment Fee Calculation Worksheet

All nursing facilities as defined in Iowa Code section 135C.1 that are free-standing facilities or are operated by a hospital licensed pursuant to Iowa Code chapter 135B shall pay a quarterly assessment to the department, as determined under this division, with the exception of:

a. Nursing facilities operated by the state.
b. Non-state government-owned or government-operated nursing facilities.
c. Distinct-part skilled nursing units and swing-bed units operated by a hospital

Provider Name and Identification Data

NPI Number*:* Report the facility's National Provider ID, taxonomy and nine-digit zip code. It is very important that all of these numbers correspond to those on file with the IME Provider Services Unit so that your facility can be correctly identified and the fee be attributed to your facility.

Type of Control: Indicate whether the facility is proprietary for-profit, voluntary non-profit, or government owned. If the facility is government-owned, no quality assurance assessment fee is due.

CCRC Registered: If the facility is registered as a Continuing Care Retirement community (CCRC) by the Iowa Insurance Division, then the question should be answered 'Yes.'

If the facility has changed its status as a Continuing Care Retirement community (CCRC) with the Iowa Insurance Division since the last quarterly Nursing Facility Quality Assurance Assessment Calculation Worksheet was filed, please answer 'Yes' and indicate the date the facility became a CCRC or terminated its designation.
Changes are only recognized at 7/1 of each year, based on information status as of 6/1.

Is Payment for a Month or Quarter: If payment is being made for a specific month, please mark in the Month box. If payment is being made for a Quarter, please mark in the Quarter box

If amount is for a month, please indicate the year and mark the appropriate month. If amount is for a quarter, please indicate the year and mark the appropriate quarter.

Note: All payments for a calendar quarter are due within 30 days of the quarter end. If you pay monthly, all payments must be made by the due date for a calendar quarter. There is no penalty for monthly payments except the third month of a quarter. For example, a payment for March (as well as January and February) must be made by the end of April to be considered timely.

Statistical Data

Beds at Beginning of Period: Report the number of authorized licensed beds at the beginning of the quarter for which this form is being completed.
Beds at End of Period: Report the number of authorized licensed beds at the end of the quarter for which this form is being completed.
Note: If there was a change in the number of beds, please submit documentation with the completed form to the address identified on the form. Changes are recognized at 7/1 of each year, based on the number of beds at 6/1.

A.1 – Total Medicaid Days for Report Period – Fee for Service: Report the number of days that a bed was occupied in the facility for which Medicaid fee-for-service was the primary payor during the quarter. Exclude leave and hospice days.

A.2 – Total Medicaid Days for Report Period – Wellpoint in Iowa: Report the number of days that a bed was occupied in the facility for which Wellpoint in Iowa was the Medicaid managed care organization (MCO) payor during the quarter. Exclude leave and hospice days.
A.3 – Total Medicaid Days for Report Period – Iowa Total Care: Report the number of days that a bed was occupied in the facility for which Iowa Total Care was the Medicaid managed care organization (MCO) payor during the quarter. Exclude leave and hospice days.
A.5 – Total Medicaid Days for Report Period – Molina: Report the number of days that a bed was occupied in the facility for which Molina was the Medicaid managed care organization (MCO) payor during the quarter. Exclude leave and hospice days.

A. Total Medicaid Days: Sum of Medicaid days from above.

B. Total Medicare Days: Report the number of days that a bed was occupied in the facility for which Medicare Part A or Part C was the payor during the quarter. This includes any day where Medicare was the primary payor and there was a secondary payor for the same day (crossover), regardless if the secondary payor was Medicaid, private insurance or any other payor. Exclude leave and hospice days.

C. Hospice Days: Report the number of days that a bed was occupied in the facility for which a resident was receiving Hospice benefits during the quarter.

D. Total Other Days for Reporting Period: Report the number of days that a bed was occupied in the facility for a payor type other than Medicaid, Medicare Part A or Medicare Part C, for the quarter. Exclude leave and hospice days.

E. Total Leave Days: Report the number of days any resident was absent, regardless of reason, and regardless of if the bed-hold was paid for.

F. Excluded Days: Report the number of days for any resident where the day is not subject to the assessment fee, for example, the payor is PACE or another State Medicaid agency.

Calculation of Quality Assurance Assessment Fee Amount

H. Patient days: Sum of the number of days from above from the Total Medicaid Day and Total Other Days (sum of A and D from above)
Note: This field will automatically calculate based on information provided in the Statistical Data section

I. Quality assurance assessment fee per bed day: The assessment fee is $33.90 per patient day except if a nursing facility:
a. Has 46 or fewer licensed beds
b. Designated as a Continuing Care Retirement Centers (CCRC)
c. Has annual Iowa Medicaid patient days of 19,000 or more
If a facility meets any of the criteria in a, b, or c the assessment fee is $6.51 per bed day.
You will only be able to choose $33.90 or $6.51 from the drop down box.

J. Total quality assurance assessment fee owed to Iowa Medicaid: The quality assurance assessment fee owed is the product of bed days from F and the quality assurance assessment fee per bed day from G.

Note: This field will automatically calculate based on information provided in H and I above.

This form and a check for the total quality assurance assessment owed are due no later than 30 days after quarter end.

Completed forms should be submitted to the following address:

Iowa Medicaid
PO Box 850280
Minneapolis, MN 55485-0285

An electronic copy of the form only should be submitted to costaudit@dhs.state.ia.us

If a package is sent requiring a signature (i.e., certified mail or overnight), send to:

Iowa Medicaid
Lockbox Services – #310280
1801 Parkview Dr. 1st Floor
Shoreview, MN 55126

Facilities whose form is received after 30 days from the end of the quarter will be required to pay a penalty in the amount of 1.5% of the quality assurance assessment owed for each month or portion of a month the payment is overdue.

This form can be found on the IME website at https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/provider-forms

Questions concerning this form should be addressed to Provider Cost Audit at 1-866-863-8610, or (515) 256-4610, or to costaudit@dhs.state.ia.us

Certification Statement

After adequate review of the completed form, the certification statement must be signed by a responsible person having authorization from the controlling body (board, owner, etc.) of the facility to make such representations. The certification statement submitted must contain original signatures.