INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY
CALCULATION WORKSHEET

This form should be completed by intermediate care facilities for individuals with an intellectual disability licensed under Iowa Code 135C.1.

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**

Quarter of Report					
July 1 through September 30		**YEAR**		October 1 through December 31	
January 1 through March 31				April 1 through June 30	

Revenue Information (ALL ICF.ID REVENUE - REGARDLESS OF PAYER)	
	Total
A. Amount received from Amerigroup Iowa	$ -
B. Amount received from Iowa Total Care	$ -
C. Amount received from Molina Healthcare of Iowa	$ -
D. Amount received from individuals for client participation	$ -
E. Amount received from Medicaid Fee-for-service	$ -
F. Amount received from private pay individuals and private insurance companies	$ -
G. Amount received from other sources	$ -

Calculation of Assessment Amount	
H. Revenue for calculation (Sum of A - G from above)	$ -
I. Assessment percentage	5.50%
J. Total assessment owed to Iowa Medicaid (H* I)	$ -

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

Make Check Payable and Mail to:
Iowa Medicaid Enterprise
PO Box 36450
Des Moines, IA 50315

CERTIFICATION STATEMENT

I certify that to the best of my knowledge and belief the information taken from the records of the provider is true, accurate, complete and verifiable. I understand that this information is submitted for the purpose of calculating the assessment for intermediate care facilities for individuals with an intellectual disability, and the ultimate collection of the assessment will be based upon the information contained herein. I understand that any person that submits false, misleading, or incomplete information, responses, or representations may be subject to criminal, civil, or administrative liability 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 Intermediate Care Facilities for Individuals with an Intellectual Disability Calculation Worksheet

For all intermediate care facilities for persons with an intellectual disability (ICFs/ID) licensed in Iowa under 481 IAC Chapter 64, including facilities not certified to participate in the Medicaid program, shall pay a quarterly assessment to the Department, as determined under this division.

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 indentified and the fee be attributed to your facility.
If multiple sites are included under one form, please provide the name, NPI number and address of each entity.

Revenue Information

For each line A through G, please report the amount of funds received for ICF/ID routine services from the named entity. The amount of revenue should include, but is not limited to, funds paid by Medicaid Managed Care, Medicaid fee-for-service, and client participation. The only source of revenue not subject to the fee is that from Medicare. The revenue should be what was received during the period, regardless of the dates of service.

Calculation of Assessment Amount

H. Revenue for calculation : Report the sum of the revenue from all sources above.

Note: This field will automatically calculate based on information provided in the Revenue Information section.

I. Assessment percentage: Per 441 Iowa Administrative Code Chapter 36, the percentage is 5.5%.

J. Total assessment owed to Iowa Medicaid: The assessment amount owed is the product of total revenue from H and the assessment percentage from I.

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 36450

Des Moines, IA 50315

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

Hoover Building

1305 E Walnut St.

Des Moines, IA 50319

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 http://www.ime.state.ia.us/Providers/Forms.html

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.