MANUAL MATERIAL TRANSMITTED					
MANUAL: Income Maintenance			**CHANGE NUMBER:** 40		
DELETE			**INSERT OR CHANGE**		
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Medicaid in these states. However, such payments from other states do not qualify a client for SSI Medicaid in West Viginia. Therefore, receipt of SSI Medicaid in another state does not always automatically result in eligibility in West Virginia.

If the client is not eligible for SSI Medicaid, no data system denial is required. The Worker must evaluate the client for all other Medicaid coverage groups and make a recording on the ES-5.

D. ESTABLISHING THE DATE OF APPLICATION

The date of application is the first day of the month which shows on the Need to Open printout as the Medicaid effective date, or the date given on the SSA referral or by the IM Buy-In Unit.

E. WHO MUST BE INTERVIEWED

No interview is required.

F. WHO MUST SIGN

No signature is required.

G. DUE DATE OF ADDITIONAL INFORMATION

All information is on the Need to Open printout, or is provided by SSA or the Buy-In Unit.

H. AGENCY TIME LIMITS

The Worker must enter the SDX information for approval within 45 days of the date of the Need to Open printout on which the client first appears, or the referral from SSA or the IM Buy-In Unit.

I. AGENCY DELAYS

Terminal entry must be made immediately upon discovery of the overdue entry.

J. PAYEE

The SSI recipient is the payee, unless the use of a substitute payee is justified.

1. The Redetermination List

QMB and SLIMB cases are redetermined yearly. QMB or SLIMB cases appear on list WEM512P1, M-219 Records Selected for Review and list, WEM530P1, Due and Overdue for Review. These lists are sent to county offices after the M-219 deadline, on approximately the 27th of each month, for cases due for redetermination the following month.

2. The Date Of The Redetermination

The State Office mails a redetermination packet to each case on the M-219 Records Selected for Review list. The packet contains a cover letter, form ES-MCAT-2, instruction sheet and a QMB/SLIMB fact sheet.

3. Scheduling The Redetermination

See item 2 above. The client may telephone the Worker or come into the office if he requires assistance completing the redetermination form.

When the client is in the office to complete a redetermination for another Program, the OMB or SLIMB redetermination must be completed at the same time. The redetermination is completed using the ES-2 when a redetermination for another Program is completed.

4. Completion Of The Redetermination

When the redetermination is completed and the individual(s) remains eligible, the new POE begins the month immediately following the month of the redetermination. The new beginning POE is coded in Block 7 in the M-219 system. The date of the next redetermination is coded in Block 87.

S. THE BENEFIT

1. QMB

The QMB recipient is the only individual who appears on the medical card.

Individuals eligible for QMB coverage only receive a yellow Medicaid card. When the QMB recipient is eligible under a coverage group which receives full

2. Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form ES-MS-1, are not paid by Medicaid.

N. REDETERMINATION SCHEDULE

1. Non-Spenddown

Non-spenddown cases are redetermined in the 6th month of the POC. The 6-month period begins with the date in Block 7. The date the next redetermination is due is coded in Block 87 in the M-219 system.

2. Spenddown

Spenddown cases are not redetermination and are closed at the end of the 6th month of the POC. The client must reapply for a new POC. The last month of the 6-month POC is coded in Block 87.

O. EXPEDITED PROCESSING

There is no expedited processing requirement.

P. CLIENT NOTIFICATION

See Chapter 6.

Q. DATA SYSTEM ACTION

Data system action is required. See Chapter 23.

R. REDETERMINATION VARIATIONS

The redetermination process is the same as the application process with the following exceptions:

1. Non-Spenddown

a. The Redetermination List

The case appears on the listing WEM530P1, Due and Overdue for Review. The list is sent to county offices after the M-219 deadline, on approximately the 27th of each month, for cases due for redetermination the following month. The county also receives computer-generated case dump sheets for all cases due for redetermination.

d. Client Notification

Spenddown cases which have met spenddown receive a computer-generated letter at the end of the 5th month of the POC. This letter informs the client that his eligibility will end at the end of the following month and that he must reapply for Medicaid coverage.

NOTE: Closed spenddown cases are reported on a monthly printout titled Cases Closed or Deleted for the Month of _____.

S. THE BENEFIT

A medical card is issued for each eligible child who has income of his own. Parents and any of their children who have no income of their own appear on one medical card, unless the parent has deemed income from an ineligible spouse. When this occurs, the parent is issued his own medical card. A specified relative, other than a parent, who has income appears on his own card.

1. Non-Spenddown

a. Retroactive Benefits

The first medical card generated by the data system shows retroactive eligibility, based on Block 7, and eligibility through the end of the current month.

b. Ongoing Eligibility

The ongoing medical card shows the eligibility dates for the current month. A new card is issued monthly which shows that month's eligibility dates.

The medical card is received on approximately the first day of each month.

c. Ending Date Of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

reimbursement for out-of-pocket medical expenses. See Chapter 2.

K. PAYEE

The recipient is the payee. Couples may decide who is the payee.

L. REPAYMENT AND PENALTIES

This does not apply to SSI-Related Medicaid.

M. BEGINNING DATE OF ELIGIBILITY

1. Non-Spenddown

The beginning date of eligibility is the first day of the month of the POC. This date may be backdated up to 3 months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

2. Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form ES-MS-1, are not paid by Medicaid.

N. REDETERMINATION SCHEDULE

1. Non-Spenddown

Non-Spenddown cases are redetermined in the 6th month of the POC. The 6-month period begins with the date in Block 7. The date the next redetermination is due is coded in Block 87 in the M-219 system.

2. Spenddown

Spenddown cases are not redetermined and are closed at the end of the 6th month of the POC. The client must reapply for a new POC. The last month of the 6-month POC is coded in Block 87 in the M-219 system.

redetermination date is coded in Block 87. This is the 6th month of the POC, beginning with the month in Block 7.

2. Spenddown Cases

a. The Redetermination List

Spenddown cases which meet spenddown appear on the listing WEM530P1, Due and Overdue For Review.

b. The Date of the Redetermination

Cases which have met spenddown may come into the office at any time to reapply for a new POC.

c. Scheduling the Redetermination

These cases are not scheduled for a redetermination. The client must apply for a new POC.

d. Client Notification

Spenddown cases which have met spenddown receive a computer-generated letter at the end of the 5th month of the POC. This letter informs the client that his eligibility will end at the end of the following month and that he must reapply for Medicaid coverage.

NOTE: Closed spenddown cases are reported on a monthly printout titled Cases Closed or Deleted for the Month of _____.

S. THE BENEFIT

A medical card is issued for each eligible individual or couple.

1. Non-Spenddown

a. Retroactive Benefits

The first medical card generated by the data system shows retroactive eligibility, based on Block 7, and eligibility through the end of the current month.

be entered in the data system before any other expenses are entered. The date entered for the expense is the first day of the POC, not the actual date of the old unpaid bills.

If there are expenses on more than one date, the expenses are entered in chronological order, beginning with the earliest date. All expenses incurred on one date are added together and transmitted as one amount for that date.

If, at some point during the entry of spenddown expenses, the system finds that there is no spenddown amount remaining, the data system response indicates that there is no spenddown amount and responds with a Period of Eligibility (POE). The beginning POE is the month, day and year of the incurred medical expense which brings the spenddown amount to $0. Refer to Chapter 1 for information about processing time limits.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form ES-MS-1, are not paid by Medicaid.

If, after the WESDN transaction, the data system response indicates that there is still a spenddown amount, the procedures described below are followed.

- The Worker prepares an ES-NL-4 and an ES-MS-1 and sends them to the client.

  If the client indicates he needs help to understand the procedure for meeting his spenddown, the Worker provides all help needed. In no instance is the client to be denied Medicaid because he is physically, mentally or emotionally unable to verify his medical expenses.

- The client is requested to keep a record of his medical expenses by date incurred, type of expense and amount, and to submit them to the Worker as

highlighted ES-MS-1 to Medical Processing in the Office of Medical Services. A copy of the ES-MS-1 is filed in the case record. The client's eligibiity begins the day the amount of incurred medical expenses at least equals his spenddown amount.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form ES-MS-1, are not paid by Medicaid.

FDG size, or until the POC expires. The spenddown process only applies to AFDC/U-Related and SSI-Related Medicaid.

a. Procedures

Once the M-219 system has determined the spenddown amount, expenses are entered in the data system in a spenddown transaction (WESDN) by date incurred, using the ES-5.

EXCEPTION: When the client reports that he owes old medical bills, these expenses must be entered in the data system before any other expenses are entered. The date entered for the expense is the first day of the POC, not the actual date of the old unpaid bills.

If there are expenses on more than one date, the expenses are entered in chronological order beginning with the earliest date. All expenses incurred on one date are added together and transmitted as one amount for that date.

If, at some point during the entry of spenddown expenses, the system finds that there is no spenddown amount remaining, the data system response indicates that there is no spenddown amount and responds with a Period of Eligibility (POE). The beginning POE is the month, day and year of the incurred medical expense which brings the spenddown amount to $0. Refer to Chapter 1 for information about processing time limits.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form ES-MS-1, are not paid by Medicaid.

If, after the WESDN transaction, the data system response indicates that there is still a spenddown amount, the procedures described below are followed.

- The Worker prepares an ES-NL-4 and an ES-MS-1 and sends them to the client.

- The Worker uses the ES-5 to code the spenddown transaction and routes it to the Terminal Operator, who notes the M-219 system's response on the ES-5 prior to returning it to the Worker.

- If the system response shows the client no longer has a spenddown, the Worker notifies the client of his eligibility. The Worker must highlight, or circle in red the bill, that met the client's spenddown, and send a copy of the highlighted ES-MS-1 to Medical Processing in the Office of Medical Services. A copy of the ES-MS-1 is filed in the case record. The client's eligibility begins the day the amount of incurred medical expenses at least equals his spenddown amount.

  NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form ES-MS-1, are not paid by Medicaid.

- If the system response shows a remaining spenddown amount, the Worker prepares Form ES-21 and sends it to the client.

- Even if no medical expenses are submitted, the process of notifying the client of his remaining spenddown amount is repeated every thirty (30) days until the spenddown is met or the POC expires.

b. Whose Medical Expenses Are Used

The medical bills of the following persons are used to meet the spenddown. There is no limit on the amount of one individual's bills which can be used to meet another individual's spenddown.

- The aged, blind or disabled individual

- The spouse of the eligible individual who lives with him

- Emergency room services
- Prescriptions
- Over-the-counter drugs prescribed by a physician
- Eye examinations
- Eye glasses
- Dental services
- Therapy prescribed by a physician
- Chiropractic services
- Prosthetic devices

F. COMPENSATION FOR LOSS OR DAMAGE

Settlements for lost or damaged assets or insurance proceeds, earmarked for medical expenses, burial costs, replacement or repair of assets, are excluded, provided the client uses the money, as intended, in a reasonable period of time. Reasonable is defined as being used in the month of receipt or the month following receipt.

EXCEPTION: For SSI-Related Medicaid, CDCS, PAC, QDWI, QMB, and SLIMB: Any payments received to replace or repair an excluded asset may be excluded for 9 months.

With Supervisory approval, the Worker may allow more time to dispose of the earmarked money. Controls must be set to follow up. Any money remaining, after the reasonable time allotted, or any money not used as earmarked, is treated as a lump sum payment.

In addition to the guidelines above, the following apply:

Food Stamps: Any governmental payments which are designated for the restoration of a home damaged in a disaster are excluded, as long as the benefit group is subject to a legal sanction if the funds are not used as intended.

AFDC/U, AFDC/U-Related Medicaid and GA for DA: Proceeds from insurance received as a result of a damaged/destroyed home are excluded, and any amount remaining after repairing/replacing the home are treated as a lump sum payment.

EXAMPLE: The client receives an insurance settlement of $8,000 as a result of an automobile accident. Of the payment amount, $1,250 is used for medical expenses and $6,000 is used to replace the vehicle destroyed in the accident. Since the insurance settlement has been used as intended, for replacement of the lost asset and reimbursement of medical expenses, only $750 remains as a lump sum payment.

SSI-Related Medicaid, CDCS, PAC, QDWI, QMB, SLIMB: Cash or in-kind items received from any source, such as, but not limited to, insurance companies, federal or State agencies, public or private organizations or other individuals, to replace or repair an excluded asset which is lost, stolen, or damaged, and any interest earned on such cash payments, are not counted as an asset for 9 months, beginning with the month the

Under no circumstances must the exclusion period for a victim of a presidentially-declared disaster or Hurricane Andrew exceed 30 months following the month of receipt.

When the client changes his intent to repair or replace the excluded asset, funds previously held for replacement or repair must be counted as an asset, effective the first moment of the month following the month the client reports the change of intent.

The cash or in-kind item(s) which is received to replace or repair non-excluded assets, or for personal injury or other purposes, is not excluded, even if the cash or in-kind item is received in conjunction with and/or from the same source as the cash or in-kind item intended to replace/repair an excluded asset.

EXAMPLE: A payment of $30,000 from a utility company, due to the loss of a recipient's home through the company's negligence, includes $28,000 for the home and household goods and $2,000 for personal injury. In this case, only the $28,000 can be subject to this exclusion. The $2,000 for personal injury is treated as lump sum.

LIST OF ASSETS

be made, the Worker must not take into account when payments can be made. When a trust provides, in some manner, that a payment can be made, even though that payment may be sometime in the future, the trust must be treated as providing that payment can be made from the trust.

(b) Undue Hardship

There is a hardship provision which allows the Department to exclude a trust when counting it results in undue hardship for the client. All decisions about undue hardship are made by the Director, Office of Family Support. Any requests for such a determination are submitted in writing and must show complete details about the undue hardship which will result. See "Undue Hardship" in the Definitions section.

GG. UNIFORM GIFTS TO MINORS ACT FUNDS	Yes	Yes	No

HH. VEHICLES	Yes *	Yes *	Yes *

The owner of a vehicle is generally the individual to whom it is titled. However, when the title of a vehicle is not in the client's name, but the client indicates it is his, the vehicle is counted as the client's asset. If the title is in the client's name, and he indicates the vehicle no longer belongs to him, and the name on the title has not been changed, the vehicle is presumed to be his, unless he can prove otherwise. Only those vehicles of members of the benefit group and disqualified individuals are considered when determining vehicle assets.

A leased vehicle, in which the individual has no equity and which he cannot sell, is excluded.

The NADA trade-in value is usually used to determine the CMV of the vehicle for Food Stamps, AFDC/U, AFDC/U-Related Medicaid and GA for DA. The NADA retail value is usually used to determine the CMV of the vehicle for SSI-Related Medicaid, CDCS, PAC, QDWI, QMB and SLIMB.

LIST OF ASSETS

specially equipped or used exclusively or primarily by the disabled person. This exclusion is not limited to one for each benefit group, but is limited to one for each physically disabled person.*

Individuals who meet the definition of disability found in Chapter 12 qualify for this exclusion. In addition, individuals receiving disability benefits from VA, SSA, or the Railroad Retirement Board qualify, as well as those suffering from a temporary disability, such as a broken leg. Ongoing disabling conditions, such as a respiratory illness or conditions requiring ongoing chemotherapy also qualify the individual for this exclusion.

- The vehicle is necessary for travel, other than daily commuting, that is essential to the employment of the individual, such as the vehicle of a traveling salesman or migrant worker following the workstream, or
- The vehicle is the individual's home.
- The vehicle is necessary to carry the primary source of fuel for home heating or water for home use.

* **NOTE:** Real property that is not excluded under other provisions in this Chapter and that is directly related to the maintenance or use of a vehicle excluded under the above three items designated with an asterick (*) is excluded as an asset. Only that portion of real property determined necessary for maintenance or use under this policy is excluded.

* **EXAMPLE:** A client owns a produce truck and uses it to earn his livelihood. He is prohibited from parking the truck in a residential area. The client owns a 10-acre field, separate from his homestead property, and uses his field to park and/or service the truck. The client needs and uses about an acre of the field for this purpose. Only the value of the acre is excluded, not the entire 10-acre field.

LIST OF ASSETS

If the value of the vehicle is $4,600 or less, no asset is counted at this point.

Unless the case has been determined ineligible at this point, the Worker considers all of the same vehicles considered in this Step again in Step 3.

STEP 3: EQUITY-EXEMPT VEHICLES

Certain other vehicles, not previously exempted, may be exempt from having the equity counted as an asset. If more than two vehicles are involved, and there is a question about which should be exempt for this step, the Worker and client must agree on which vehicle(s) meets the criteria below.

- One licensed vehicle used for household transportation. However, if the trade-in value exceeds $4,600 from Step 2, the excess CMV amount is still an asset.

- Any additional licensed vehicles necessary for benefit group members to seek, accept or continue employment, training or education which is preparatory to employment. However, if the trade-in value exceeds $4,600 from Step 2, the excess CMV amount is still an asset.

This exclusion extends through temporary periods of unemployment when the vehicle is not in use.

STEP 4: ALL OTHER VEHICLES

If the benefit group has any other vehicles not excluded by Steps 1 or 3, the equity of the vehicles must be considered. This includes unlicensed vehicles, which are only taken into consideration in this Step. The equity value is an asset. However, when a licensed vehicle has a trade-in value of more than $4,600 and is also considered for equity value, the Worker must use the higher of the two figures (trade-in or equity) in determining the total assets.

The client's statement of the value of the vehicle is accepted, unless he does not know, or his stated value

NURSING CARE SERVICES

17.9 INCOME

There is a two-step income process for providing Medicaid coverage for nursing care services to individuals in nursing facilities. The client must be eligible for Medicaid by being a member of a full Medicaid coverage group, by being a QMB recipient or by meeting a special income test. See Chapter 16 to determine which coverage groups provide full Medicaid coverage. If the client has a spenddown, it must be met before he is eligible for nursing care services or it must be able to be met by the cost of the nursing care. Once Medicaid eligibility is established, the client's contribution toward his cost of care in the facility is determined in the post-eligibility process. These processes are described in item D below.

A. EXCLUDED INCOME SOURCES

Income sources that are excluded for the coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing care services. See Chapter 10, Section 10.3 for the appropriate coverage group.

B. BUDGETING METHOD

See Chapter 10, Section 10.6,B. A monthly amount of income is determined based on averaging and converting income from each source.

Regardless of the day of the month on which the client enters or leaves the nursing facility, all income the client is determined to have, according to Chapter 10, for each month he resides even one day in the facility must be counted in determining eligibility and in post-eligibility calculations. No deductions or exclusions are allowed for income already spent in the month the client enters the nursing facility or for expenses he anticipates in the month he leaves.

During the first month and last month that Medicaid participates in the cost of care, it is necessary to prorate the client's contribution to his care when he does not spend the full calendar month in the facility. This proration is accomplished as follows:

NURSING CARE SERVICES

- Determine the number of days in the calendar month the client expects to reside in the facility and multiply the number of days by the daily deduction rate of the specific deduction. The result is the amount of income the client may retain for the PNA, CSMA or FMA. After all computations have been completed, any cents calculated as part of the result are rounded up.

17.14 SPECIAL DATA SYSTEM INSTRUCTIONS

Coding to accomplish payment for nursing care services is as follows:

A. AFDC/U; SSI MEDICAID CASES WITH NO OTHER INCOME (C-219 System)

Members of AFDC/U cases and SSI Medicaid cases with no income other than SSI, who receive nursing care services must have the following Blocks coded to allow payment for such services: 41, 71 and 74. In addition, those AFDC/U cases which qualify for a special needs allowance for the institutionalized individual's personal needs allowance, must have Block 44 coded with the amount.

Post-eligibility calculations are not required for these cases, so the client is not required to contribute toward his cost of care.

B. QMB CASES (M-219 System)

There is no special coding required for payment of nursing care services for an individual who receives QMB coverage under a case number with a Q prefix.

However, the Worker must notify the LTC/AC Unit in OMS immediately upon learning that the QMB client entered a nursing facility.

Post-eligibility calculations are not completed for a QMB client, so he has no cost contribution to the facility.

C. ALL OTHER MEDICAID CASES

Except as specified in items A and B above, all other Medicaid clients must have a case opened in the M-219 system to have nursing care services paid.

If the client already has an active C-219 system Medicaid case and becomes eligible for nursing care services, the C-219 system case, other than the AFDC/U or SSI with no other income case, is closed and a case opened in the M-219 system to determine the client's resource amount and total contribution toward his cost of care. When Block 48 is greater than 0 in an M-219 system case, the system performs only the post-eligibility calculations.

M: Medicare, Parts A and B

C: Court-ordered medical coverage by the absent parent

L: Potential coverage by liable party as the result of accident or injury through insurance, such as automobile insurance

S: Medical coverage available or possible as the result of a law suit

W: Medical coverage through Workers' Compensation

An entry in this section cannot be made as a continuous entry when adding an individual to the benefit group or approving a case. Instead, a separate entry must be made.

When adding an individual to the benefit group or approving an application, the Terminal Operator enters all of the required information in Blocks 11-25. As a separate entry in that same transaction, the Terminal Operator enters the medical insurance code, if appropriate, as 11-H*P(space)# to indicate the individual's medical insurance is from a private source.

To change the medical insurance code, follow the procedure described above.

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
27	Approval Date	N/A	6	Numeric

The M-219 system determines the date in this Block as follows:

When the case is a non-nursing home, spenddown case, the system enters the date the spenddown is met.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form ES-MS-1, are not paid by Medicaid.

In all other cases, the date the Worker enters in Block 7 is moved to this Block.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N/A	Y	All	7

38. Danville - Madison Nursing Center	5005801: 5005701:	SNF/ICF - 24 Beds ICF - 96 Beds
39. Davis Street Group Home	5009701:	ICF/MR - 6 Beds
40. Dawn View Manor	5088601:	ICF - 96 Beds
41. Denmar Hospital	5094101:	ICF - 155 Beds
42. E. A. Hawse Continuous	5139401:	ICF - 60 Beds
43. East End Group Home	5004401:	ICF/MR - 8 Beds
44. Eldercare of West Virginia	5007801:	SNF/ICF -120 Beds
45. Elkins Convalescent Hospital	5009601:	SNF/ICF -105 Beds
46. Fairhaven Rest Home	5010001:	SNF/ICF - 41 Beds
47. Fairmont General Hospital	5006001:	SNF/ICF - 35 Beds
48. Fayette Continuous	5005301:	ICF - 60 Beds
49. Fox Nursing Home	5011801:	ICF - 60 Beds
50. Gaboya Place Group Home	5005901:	ICF/MR - 8 Beds
51. Gihon Road Group Home	5007401:	ICF/MR - 8 Beds
52. Glenwood Park United Methodist Home	5012601:	SNF/ICF - 61 Beds
53. Good Shepherd Nursing Home	5013401:	SNF/ICF -192 Beds
54. Grafton City Hospital -DP-SNF/ICF	5015101: 5000501:	SNF/ICF - 22 Beds ICF - 46 Beds
55. Grant County Nursing Home	5119001	ICF - 60 Beds
56. Grant Memorial Hospital - SNF	5016901:	SNF - 10 Beds
57. Green Acres Regional Center, Inc.	5122001:	ICF/MR - 35 Beds
58. Greenbrier Center Voca Corp. -ICF/MR	5012001:	ICF/MR - 56 Beds