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State/Territory Name: UT

State Plan Amendment (SPA) #: 21-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

November 29, 2021

Emma Chacon, Acting Director
Division of Health Care Financing
Utah Department of Health
P.O. Box 143101
Salt Lake City, UT 84114-3101

Re: Utah 21-0005

Dear Ms. Chacon:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0005. Effective for services on or July 1, 2021, this amendment updates the methodology for Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) providers. Specifically, it provides clarification for existing Quality Improvement Incentive (QII) provisions for NFs, adds a new QII payment provision for ICF/IDs, modifies the provider's filing period for facility cost profiles (FCPs), clarifies the fair rental value (FRV) calculation when providers reduce existing beds, updates the rental factor and implements an emergency exception for a NF to complete an FRV project.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 21-0005 is approved effective July 1, 2021. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at Christine.storey@cms.hhs.gov or (303) 844-7044.

Sincerely,

For
Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: U T — 21-0005
2. STATE: UTAH
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Section 1902(a)(30)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 2021 +$621,250
b. FFY 2022 +$2,485,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Section 200 of ATTACHMENT 4.19-D;
Section 332 of ATTACHMENT 4.19-D;
Section 634 of ATTACHMENT 4.19-D;
Section 927 of ATTACHMENT 4.19-D;
Section 1195 of ATTACHMENT 4.19-D.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Section 200 of ATTACHMENT 4.19-D;
Section 332 of ATTACHMENT 4.19-D;
Section 634 of ATTACHMENT 4.19-D;
Section 927 of ATTACHMENT 4.19-D;
Section 1195 of ATTACHMENT 4.19-D.

10. SUBJECT OF AMENDMENT
Quality Improvement Incentive, Facility Cost Profile, and Fair Rental Value

10. GOVERNOR'S REVIEW *(Check One)*

■ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME Richard G. Saunders

14. TITLE Executive Director, Utah Department of Health

15. DATE SUBMITTED June 15, 2021

16. RETURN TO
Craig Devashrayee, Manager
Technical Writing Unit
Utah Department of Heath
PO Box 143102
Salt Lake City, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
June 15, 2021

18. DATE APPROVED
November 29, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL
For

YPED NAME
Rory Howe

22. TITLE
Director, Financial Management Group

23. REMARKS

FRV DATA REPORT means:	The Fair Rental Value Data report is an optional report that provides the State with more timely information for inclusion in the FRV calculation.
BANKED BEDS means:	Beds that have been taken off-line by the provider, through the process defined by Utah Department of Health, Bureau of Facility Licensing, to reduce the operational capacity of the facility, but does not reduce the licensed bed capacity.
LABOR COSTS means:	Labor costs as reported on the FCPs, but not including FCP reported management, consulting, director, and home office fees.
BED REPLACEMENT means:	As used in the fair rental value calculation, a capitalized project that furnishes a bed in the place of another, previously existing, bed. Room remodeling is not a replacement of beds. This must be new and complete construction.
MAJOR RENOVATION means:	As used in the fair rental value calculation, a capitalized project with a cost equal to or greater than $500 per licensed bed. A renovation extends the life, increases the productivity, or significantly improves the safety (such as by asbestos removal) of a facility as opposed repairs and maintenance which either restore the facility to, or maintain it at, its normal or expected service life. Vehicle costs are not a major renovation capital expenditure.
BED ADDITION means:	As used in the fair rental value calculation, a capitalized project that adds additional beds to the facility. This must be new and complete construction. An increase in total licensed beds and new construction costs support a claim of additional beds.
BED REDUCTION means:	As used in the fair rental value calculation, a reduction in licensed beds based on delicensing beds or transferring licensed beds to another facility.
URBAN PROVIDER means:	a facility located in a county which has a population greater than 90,000 persons.
RURAL PROVIDER means:	a facility that is not an urban provider.

300 REPORTING AND RECORDS

310 INTRODUCTION

This section of the State Plan addresses five major areas: (1) the accrual basis of accounting; (2) reporting and record keeping requirements; (3) FCP reporting periods; (4) State audits; and (5) federal reporting.

320 BASIS FOR ACCOUNTING

Long-term care providers must submit financial cost reports which are prepared using the accrual basis of accounting in accordance with Generally Accepted Accounting Principles. To properly facilitate auditing and rate calculations, the accounting system must be maintained so that expenditures can be grouped in accounting classifications specified in the facility cost profile (FCP).

330 REPORTING AND RECORD KEEPING

The FCP is the basic document used for reporting historical costs, revenue and patient census data. The FCP is sent to providers at least 60 days prior to the due date.

The Fair Rental Value Data Report is used for reporting banked beds, capital improvements and related items for use in the FRV calculation.

331 FACILITY COST PROFILES

The FCP represents the presentation of the costs involved in providing patient care. Therefore, it is essential that the FCPs are filed with accurate and complete data. The provider, and not the auditor authorized by the State, is responsible for the accuracy and appropriateness of the reported information.

331b FAIR RENTAL VALUE DATA REPORT

In order to recognize, in a more timely manner, facility construction costs and bed banking, this optional report must be submitted if the facility wishes the Department to include that information in calculating its Fair Rental Value.

332 REPORTING

FCP: The FCP is due three months after the end of the reporting period. (See Section 340). Failure to file timely FCPs may result in the withholding of payments as described in section 720.

634 FAIR RENTAL VALUE FOR PROPERTY

Property costs will be calculated and reimbursed as a component of the facility rate based on a Fair Rental Value (FRV) System.

(a) Under this FRV system, the Department reimburses a facility based on the estimated value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent or lease expenses. The FRV system establishes a nursing facility's bed value based on the age of the facility and total square footage.

(i) The initial age of each nursing facility used in the FRV calculation is determined as of September 15, 2004, using each facility's initial year of construction.

(ii) The age of each facility is adjusted each July 1 to make the facility one year older.

(iii) The age is reduced for replacements, major renovations, or additions placed into service since the facility was built, provided there is sufficient documentation to support the historical changes.

A. If a facility adds new beds, these new beds are averaged into the age of the original beds to arrive at the facility's age. The number of beds added is obtained through the State's facility licensing entity prior to calculating the FRV for the new rate period.

B. If a facility reduces beds, the reduced beds are subtracted from the total beds used. The number of beds added or reduced is obtained through the State's facility licensing entity prior to calculating the FRV for the new rate period.

C. If a facility has replacement beds, these replacement beds are averaged into the age of the original beds to arrive at the facility's age.

I. The project must have been completed during a 24-month period, except during an emergency as declared by the president of the United States or the governor, affecting the building or renovation of the physical facility which may extend up to 24 additional months as approved by the Utah Medicaid director or designee, and reported on the FRV Data Report for the reporting period used for the July 1 rate year and be related to the reasonable functioning of the nursing facility.

D. If a facility completed a major renovation, the cost of the project is represented by an equivalent number of new beds.

(ii) A nursing facility's annual FRV is calculated by multiplying the facility's newly calculated bed value times a rental factor. The rental factor is 9 percent.

(iii) The facility's annual FRV is divided by the greater of:

(A) the facility's annualized actual resident days during the cost reporting period; and
(B) for rural providers, 65 percent of the annualized licensed bed capacity of the facility and, for urban providers, 85 percent of the annualized licensed bed capacity of the facility.

(iv) The FRV per diem determined under this fair rental value system shall be no lower than $8.

(c) A pass-through component of the rate is applied and is calculated as follows:

(i) The nursing facility's per diem real property tax and real property insurance cost is determined by dividing the sum of the facility's allowable real property tax and real property insurance costs, as reported in the most recent FCP or FRV Data Report, as applicable, by the facility's actual total patient days.

(ii) For a newly constructed facility that has not submitted an FCP or FRV Data Report, the per diem real property tax and real property insurance is the average daily real property tax and real property insurance cost of all facilities in the FRV calculation.

For examples of fair rental value calculations, please go to https://medicaid.utah.gov/stplan/longtermcare/.

Deleted 7-1-21

900 RATE SETTING FOR NFs (Continued)

927 QUALITY IMPROVEMENT INCENTIVE

In order for a facility to qualify for any Quality Improvement Incentive or Initiative in Subsections (1) or (2) or (3):

- The facility must submit all required documentation;
- The facility must clearly mark and organize all supporting documentation to facilitate review by Department staff;
- The facility must submit the application form and all supporting documentation for that incentive or initiative via email, to qii_dmhf@utah.gov, no later than May 31st of each year.

(1) Quality Improvement Incentive 1 (QII1):

(a) Funds in the amount of $1,000,000 shall be set aside from the base rate budget annually to reimburse current Medicaid-certified non-ICF/ID facilities that have:

(i) A meaningful quality improvement plan that includes the involvement of residents and family, which includes the following (weighting of 50%);

1) A demonstrated process of assessing and measuring that plan; and

2) Four quarterly customer satisfaction surveys conducted by an independent third party with the final quarter ending on March 31 of the incentive period, along with an action plan that addresses survey items rated below average for the year;

(ii) A plan for culture change along with an example of how the facility has implemented culture change (weighting of 25%);

(iii) An employee satisfaction program (weighting of 25%);

(iv) No violations that are at an "immediate jeopardy" level as determined by the Department during the incentive period; and

(v) A facility that receives a substandard quality of care level F, H, I, J, K, or L during the incentive period is eligible for only 50% of the possible reimbursement. A facility that receives substandard quality of care in F, H, I, J, K, or L in more than one survey during the incentive period is ineligible for reimbursement under this incentive.

(b) The Department shall distribute incentive payments to qualifying, current Medicaid-certified facilities based on the proportionate share of the total Medicaid patient days in qualifying facilities.

(c) If a facility seeks administrative review of the determination of a survey violation, the incentive payment will be withheld pending the final administrative adjudication. If violations are found not to have occurred, the Department will pay the incentive to the facility. If the survey findings are upheld, the Department will distribute the remaining incentive payments to all qualifying facilities.

(d) This QII1 period is from July 1st through June 30th of each State Fiscal Year for that State Fiscal Year.

900 RATE SETTING FOR NFs (Continued)

(A) A new side-entry bathing system that allows the resident to enter the bathing system without having to step over or be lifted into the bathing area;
(B) Heat lamps or warmers (e.g. blanket or towel);
(C) Bariatric equipment (e.g. shower chair, shower gurney; and
(D) General improvements to the patient bathing/shower area(s).

(iv) Incentive for facilities to purchase or enhance patient life enhancing devices. Qualifying Medicaid providers may receive the QII2 limit amount for each Medicaid-certified bed. Patient life enhancing devices are restricted to:
(A) Telecommunication enhancements primarily for patient use. This may include land lines, wireless telephones, voice mail, and push-to-talk devices. Overhead paging, if any, must be reduced;
(B) Wander management systems and patient security enhancement devices (e.g., cameras, access control systems, access doors, etc.);
(C) Computers, game consoles, or personal music system for patient use;
(D) Garden enhancements;
(E) Furniture enhancements for patients;
(F) Wheelchair washers;
(G) Automatic doors;
(H) Flooring enhancements;
(I) Automatic Electronic Defibrillators (AED devices);
(J) Energy efficient windows with a U-factor rating of 0.35 or less;
(K) Exercise equipment for group fitness classes (e.g., weights, exercise balls, exercise bikes, etc.);
(L) Environmental management programs (e.g. water management programs, disinfectant fogger, etc.); and
(M) Fall-reduction beds.

(v) Incentive for facilities to educate staff as specified on the application form. Qualifying Medicaid providers may receive $110 for each Medicaid-certified bed.

(vi) Incentive for facilities to purchase or make improvements to van and van equipment for patient use. Qualifying Medicaid providers may receive $320 for each Medicaid-certified bed.

(vii) Incentive for facilities to purchase or lease new or enhance existing clinical information systems or software or hardware or backup power. Qualifying Medicaid providers may receive the QII2 limit amount for each Medicaid-certified bed.
(A) The software must incorporate advanced technology into improved patient care that includes better integration, captures more information at the point of care, and includes more automated reminders, etc. A facility must include the following tracking requirements in the software:
(I) Care plans:
(II) Current conditions;
(III) Medical orders;
(IV) Activities of daily living;
(V) Medication administration records;
(VI) Timing of medications;
(VII) Medical notes; and
(VIII) Point of care tracking.
(B) The hardware must facilitate the tracking of patient care and integrate the collection of data into clinical information systems software that meets the tracking criteria in Subsection A above.

(viii) Incentive for facilities to purchase a new or enhance its existing heating, ventilating, and air conditioning system (HVAC). Qualifying Medicaid providers may receive $162 for each Medicaid-certified bed.

(ix) Incentive for facilities to use innovative means to improve the residents' dining experience. These changes may include meal ordering, dining times or hours, atmosphere, more food choices, etc. Qualifying Medicaid providers may receive $200 for each Medicaid-certified bed.

(x) Incentive for facilities to achieve outcome proven awards defined by either the American Health Care Association Quality First Award program or the Malcolm Baldridge Award. Qualifying Medicaid providers may receive $100 per Medicaid-certified bed.

(xi) Incentive for facilities to provide flu or pneumonia immunizations for its employees at no cost to the workers. Qualifying Medicaid providers may receive $15 per Medicaid-certified bed. The application must include a signature list of employees who receive the free vaccinations.

(xii) Incentive for facilities to purchase new patient dignity devices. Qualifying Medicaid providers may receive $100 for each Medicaid-certified bed. Patient dignity devices are restricted to:
(A) Bladder scanner.
(B) Bariatric scale capable of weighing patients up to at least 600 pounds.

(xiii) Incentive for facilities to provide COVID-19 vaccinations for its employees with a minimum incentive value of $50 (e.g., cash, gift card, etc.) to each employee who received the full vaccination regimen. Qualifying Medicaid providers may receive $50 for each employee who received the full vaccination regimen not to exceed $300 per Medicaid-certified bed. The application must include a list of employees who received the full vaccination regimen, verification the employee received the incentive and each employee's signature attesting to each person's having met the parameters.

1195 INCENTIVES

In order for an ICF/ID to qualify for any Quality Improvement Incentive or Initiative in Subsections (1) or (2):

- The ICF/ID must submit all required documentation;
- The ICF/ID must clearly mark and organize all supporting documentation to facilitate review by Department staff;

The ICF/ID must submit the application form and all supporting documentation for that incentive or initiative via email, to qii_dmhf@utah.gov, no later than May 31st of each year.

1) Quality Improvement Incentive 1 (QII1):
   a) The Department shall set aside $200,000 annually from the base rate budget for incentives to current Medicaid-certified ICF/IDs. In order for an ICF/ID to qualify for an incentive:
      i) The application form and all supporting documentation for this incentive must be emailed or mailed with a postmark during the incentive period. Failure to include all required supporting documentation precludes an ICF/ID from qualification.
      ii) The ICF/ID must clearly mark and organize all supporting documentation to facilitate review by Department staff.
   b) In order to qualify for an incentive, an ICF/ID must have:
      i) A meaningful quality improvement plan which includes the involvement of residents and family with a demonstrated means to measure that plan (weighting of 50%);
      ii) Four quarterly customer satisfaction surveys conducted by an independent third party with the final quarter ending on March 31 of the incentive period, along with an action plan that addresses survey items rated below average for the year (weighting of 25%);
      iii) An employee satisfaction program (weighting of 25%); and
      iv) No violations, as determined by the Department, that are at an "immediate jeopardy" level during the incentive period.
      v) An ICF/ID receiving a condition level deficiency during the incentive period is eligible for only 50% of the possible reimbursement.
   c) The Department shall distribute incentive payments to qualifying ICF/IDs based on the proportionate share of the total Medicaid patient days in qualifying ICF/IDs.
   d) If an ICF/ID seeks administrative review of a survey violation, the incentive payment will be withheld pending the final administrative determination. If violations are found not to have occurred at a severity level of immediate jeopardy or higher, the incentive payment will be paid to the ICF/ID. If the survey findings are upheld, the Department shall distribute the remaining incentive payments to all qualifying ICF/IDs.

This QII1 period is from July 1st through June 30th of each State Fiscal Year for that State Fiscal Year.

1195 QUALITY IMPROVEMENT INCENTIVE

3) Quality Improvement Incentive 2 (QII2)
   a) In addition to the above incentives, funds in the amount of $3,710,000 have been allocated to fund the QII2 for improvements made in State Fiscal Year 2022.
   b) This QII2 period is for incentive programs completed from July 1, 2021 until May 31, 2022.
   c) In order to qualify for the QII2:
      i) A facility must demonstrate proof of completing the incentive by the end of the defined period;
      ii) The facility's proposal and execution documentation must include a detailed description demonstrating how the selected categories were successfully implemented during the time period for which payment is being requested.
   d) Each Medicaid provider may apply for the following quality improvement incentives:
      i) Incentive for facilities to enhance resident dignity. Qualifying ICF/ID facilities may receive $30,000 for each Medicaid-certified bed that is de-licensed and de-certified to better resident dignity, privacy, autonomy, and choice. Qualifying criteria are as follows:
         (A) The incentive will be available for a total of no more than 60 Medicaid-certified beds. The 60- bed potential shall be available for allocation based upon the order in which complete applications are received.
         (B) In no case shall the incentive be paid for a facility to reduce its beds to fewer than 6 Medicaid-certified beds.
         (C) The facility shall provide a proposal, no more than once per quarter, to the Department detailing how the QII(2)(i) payments will be utilized to enhance resident dignity as well as the specific timing for de-licensing/de-certifying beds throughout the incentive period. The proposal shall be submitted on, or before the last day of the first month of the quarter or within 30 days after this State Plan amendment's (T.N. #21-0005) approval date;
         (D) The proposal shall include the following elements:
            I. Resident privacy;
            II. Resident choice surrounding furnishings and environment; and
            III. Resident choice with awake, bed, and relaxation times and environmental preferences for those times.
         (E) When reviewing applications, priority will be given to comprehensive submissions received, in order of receipt date (not time), which address safe discharge of residents to another facility or to home and community-based settings. Partial approval or denial may be necessary for some applications depending on the availability of funding. If applications are received in excess of the 60 total available in this incentive, priority will be given to reducing facilities having 50 or more total beds, then the other applications will be reduced proportionately based on the requested reduction for patient dignity.
         (F) Incomplete applications will be returned to the provider and the provider will need to resubmit its application which will be reviewed based on received date.
         (G) The facility shall submit an execution application detailing how each proposal, or portion of a proposal, was successfully implemented. If the proposal noted bed de-licensing/de-certifying throughout the incentive period, an execution application should be submitted to coordinate with the timing of the proposal or portion of the proposal. The application must address all elements of Subsection (d)(i)(D). The execution application for each proposal shall be submitted no later than May 31, 2022. Upon approval of the execution application, the ICF/ID shall receive $30,000 for each qualifying resident dignity bed that was de-licensed and de-certified.
      ii) Incentive for facilities to implement, for each resident, based upon the ability of the individual served, employment opportunity, work assessment, community integration or staff education programs. Qualifying ICF/ID facilities may receive $4,021.05 for each Medicaid-certified bed, as of July 1, 2021, up to a maximum of 50. Qualifying criteria are as follows:
         (A) The facility shall select two programs under this Subsection (ii)(D), (E), (F), (G) or (H) to complete during the SFY;
         (B) The facility shall provide a proposal, no later than September 30 or within 30 days of approval of this State Plan amendment's (T.N. #21-0005) approval date, to the Department detailing how the QII(2)(d)(ii) payments will be utilized to establish and execute the selected programs during the SFY (25%);
         (C) The facility shall submit an application detailing the implementation of the proposal to the Department 30 days before the end of quarters 2, 3 and 4 or within 30 days of approval of this State Plan amendment's (T.N. #21-0005) approval date. The detail should denote how the selected QII(2)(ii) programs were successfully implemented during the quarter (25% for each quarter);

1195 QUALITY IMPROVEMENT INCENTIVE

(D) The proposal and execution applications for implementing an employment, vocational, or life skills training opportunity program, uniquely tailored to each individual, shall include the following elements:

I. Employment opportunity (unless the individual is in school or of retirement age);
II. Vocational opportunity as required through the state vocational rehabilitation office (unless the individual is of retirement age); or
III. Life skills training or, for individuals of retirement age, retirement activities and outings

(E) The proposal and execution applications for implementing a work assessment program shall address cognitive, physical, social, behavioral appropriateness, and communication abilities appropriate for the work environment.

(F) The proposal and execution applications for implementing a community integration program shall address how the facility facilitates a community integration process with membership, community opportunity, normalized errands, housing, adaptive equipment, financial services, healthcare services, individualized interests and transportation services.

(G) The proposal and execution application for implementing a staff education program shall include the following elements:

I. Resident rights; and
II. Community opportunity and integration resources;

(H) The proposal and execution application for implementing a COVID-19 staff vaccination program including payment incentives of at least $50 for staff receiving the full vaccination regimen. This includes staff who were fully vaccinated against COVID-19 prior to the start of SFY 2022. The application must include a list of employees who received the full vaccination regimen, verification the employee received the incentive and each employee's signature attesting to each person's having met the parameters.

(I) If COVID-19 restrictions interfere with the execution of the QII2(ii) program proposed for any given period, the ICF/ID may qualify for funds by demonstrating execution of the program with modifications appropriate during the national public health emergency as declared by the President of the United States for the program.

iii) Any funds having not been disbursed for the QII(2)(d)(ii) program are available to reimburse qualifying ICF/ID facilities having achieved 100% of eligible payment in QII(2)(d)(ii). The Department shall distribute incentive payments to qualifying ICF/ID facilities based on the proportionate share of unused funds divided by the number of Medicaid certified beds as of July 1, 2021, not to exceed 50.

e) The Department shall distribute incentive payments to qualifying, current Medicaid-certified ICF/ID facilities based on the following example which is for illustrative purposes only:

1195 QUALITY IMPROVEMENT INCENTIVE

		Per Bed
QII Total	$3,710,000	
QII(2)(i)	$1,800,000	$30,000
QII(2)(ii)	$1,910,000	$4,021.05
QII(2)(iii)	$579,032	$2,060.61

Facility	# of Beds	Proposed Dignity Beds	Beds (Max of 50 per facility)	QII(2)(i) Execution	QII(2)(ii) Maximum Potential	QII(2)(ii) Proposal	QII(2)(ii) Q2	QII(2)(ii) Q3	QII(2)(ii) Q4	QII(2)(ii) Not earned	Qualifying Bed Count	QII(2)(iii)Total Award
A	12		12	$0	$48,252.63					$48,252.63		$0.00
B	15		15	$0	$60,315.79	$15,078.95	$15,078.95	$15,078.95	$15,078.95	$0.00	15	$30,909.16
C	16		16	$0	$64,336.84	$16,084.21	$16,084.21	$16,084.21	$16,084.21	$0.00	16	$32,969.77
D	16	2	14	$60,000	$64,336.84	$16,084.21	$16,084.21	$16,084.21	$16,084.21	$0.00	16	$32,969.77
E	16		16	$0	$64,336.84	$16,084.21	$16,084.21	$16,084.21	$16,084.21	$0.00	16	$32,969.77
F	35		35	$0	$140,736.84	$35,184.21	$35,184.21	$35,184.21	$35,184.21	$0.00	35	$72,121.37
G	35	5	30	$150,000	$140,736.84	$35,184.21	$35,184.21	$35,184.21	$35,184.21	$0.00	35	$72,121.37
H	41		41	$0	$164,863.16					$164,863.16		$0.00
I	41	7	34	$210,000	$164,863.16					$164,863.16		$0.00
J	50	8	42	$240,000	$201,052.63	$50,263.16	$50,263.16	$50,263.16	$50,263.16	$0.00	50	$103,030.53
K	53	3	50	$90,000	$201,052.63	$50,263.16	$50,263.16	$50,263.16	$50,263.16	$0.00	50	$103,030.53
L	48		48	$0	$193,010.53	$48,252.63	$48,252.63	$48,252.63	$48,252.63	$0.00	48	$98,909.31
M	82	20	62	$600,000	$201,052.63	$50,263.16	$50,263.16			$100,526.32		$0.00
N	65	15	50	$450,000	$201,052.63	$50,263.16			$50,263.16	$100,526.32		$0.00
TOTALS	525	60	465	$1,800,000	$1,910,000	$383,005.26	$332,742.11	$282,478.95	$332,742.11	$579,031.58	281	$579,031.58

Example Narrative

Column 1: This represents the distinct ICF/ID.

Column 2: This represents the number of Medicaid-certified beds in the distinct ICF/ID as of July 1, 2021.

Column 3: This represents the number of Medicaid-certified beds reduced to enhance resident dignity.

Column 4: This represents the number of Medicaid-certified beds in the distinct ICF/ID period at the end of the SFY.

Column 5: This represents the amount of money earned by the distinct ICF/ID facility by successfully executing a dignity program.

Column 6: This represents the amount of money allowed for the distinct ICF/ID facility in QII(2)(ii).

Column 7: This represents the amount of money earned by the distinct ICF/ID facility by successfully completing a proposal (25% of column 6).

Column 8: This represents the amount of money earned by the distinct ICF/ID facility by successfully executing the proposal during quarter 2 (25% of column 6).

Column 9: This represents the amount of money earned by the distinct ICF/ID facility by successfully executing the proposal during quarter 3 (25% of column 6).

Column 10: This represents the amount of money earned by the distinct ICF/ID facility by successfully executing the proposal during quarter 4 (25% of column 6).

Column 11: This represents the amount of money not earned in QII(2)(ii) by the distinct ICF/ID facility to be used in QII(2)(iii).

Column 12: This represents the number of Medicaid-certified beds to be used as the denominator to calculate the QII(2)(iii) amount awarded to the distinct ICF/ID facility.

Column 13: This represents the money awarded to the distinct ICF/ID facilities qualifying for QII(2)(iii).