DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 52-'lh-12
Baltimore, Maryland 21244-1850

Centers for Medicaid, CHIP, and Survey & Certification

Ms. Emma Forkner
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

FEB - 2 2011

RE: SPA SC 10-006

Dear Ms. Forkner:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-006. Effective October 1, 2010 this amendment modifies the State's reimbursement methodology for setting payment rates for nursing facility services. Specifically, the amendment will update the base year cost reports to 2009 that will be used to set prospective payment rates. In addition the state will eliminate the requirement for providers to file an annual cost report if they have 3000 Medicaid patient days or less per year.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the impementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2010. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please ca11 Stanley Fields at (502) 223-5332.

Sincerely

//s//

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: SC 10-006	2. STATE South Carolina
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2010	

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: 42 CFR, Subpart C	7. FEDERAL BUDGET IMPACT: ($5.2 Million X 7243) a. FFY 2011 $3,766,360 b. FFY 2012 $3,766,360
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Pages 1, 2, 6, 8, 13 through 40	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D, Pages 1, 2, 6, 8, 13 through ~~45~~ 40

10. SUBJECT OF AMENDMENT:
Nursing facility rate update effective October 1, 2010 based upon annual rebasing and update to the Upper Payment Limit Reimbursement Program for Essential Public Safety Net Nursing Facilities.

11. 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:
Ms. Forkner was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, SC 29202-8206
13. TYPED NAME: Emma Forkner	
14. TITLE: Director	
15. DATE SUBMITTED: July 29, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 02-02-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: [illegible] 2010	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS

23. REMARKS:
Pen & ink change made to block #9

FORM HCFA-179 (07-92)

PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF SOUTH CAROLINA

The Medicaid Agency Rate Setting Policies, Procedures and Methods for Nursing Facilities, Facilities for the Mentally Retarded, and Long Term Care Institutions for Mental Diseases

I. Cost Finding and Uniform Cost Reports

A) Each nursing facility shall complete and file with the Medicaid Agency, Division of Long Term Care Reimbursements, an annual financial and statistical report supplied by the Medicaid Agency. Effective for the cost reporting period ending September 30, 2001, all nursing facilities will be required to submit their financial and statistical report using the new SENIORS (South Carolina Electronic Nursing Home Income/Expense Operating Report System) program software provided by the Medicaid Agency. Nursing facilities must report their operations from October 1 through September 30 on a fiscal year basis. Government owned and ICF/MR facilities may report their operations from July 1 through June 30. Hospital based facilities with fiscal year ends other than September 30 will be allowed effective with the 1990 cost reports to use their fiscal year end due to the reporting difficulties of nonconcurrent Medicare and Medicaid fiscal year ends. However, no additional inflation adjustment will be made.

Effective October 1, 2010, nursing facilities which have an annual Medicaid utilization of 3,000 days or less will not be required to file an annual financial and statistical report.

Nursing facilities which incur home office cost/management fees through a related organization are responsible for submitting a hard copy of an annual cost report detailing the cost of the related organization (home office) to the Medicaid Agency. The cost report period should be from October 1 to September 30. However, large chain operations which do business in other states may request a different cost reporting period for their home office cost report; however, no additional inflation adjustment will be made.

B) Nursing facilities are required to detail their cost for the entire reporting period or for period of participation in the plan, if less than the full cost reporting period. These costs are recorded by the facility on the basis of generally accepted accounting principles and the accrual method of accounting. The cash method of accounting is acceptable for public institutions.

C) Nursing facilities are required to list the cost of the various services provided under the plan in accordance with the Medicaid Agency's cost reporting format. However, facilities providing services not covered by the plan will be required to use a step down method of cost finding as described in 42 CFR 413.24(d)(1) to apportion cost between the services covered and the services not covered by the plan before listing the cost of the various services provided under the plan. Services not covered by the plan include, but are not limited to, private pay wings of a facility which participates in the Medicaid (XIX) Program. In regard to stepping down capital related cost and maintenance cost of a private pay wing, the facility must allocate capital related cost (depreciation, interest, etc.) and maintenance cost directly associated with the wing in lieu of using square footage as the statistical base for allocating total capital costs and maintenance costs of the facility.

D Nursing facilities are required to report cost on a Uniform Cost Report form provided by the Medicaid Agency. All Uniform Cost Reports must be filed with the Medicaid Agency no later than January 1. However, a thirty (30) day extension of the due date may be granted for good cause. Effective for the cost reporting period ending September 30, 2001, nursing facilities will be required to submit their financial and statistical report using the SENIORS software program. Hospital based/related nursing facility cost reports will be due no later than 30 calendar days after the due date of the hospital's Medicare cost report.

The financial and statistical report shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

A new contract will not be executed until all cost reporting requirements are satisfied. Additionally, if such report properly executed has not been submitted by the required date, the Medicaid Agency shall withhold all funds, or any portion thereof to be determined by the Director, due the Provider until such report is properly submitted and a new contract executed.

Since the return on capital payment is provided as an incentive for the expansion of Medicaid services by the private sector, only those facilities that were established as profit earning centers were selected for the calculation of the base period costs. Non-profit facilities were excluded from the base period calculation.

2) Inflation Adjustment To Current Period "Deemed Asset Value"

The plan uses the index for the rental value of a home computed as part of the CPI as the appropriate measure for approximating the increase in the value of nursing home assets in South Carolina since 1980-1981. This index measures the increase in the amount that homeowners on average could get for renting their homes. For the period from 1980-1981 through the federal cost year 2008-2009, this index rose 210.948 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2008-2009 is $48,564 per bed and will be used in the determination of nursing facility rates beginning October 1, 2010.

3) Calculation of "Deemed Depreciated Value"

The plan will exclude depreciation payments already received by operators from the Deemed Asset Value on the theory that the depreciation charges represent a reasonable valuation of the decline in the worth of the assets from old age. The result is the "Deemed Depreciated Value."

For a facility existing prior to July 1, 1989, the plan will continue to reimburse for actual depreciation costs based on a straight line apportionment of the original cost of the facility and the actual value of any additions. Effective October 1, 1990, for new facilities established or new beds entering the Medicaid Program on and after July 1, 1989, depreciation payments will be set based on actual construction costs, or the Deemed Asset Value when the facility begins operations, whichever is lower, and on applicable Medicare guidelines for depreciation. However, building depreciation for all new facilities/new beds on line on or after July 1, 1991 will be assigned a useful life of 40 years. Accumulated depreciation to be used to offset the deemed asset value for new facilities will be based on accumulated allowed depreciation (i.e. the lesser of actual depreciation or that determined by the Deemed Asset Value).

For bed increases of less than 50% (i.e. no six months cost report is filed), recognition of capital costs will be made at the point in time these beds are certified for Medicaid participation. For clarification, the Deemed Asset Value in effect at the time the beds are certified for Medicaid

could be raised by borrowing from the banks. But this would be rather costly for the small investor, who would probably have to pay a rate of interest in excess of the prime rate.

The plan sets the rate of return for a fiscal year at the average of rates for thirty year Treasury bonds for the latest three completed calendar years prior to the fiscal year, as determined by the Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 2010, this rate is 4.40%.

Acknowledging a newly constructed facility's plight of high per bed construction costs and interest rates as great and greater than the market rate of return, the rate of return for these facilities will be the greater of the interest rate incurred by the facility or the industry market rate of return as determined by the Budget and Control Board. These facilities will only be allowed their interest rate (if greater) during a transition period which is defined as the rate period beginning with the facility's entrance into the Medicaid program and ending at that point in time in which the facility files its first annual FYE September 30 cost report that will be used to establish the October 1 rate (i.e. period ends September 30). In no circumstances will the allowed interest rate exceed 3% above the industry market rate of return.

5) Additions To Facilities After 1981

The plan intends to provide adequate incentives for the expansion of nursing home services by the private sector of the state. The Deemed Depreciated Value takes into account the wearing out of facilities, but does not include any factor for additions or upgradings to the facilities. Operators who have made capital improvements to their facilities since 1981 are permitted to add the amount of the investment to their Deemed Asset Value. Operators are also permitted to add the cost of future additions and upgradings of facilities to their Deemed Asset Value. This provision will provide an incentive to operators to reinvest part of their cash flow back into the facility to maintain and improve the level of service provided by the operator. For clarification purposes, capital expenditures incurred by new beds on line on or after July 1, 1989 during the initial cost reporting period will not be considered as improvements, but as part of actual construction costs.

6) Computation of Cost of Capital

The cost of capital for each patient day served would be calculated for each nursing home based on the Deemed Asset Value. The computation of the rate of reimbursement for the cost of capital is illustrated below in Table 1 for the

A. REIMBURSEMENT METHODOLOGY TO BE USED IN THE CALCULATION OF THE MEDICAID REIMBURSEMENT RATES

A prospective rate shall be established for each nursing facility separately based on the facility's cost report, and upon the standard costs which are developed in accordance with the methodology described below. In the event that audit adjustments are made to cost reports in accordance with Title XIX and Title XVIII Program rules, regulations, policies and procedures, the rate of payment will be established so as to be consistent with the facility's cost as audited. In the event that such adjustment is made subsequent to the date that a facility was paid an incorrect rate based on unaudited costs, the facility will be liable to repay to the South Carolina Department of Health and Human Services the difference between the audited rate and the interim rate for the contract period. In a case in which an audited rate exceeds the interim rate, the South Carolina Department of Health and Human Services will be liable to repay the facility the difference between the audited rate and the interim rate for the contract periods beginning on or after October 1, 1994.

Effective October 1, 2010, nursing facilities which do not incur an annual Medicaid utilization in excess of 3,000 patient days will receive a prospective payment rate which will represent the weighted average industry rate at the beginning of each rate cycle. This rate will not be subject to change as a result of any field audit, but will be subject to change based on the lower of cost or charges test to ensure compliance with the state plan.

Minimum occupancy levels of 96% are currently being utilized for Medicaid rate setting purposes. Effective on and after October 1, 2003, Medicaid rates for nursing facilities located in counties where the county occupancy rate is less than 90% based upon the FYE September 30 cost report information will be established using the following policy:

- The SCDHHS will waive the 96% minimum occupancy requirement used for rate setting purposes for those nursing facilities located in counties whose occupancy is less than 90%. However, standards will remain at the 96% minimum occupancy level.
- The SCDHHS will calculate the affected nursing facilities' Medicaid reimbursement rate based upon the greater of the nursing facility's actual occupancy or the average of the county where the nursing facility is located.
- In those counties where there is only one contracting nursing facility in the county, the nursing facility Medicaid reimbursement rate will be based upon the greater of the nursing facility's actual occupancy or 85%.

PROVIDER NAME: 0
PROVIDER NUMBER: 0
REPORTING PERIOD: 10/01/08 through 09/30/09 DATE EFF. 10/1/2010

		MAXIMUM BED DAYS:		0
PATIENT DAYS USED:	0	PATIENT DAYS INCURRED:		0
TOTAL PROVIDER BEDS:	0	ACTUAL OCCUPANCY %:	0.00	
% LEVEL A	0.000	PATIENT DAYS @	0.96	0

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		0.00	0.00	
DIETARY		0.00	0.00	
LAUNDRY/HOUSEKEEPING/MAINT.		0.00	0.00	
SUBTOTAL	0.00	0.00	0.00	0.00
ADMIN & MED REC	0.00	0.00	0.00	0.00
SUBTOTAL	0.00	0.00	0.00	0.00
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		0.00		0.00
SPECIAL SERVICES		0.00		0.00
MEDICAL SUPPLIES AND OXYGEN		0.00		0.00
TAXES AND INSURANCE		0.00		0.00
LEGAL COST		0.00		0.00
SUBTOTAL		0.00		0.00
GRAND TOTAL		0.00		0.00
INFLATION FACTOR 2.00%				0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)				0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF $1.75 CAP ON COST/PROFIT INCENTIVES			$0.00	0.00
REIMBURSEMENT RATE				0.00

Effective October 1, 1995, for the purpose of establishing all cost center standards, the facilities are grouped according to bed size. The bed groupings are:

0 Through 60 Beds
61 Through 99 Beds
100 Plus Beds

B. ALL STANDARDS, EXCEPT FOR GENERAL SERVICES, FOR PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED) WILL BE COMPUTED USING PROPRIETARY FACILITIES ONLY. EFFECTIVE OCTOBER 1, 1997, HOSPITAL BASED PROPRIETARY NURSING FACILITIES WILL BE EXCLUDED FROM THE COMPUTATION OF ALL STANDARDS, EXCEPT FOR GENERAL SERVICES. THE GENERAL SERVICE STANDARD WILL BE COMPUTED USING PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED). A BRIEF DESCRIPTION ON THE CALCULATION OF ALL THE STANDARDS IS AS FOLLOWS:

1. General Services:

a. Accumulate all allowable cost for the General Services cost center (Nursing & Restorative) for all facilities in each bed size.

b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 96%).

c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).

d. Calculate the standard by multiplying the mean by 105%.

e. The establishment of the General Services standard for all nursing facilities (excluding state owned facilities) will be based on the average of the percentage of Medicaid Level A patients/total Medicaid patients served. Rates effective on or after October 1, 2000 will be computed annually using nursing facility utilization (including nursing facility days paid under the Hospice Benefit) by patient acuity based upon the preceding July 1 through June 30 data period. Effective October 1, 2003, co-insurance days for dual eligibles are excluded from the computation. The General Services standard for each separate facility will be determined in relation to the percent of Level A Medicaid patients served, i.e., the base standard determination in (d.) above will be decreased as the percent of Level A Medicaid patients is decreased and increased as the percent of Level A Medicaid patients is increased.

2. Dietary; Laundry, Maintenance and Housekeeping; Administration and Medical Records & Services: The standard for each of these three cost categories is calculated as follows:

   a. Accumulate all allowable cost for each cost center for all facilities in each bed size.

   b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 96%).

   c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).

   d. Calculate the standard by multiplying the mean by 105%.

C. RATE COMPUTATION:

Rates will be computed using the attached rate computation sheet (see page 14) as follows:

1. For each facility, determine allowable cost for the following categories:

   COST SUBJECT TO STANDARDS:

   General Services
   Dietary
   Laundry, Maintenance and Housekeeping
   Administration and Medical Records & Services

   COST NOT SUBJECT TO STANDARDS:

   Utilities
   Special Services
   Medical Supplies
   Property Taxes and Insurance Coverage - Building and Equipment
   Legal Fees

2. Calculate actual allowable cost per day based on the cost reports for each category by dividing allowable cost by actual days. If the facility has less than 96% occupancy, actual days will be adjusted to reflect 96% occupancy.

3. For cost subject to standards, the lower of cost determined in step 2 or the cost standard will be allowed in determining the facility's rates. Effective October 1, 1997, the General Services, Dietary, and Laundry, Housekeeping, and Maintenance cost centers are combined. Therefore, compare the sum of the allowable cost of these three cost centers to the sum of these three cost standards.

4. For costs not subject to standards, the cost determined in step 2 will be allowed in determining the facility's rate.

5. Accumulate costs determined in steps 3 and 4.

6. Inflate the cost in step 5 by multiplying the cost in step 5, by the inflation factor. The maximum inflation factor that can be used will be that provided by the State of South Carolina Division of Research and Statistical Services and is determined as follows:

   a. Proxy indices for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.) during the third quarter of 2010 were weighted by the expenditure weights of the long term care facilities. These eleven weighted indices are summed to one total proxy index for the third quarter of 2010.

   b. Proxy indices are estimated for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.), during the third quarter of 2011 and then weighted by the same expenditure weights as in step a. These weighted proxy indices were summed to one total proxy index for the third quarter of 2011.

   c. The percent change in the total proxy index during the third quarter of 2010 (as calculated in step a), to the total proxy index in the third quarter of 2011 (as calculated in step b), was 4.1%. Effective October 1, 2010 the inflation factor used was 2.0%.

7. The per patient day cost of capital will be calculated by dividing capital cost as determined under I.(F)(c) of this plan by actual patient days. However, if the facility has less than 96% occupancy, actual days will be adjusted to reflect 96% occupancy.

8. Cost Incentive - General Services, Dietary, and Laundry, Housekeeping, and Maintenance

   If the facility's actual allowable costs for these three cost centers are below the sum of these three allowable cost standards, the facility will be eligible for a cost incentive of an amount equal to the difference between the sum of the standards and the sum of the facility's actual costs, up to 7% of the sum of the standards.

9. Profit will be allowed if the provider's allowable cost is lower than the standard as follows:

   a. Administration and Medical Records & Services - 100% of difference with no limitation.

Ceiling on profit will be limited to 3 1/2% of the sum of the provider's allowable cost determined in step 2. The sum of the cost incentive and the profit cannot exceed $1.75 per patient day.

10. For rates effective October 1, 2010, the provider's reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive and profit.

D. Payment for Hospital-based and Non-profit Facilities

Hospital-based and non-profit facilities will be paid in accordance with Sections III A, B, and C.

E. Payment determination for a new facility, replacement facility, change of ownership through a purchase of fixed assets, change of ownership through a lease of fixed assets, when a facility changes its bed capacity by more than fifty percent (50%), or when temporary management is assigned by the state agency to run a facility.

1. Payment determination for a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

The following methodology shall be utilized to determine the rate to be paid to a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

Based on a six (6) month's projected budget of allowable costs covering the first six months of the Provider's operation under the Medicaid program, the Medicaid agency will set an interim rate to cover the first six (6) months of operation or through the last day of the sixth (6th) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate except that all standards to be used will be one hundred twenty percent (120%) of the standards for the size of facility to adjust for lower initial occupancy. The one hundred twenty percent (120%) adjustment is determined by considering the average eighty percent (80%) occupancy for the first six (6) months of operation of a new facility versus the minimum of ninety-six percent (96%) occupancy required for all facilities that have been in operation for more than six (6) months.

Within ninety (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date.

This report will be used to determine allowable reimbursement of the provider for the initial rate cycle. A new prospective rate, based upon the Uniform Financial and Statistical Report, will be determined using the methodology as previously stated in Section III C of this plan except for the following methodology:

a. Payment for the first six months will be retrospectively adjusted to actual costs not to exceed 120% of the standards and actual occupancy.

b. No inflation adjustment will be made to the first six (6) months cost.

c. Effective on the first (1st) day of the seventh (7th) month of operation through the September 30 rate, the per diem costs effective July 1, 1994 will be adjusted to reflect the higher of:

   1. Actual occupancy of the provider at the last month of the initial cost report; or

   2. 90% occupancy.

Facilities that decertify and recertify nursing facility beds that results in a change in its bed capacity by more than fifty percent (50%) will not be entitled to a new budget.

2. Payment determination for a replacement facility, or a change of ownership through a purchase of fixed assets:

A change in ownership will be defined as a transaction that results in a new operating entity. A purchase of the leased fixed assets by a lessee (owner of operating entity) will not be considered a change of ownership unless allowable Medicaid capital costs will be reduced (i.e., purchase price less than historical costs). Each change of ownership request will be reviewed individually to determine whether a six-month cost report will be required. Effective November 22, 1991, to qualify for a "new facility rate' based upon a six month cost report under a change of ownership, a sale or lease of assets between unrelated parties must occur. A new operator who leases a facility from a related party will not be entitled to a "new facility rate". Also, facilities in the process of obtaining a certificate of need due to a sale or lease between related parties prior to November 22, 1991 will be grandfathered in under the existing system.

The following methodology shall be utilized to determine the rate to be paid to a replacement facility and a new owner, where a change of ownership has occurred through a purchase of fixed assets:

Based on a six (6) month's projected budget of allowable costs covering the first six months of the provider's operation under the Medicaid program, the Medicaid Agency will set an interim rate to cover the first six (6) months of operation through the last day of the sixth (6th) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate as described in Section III C of this plan, with the exception of inflation. No inflation adjustment will be made to the interim rates for the first six (6) months cost.

Within (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical Report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date.

This report will be used to determine allowable reimbursement of the provider for the initial rate cycle. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate as described in Section III C of this plan, with the exception of inflation. No inflation adjustment will be made to the interim rates for the first six (6) months cost. Payment for the first six months will be retrospectively adjusted to actual costs not to exceed the standards. Effective on the first (1st) day of the seventh (7th) month of operation, a new prospective rate, based upon the Uniform Financial and Statistical Report, will be determined using the methodology as previously stated in Section III C of this plan.

The Medicaid agency will determine the percent of Level A Medicaid patients served for a replacement facility or a change of ownership, using the most recent twelve months of data (See Page 15, Paragraph B-1 (e) for the time periods) as reflected on the SCDHHS Medstat report to establish rates.

3. Payment determination for a change in ownership through a lease of fixed assets:

In the event of a lease of fixed assets between unrelated parties, the new operator (i.e., lessee) will receive the prior operator's rate (i.e., lessor) for the first six full calendar months of operation. For a lease effective on October 1, the State agency will determine the new operator's rate based upon the prior year's cost report filed by the prior operator on January 1. The new operator's rate for the first six full calendar months of operation will not be affected by any subsequent audits of the prior operator's cost report which was used to set the rate. In the event that the initial six full calendar months rate period crosses over into a new rate setting period effective October 1, the new operator will be entitled to receive a rate increase based upon the industry allowed inflation factor, plus any industry wide approved add on, if applicable.

For clarification purposes, we intend to use the prior operator's most recently filed and available FYE September 30 cost report to calculate the new operator's rate effective October 1 of each rate cycle during the initial six full calendar month rate period. Depending upon which most recently filed cost report is available will dictate

the method used to determine the October 1 rate during the initial six full calendar month rate period (i.e. the October 1 rate during the initial six full calendar month rate period will be the prior owner's September 30 rate inflated, or the October 1 rate that the prior owner would have received if no change of ownership had taken place).

Effective the seventh month of operation, the new operator will be entitled to a new rate based upon his actual cost. The rate calculation for the new operator, based upon his actual costs, will be made in accordance with the rate setting method as described under Section III C of this plan. The actual cost report that will be filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends on September 30, provided that this time period includes at least six full calendar months of operation. In other words, if the lease is effective between October 1 and March 31, the cost report filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends on September 30. If the lease is effective between April 1 and September 30, the cost report filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends after six full calendar months of operation by the new operator. This cost report will be due within ninety (90) days after the end of the cost reporting period; however, a thirty (30) day extension can be granted for good cause. This cost report will determine a rate which will be effective retroactive to the new operator's seventh month of operation.

4. <u>Rate determination for a facility in which temporary management is assigned by the state agency to run the facility</u>:

In the event of the Medicaid agency having to place temporary management in a nursing facility to correct survey/certification deficiencies, reimbursement during the time in which the temporary management operates the facility will be based on 100% of total allowable costs subject to the allowable cost definitions set forth in this plan, effective October 1, 1990. These costs will not be subject to any of the cost standards as reflected on page 4 of the plan. Capital reimbursement will be based on historical cost of capital reimbursement in lieu of the Medicaid agency's current modified fair rental value system. Initial reimbursement will be based on projected costs, with an interim settlement being determined once temporary management files an actual cost report covering the dates of operation in which the facility was being run by the temporary management.

This report will be due within ninety (90) days after the end of the period of operation. Once new ownership or the prior owner begins operation of the facility, reimbursement will be determined as previously described for a new owner under paragraph E (2).

F. Payment for State Government Nursing Facilities and Institutions for Mental Diseases

Because State Government facilities operate on budgets approved by the General Assembly and overseen by the Budget and Control Board, State Government nursing facilities and long term care IMD's will be paid retrospectively their total allowable costs subject to the allowable cost definitions set forth in this plan effective October 1, 1989. Effective October 1, 1991, allowable costs will include all physician costs, excluding the professional component side of physician cost. The professional component side will be billed separately under the physician services line of the South Carolina Medicaid Program.

Nursing facilities owned by the South Carolina Department of Mental Health and deemed eligible to certify by the State will be reimbursed on Medicaid costs, based on certification by the facilities of their allowable Medicaid costs of providing nursing home care via the submission of annual Medicaid cost reports. An interim per diem rate will be established based upon each facility's most recently filed desk reviewed/cost settled South Carolina Department of Health and Human Services' (SCDHHS) Financial and Statistical Report for Nursing Homes trended by the annual inflation factor paid to all other non state owned nursing facilities in effect at the time when the cost report was settled. After the filed SCDHHS Financial and Statistical Report for Nursing Homes for the payment period for which the interim rate was paid has been received, the interim rate will be reconciled to actual allowable Medicaid costs. Upon final settlement of the SCDHHS Financial and Statistical Report for Nursing Homes, the difference between the final and interim allowable Medicaid costs will be an adjustment(s) to the applicable period for which the allowable Medicaid cost was incurred and initial claim was made.

G. Payment Determination for ICF/MR's

1. All ICF/MR's shall apply the cost finding methods specified under 42 CFR 413.24(d) to its allowable costs for the cost reporting year under the South Carolina State Plan. ICF/MR facilities will not be subject to the allowable cost definitions Q (A) through Q (K) as defined in the plan.

2. All State owned/operated ICF/MR's are required to report costs on the Medicare Cost Reporting Form 2552. For cost reporting periods beginning on or after July 1, 1986, all other ICF/MR's which are not operated by the State (S.C. Department of Disabilities and Special Needs) will file annual financial and statistical report forms supplied by the Medicaid Agency. All cost reports must be filed with the Medicaid Agency within one hundred twenty (120) days from close of each fiscal year.

3. ICF/MR's will be reimbursed on a retrospective cost related basis as determined in accordance with Medicare (Title XVIII) Laws, Regulations, and Policies adjusted for services covered by Medicaid (Title XIX).

Items of expense incurred by the ICF/MR facility in providing care are allowable costs for inclusion in the facility's cost report. These allowable costs are defined as items of expense which the provider may incur in meeting the definition of intermediate care or any expenses incurred in complying with state licensing or federal certification requirements.

Medicaid payment to the ICF/MR includes, but is not limited to, reimbursement for the following services:

a) Room and board including all of the items necessary to furnish the individual's room (luxury items/fixtures will not be recognized as an allowable cost). 42 CFR §483.470(b), (c), (d), (e), (f), and (g)(1).

b) Direct care and nursing services as defined for each living unit of the facility. 42 CFR §483.460(c).

c) Training and assistance as required for the activities of daily living, including, but not limited to, toileting, bathing, personal hygiene and eating as appropriate. 42 CFR §483.440(a).

d) Walkers, wheelchairs, dental services, eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. If any of these services are reimbursable under a separate Medicaid program, the cost will be disallowed in the cost report (effective for cost reporting periods beginning July 1, 1989).

e) Maintenance in good repair of dentures, eyeglasses, hearing aids, braces, and other aids prescribed for a resident by an appropriate specialist effective for cost reporting periods beginning July 1, 1989. 42 CFR §483.470(g)(2).

f) Therapy services including, but not limited to, speech, recreation, physical, and occupational, as prescribed by the resident's individual habilitation plan. 42 CFR §483.430(b).

g) Transportation services as required to provide other services including vehicles with lifts or adaptive equipment, as needed. The cost of ambulance services will not be included as part of allowable costs.

h) Psychological services as described in 42 CFR §483.430(b)(1) and (b)(5)(v).

i) Recreational services as described in 42 CFR §483.430(b)(1) and (b)(5)(viii).

j) Social services as described in 42 CFR §483.430(b)(1) and (b)(5)(vi).

k) Speech and hearing services as described in 42 CFR §483.430(b)(1) and (b)(5)(vii).

l) Food and nutritional services as described in 42 CFR §483.480.

m) Safety and sanitation services as described in 42 CFR §483.470(a), (g)(3), (h), (i), (j), (k), and (l).

n) Physician services as described in 42 CFR §483.460(a).

Any service (except for physician services) that is required of an ICF/MR facility that is reimbursable under a separate Medicaid program area must be billed to the respective program area. Any costs of this nature cannot be claimed in the Medicaid cost report.

4. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) owned by the South Carolina Department of Disabilities and Special Needs (SCDDSN) and deemed eligible to certify by the State will be reimbursed on Medicaid costs, based on certification by the facilities of their allowable Medicaid costs of providing ICF/MR care via the submission of annual Medicaid cost reports. An interim per diem rate will be established based upon the SCDHHS review of each facility's most recently filed desk reviewed/cost settled Medicare 2552 report along with budgeted cost report information supplied by the SCDDSN. After the filed Medicare 2552 report for the payment period for which the interim rate was paid has been received, the interim rate will be reconciled to actual allowable Medicaid costs. Upon final settlement of the 2552 report, the difference between the final and interim allowable Medicaid costs will be an adjustment(s) to the applicable period for which the allowable Medicaid cost was incurred and initial claim was made.

5. The Medicaid Agency will not pay more than the provider's customary charge except governmental facilities that provide services free or at a nominal charge. Reimbursement to governmental facilities will be limited in accordance with 42 CFR §447.271(b).

H. Payment for Swing-Bed Hospitals

Effective July 1, 1989, the South Carolina Medicaid Program will participate in the provision of nursing facility services in swing bed hospitals. A rate will be determined in accordance with the payment methodology as outlined in this state plan, adjusted for the following conditions:

A) Effective October 1, 1992, all nursing facilities in operation will be used in the calculation of the rate.

B) The rate excludes the cost associated with therapy services.

C) The rate reflects a weighted average rate using the state's prior FYE June 30 Medicaid permit days. Effective July 1, 1991, projected Medicaid days were used.

I. Intensive Technical Services Reimbursement

Effective December 1, 2008, an enhanced rate of $364.00 per patient day will be available for nursing facility level of care recipients who require more intensive technical services (i.e., those recipients who have extreme medical conditions which requires total dependence on a life support system). In order to develop this rate, the SCDHHS reviewed budgeted cost information relating to the

operation of a ventilator unit (i.e. 20 beds) established within a South Carolina Medicaid contracting 132 bed nursing facility as well as the budgeted cost information relating to the operation of the remaining 112 beds. Two rate components were developed during this process that represented (1) - the projected base Medicaid rate associated with the 112 nursing facility beds that would serve the non-ventilator population and (2) - the projected add-on to the base Medicaid rate associated with the direct costs associated with the ventilator unit. The projected direct costs associated with the ventilator unit would include, but not be limited to, the following: contracting pulmonologist, respiratory therapists, physician assistants, non-prescription drugs, medical supplies, oxygen, and equipment rental. In regards to the ventilator unit, any professional or billable ancillary costs allowed under the Medicare Part B Program must be billed by the provider on behalf of dually eligible residents and year end reconciliations will be performed by the South Carolina Department of Health and Human Services (SCDHHS) to determine the amount of Medicare Part B reimbursement to be refunded to the SCDHHS. Since this rate was developed on budgeted cost, the SCDHHS will review actual cost report data associated with the 132 bed nursing facility and adjust future rates accordingly. This set per diem rate will represent payment in full and will not be cost settled. Providers receiving payment for intensive technical services patients will be required to step down cost applicable to this nonreimbursable cost center in accordance with item I(C) of this plan, upon submission of their annual cost report.

J. Payment for Out-of-State Long Term Care Facilities

In order to provide services to the South Carolina Medicaid patients awaiting placement into a nursing facility, the agency will contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The agency will use the out-of-state facility's survey conducted by their survey and certification agency for our survey and certification purposes. Placement of a South Carolina Medicaid recipient into an out-of-state facility will only occur if a bed is unavailable in South Carolina. No year end South Carolina Medicaid long term care cost report will be required from the participating out-of-state facilities.

K. Essential Public Safety Net Nursing Facility Supplemental Payment

As directed by the actions of the South Carolina General Assembly via proviso Number 21.39 of the State Fiscal Year 2008/2009 State Appropriations Act, the South Carolina Medicaid Program will implement an Upper Payment Limit Payment Program for qualifying non-state owned governmental nursing facilities.

Therefore, for nursing facility services reimbursed on or after October 1, 2008, qualifying Medicaid nursing facilities shall receive a Medicaid supplemental payment (in addition to the per diem payment). The qualification, upper payment limit calculation, and payment methodology are described below.

(1) Qualifications

In order to qualify for a supplemental payment as an Essential Public Safety Net nursing facility, a nursing facility must meet all of the following criteria:

a) The nursing facility is a non-state owned governmental nursing facility;
b) The nursing facility is located in the State of South Carolina;
c) The nursing facility is licensed as a nursing facility by the State of South Carolina and is a current Medicaid provider;

and one of the following criteria:

(i) The nursing facility is hospital based; or
(ii) The nursing facility is owned by a rural non-state owned governmental hospital and the total licensed beds owned by the hospital at all of its nursing facilities exceeds 200 beds; or
(iii) The nursing facility's total licensed beds is in excess of 300 beds.

(2) Upper Payment Limit Calculation

The upper payment limit effective for services beginning on and after October 1, 2008 for Essential Public Safety Net nursing facilities will be calculated using the Medicaid frequency distribution of all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program. This frequency distribution will be determined using the Medicaid MDS assessments completed during the most recently completed calendar year (i.e. January 1 through December 31) prior to the effective date of the plan amendment. The results of each nursing facility's Medicaid frequency distribution will then be applied to the total Medicaid patient days (less coinsurance days) paid to the nursing facility during each federal fiscal year beginning October 1, 2008 in order to allocate the Medicaid days across the 53 Medicare RUG categories. The applicable Medicare rates for the payment year for each RUG category will be applied against the Medicaid days for each RUG category, and then summed, to determine the maximum upper payment limit to be used in the determination of the Essential Public Safety Net nursing facility payments.

In order to adjust for program differences between the Medicare and Medicaid payment programs, the SCDHHS will calculate Medicaid payments in accordance with Section K(3)(b) of the plan.

(3) Payment Methodology

The South Carolina Department of Health and Human Services will make a supplemental Medicaid payment in addition to the standard nursing facility reimbursement to qualifying Essential Public Safety Net nursing facilities. Such payments will be made on an annual basis after services have been furnished. The payment methodology is as follows:

a) The upper payment limit for all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program will be computed as described under section K(2) above.

b) Medicaid reimbursement payments for all licensed South Carolina non-state owned governmental nursing facilities which contract with the South

Carolina Medicaid Program will be computed using the corresponding federal fiscal year Medicaid days paid during the period beginning October 1, 2008. The Medicaid reimbursement payments will incorporate: (1) the gross per diem payments based upon the Medicaid rate(s) in effect during the payment period as computed in accordance with the state plan, and (2) ancillary service payments which are not reflected within the gross Medicaid rate. The ancillary services would include pharmacy, lab, x-ray and ambulance. In order to determine these costs, only Medicaid eligible recipients residing in nursing facilities will be used. Additionally, Publications 12 (The Skilled Nursing Facility Manual) and 100-04 (Medicare Claims Processing Manual) will provide the criteria to be used in determining the appropriate pharmacy, lab, x-ray and ambulance services to be pulled. Eligibility information from MEDS as well as paid claims data from MMIS and/or Medstat will be used in the analysis. In order to adjust the ancillary service costs to a per patient day basis, the number of nursing facility days paid on behalf of each individual will also be accumulated from MMIS and/or Medstat.

c) The sum of the upper payment limit as described in K(3)(a) will be reduced by the sum of the Medicaid reimbursement payments as described in K(3)(b) to determine the amount of the upper payment limit pool payments to be paid to the qualifying Essential Public Safety Net nursing facilities (as defined in section K(1)).
d) Each qualifying Essential Public Safety Net nursing facility's supplemental payment will be calculated by taking the upper payment limit pool as described in K(3)(c) and multiplying by each Essential Public Safety Net nursing facility's percentage of unreimbursed UPL cost to total unreimbursed UPL cost of the Essential Public Safety Net nursing facilities.

The total payments made to the licensed South Carolina non-state owned governmental nursing facilities that contract with the South Carolina Medicaid Program, including the Essential Public Safety Net nursing facility supplemental payments, will not exceed the aggregate Upper Payment Limit amount for the non-state owned governmental nursing facilities. Additionally, the Essential Public Safety Net nursing facility supplemental payments will not be subject to the lower of costs or charges limitation.

L. Payment Assistance

The Medicaid Agency will pay each Provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the Provider under the Plan according to the methods and standards set forth in Section III of this attachment.

M. Upper Limits

1. The Medicaid Agency will not pay more than the provider's customary charge for private-pay patients except governmental facilities that provide services free or at a nominal charge. These facilities will be reimbursed on a reasonable cost related basis.

2. Any limitation on coverage of cost published under 42 CFR 413.30 and 413.35 will be applied to payments for long-term care facility services.

3. The cost of services, facilities and supplies furnished by organizations related by common ownership or control will not exceed the lower of the cost to the organization or the price of comparable services, facilities or supplies purchased elsewhere. The Medicaid Agency's cost report requires related organizations and costs to be identified and certified.

4. The Medicaid Agency may not pay more in the aggregate for long term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. If it is determined that SCDHHS is paying more in the aggregate for long term care services, then the Medicaid rate for each facility will be limited to the Medicare rate retroactive to the beginning of the contract period. Upper Payment Limits will be calculated and tested against the following three groupings - State owned/operated; Non-state owned/operated governmental facilities; and Privately owned/operated facilities.

N. Provider Participation

Payments made under this State Plan are designed to enlist participation of a sufficient number of Providers of services in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public. In accordance with the Balanced Budget Act of 1997, the state has provided for a public process in which providers, beneficiaries and their representatives, and other concerned state residents are given the reasonable opportunity to review and comment on the determination of rates under this plan.

O. Payment in Full

Participation in the program shall be limited to Providers of services who accept, as payment in full, the amounts paid in accordance with the provisions of this attachment for covered services provided to Medicaid recipients in accordance with 42 CFR 447.15.

P. Medicare Part A Coinsurance Days

Effective for dates of service beginning December 1, 2001, the South Carolina Department of Health and Human Services (SCDHHS) will no longer reimburse Medicaid contracting nursing facilities for Medicare Part A coinsurance days (Swing Bed Hospitals are exempted from this provision). Effective for dates of service beginning October 1, 2008, the SCDHHS will reimburse coinsurance payments applicable to Medicaid eligibles that qualify as a "Qualified Medicare Beneficiary (QMB) in accordance with the following payment methodology - the Medicaid payment will amount to the gross Medicaid rate/day less the amount paid by Medicare/day not to exceed the Medicare coinsurance rate/day.

Q. Allowability of Certain Costs

A) Auto Expense:

Allowable costs shall not include actual costs of administrative vehicles used for business purposes or regular vehicles used for patient care related activities (depreciation, maintenance, gas and oil, etc.). Allowable costs shall include administrative vehicle expense and regular vehicles expense used for patient care related activities only through documented business miles multiplied by the current mileage rate for the State of South Carolina employees.

Allowable costs shall include the actual costs of specialty vehicles (e.g., vans, trucks). These costs will be classified to the appropriate cost centers for Medicaid cost reporting purposes. Allowable costs would include operation, maintenance, gas and oil, and straight line depreciation (over a 5 year useful life). Should these specialty vehicles be made available for personal use of the facility employees, then that percentage of cost would be reclassified to nonallowable expense.

It is the intent of the SCDHHS to recognize as specialty vehicles, station wagons with a seating capacity of more than six (6) passengers used in patient care related activities, vans, and trucks. The cost of sedans or station wagons with a seating capacity of six (6) or less passengers used for patient transport or other patient care related activities will be limited to the state employee mileage rate and charged to the appropriate cost center(s) based upon miles documented by a log effective August 1, 1986.

For cost reporting requirements prior to August 1, 1986, actual allowable costs which would include operation, maintenance, gas and oil, and straight-line depreciation (over a 5 year useful life and limited to 10,000 maximum vehicle cost) will be used in determining allowable costs for cost centers other than administration. Should these specialty vehicles be made available for personal use of the facility employees, then that percentage of cost would be reclassified to nonallowable expense.

Any vehicle that cannot be identified to charge to the appropriate cost center will be charged to administration and follow administration vehicle allowable cost guidelines. However, only that portion of such costs related directly to patient care related purposes will be allowed.

B) Dues

Association dues will be recognized for reimbursement purposes only when the dues are for professional services that are patient care related. Any component of association dues related to legal actions against state agencies, lobbying, etc., will not be recognized as an allowable cost for Medicaid rate setting purposes.

C) Legal Fees

For rates effective October 1, 2006, allowable Medicaid reimbursable costs include reasonable legal fees arising from normal day-to-day business activities related to patient care as defined in HIM-15. Any legal fees recognized as allowable Medicaid costs must be demonstrated to be necessary for the efficient delivery of needed health care services provided by the facility.

Other legal charges including, but not limited to, those incurred in administrative appeals and/or litigation involving state or federal agencies will not be considered an allowable cost for Medicaid rate setting purposes. However, reasonable legal fees incurred in administrative appeals of audit exceptions may be refundable through an adjustment outside of the rate setting system. The amount of the adjustment shall be determined by the Agency Hearing Panel, upon documentation, but shall not exceed fifteen percent of the amount recovered through appeals or $1,000, whichever is lower. Additionally, retainer fees would not be considered an allowable cost.

D) Travel

Patient care related travel will be recognized in accordance with South Carolina state employees per diem and travel regulations. Out-of-state travel will be limited to the 48 states located within the continental United States. Further, such out-of-state travel must be either the reasonable allocable portion of cost for chain facilities with out-of-state offices; or (1) be for the purpose of meeting continuing education requirements and (2) must be to participate in seminars or meetings that are approved for that purpose by the South Carolina Board of Examiners for Nursing Home Administrators. Allowable cost for attendance at out-of-state meetings and seminars will be limited to two trips per year per facility. Also, out-of-state travel does not include travel to counties bordering the State of South Carolina. Effective for July 1, 1990 payment rates, travel to the following states/areas are treated as in-state travel, and thus are not subject to the limits on out-of-state travel: Georgia, North Carolina, Washington D.C., and Baltimore, Maryland.

E) Director Fees

Director fees and costs associated with attending board meetings or other top management responsibilities will not be allowed. However travel to and from the directors meetings will be allowed at the per mile rate for state employees and will be limited to in-state travel.

F) Compensation: (Direct and Indirect) (These limits below do not include fringe benefits provided on a non-discriminatory basis.) ALLOWABLE COMPENSATION RANGES FOR OWNERS (LESSORS) AND/OR THEIR RELATIVES AND LESSEES AND/OR THEIR RELATIVES:

JOB TITLE	0-60 BEDS MAX ALLOWED ANNUAL SALARY	61-99 BEDS MAX ALLOWED ANNUAL SALARY	100+ BEDS MAX ALLOWED ANNUAL SALARY
DIRECTOR OF NURSING (DON)	$60,062	$65,419	$79,704
RN	$51,785	$51,785	$53,193
LPN	$40,063	$40,650	$42,520
CAN	$20,399	$20,650	$21,428
SOCIAL SERVICES DIRECTOR	$28,928	$33,718	$41,491
SOCIAL SERVICES ASSISTANT	$21,512	$23,487	$32,100
ACTIVITY DIRECTOR	$23,887	$26,743	$30,335
ACTIVITY ASSISTANT	$17,647	$21,155	$21,155
DIETARY SUPERVISOR	$31,239	$34,642	$44,201
DIETARY WORKER	$16,995	$17,941	$19,033
LAUNDRY SUPERVISOR	$18,676	$21,134	$28,886
LAUNDRY WORKER	$16,009	$17,038	$17,038
HOUSEKEEPING SUPERVISOR	$20,819	$23,382	$30,966
HOUSEKEEPING WORKER	$15,168	$16,429	$17,773
MAINTENANCE SUPERVISOR	$29,831	$33,928	$41,995
MAINTENANCE WORKER	$28,046	$28,046	$28,046
ADMINISTRATOR	$66,700	$81,112	$101,237
ASSISTANT ADMINISTRATOR	$30,252	$48,696	$60,671
BOOKKEEPER / BUSINESS MGR	$32,352	$32,751	$39,768
SECRETARY / RECEPTIONIST	$20,650	$21,806	$25,398
MEDICAL RECORDS SECRETARY	$23,802	$24,832	$25,357

Note: Last year guidelines were increased by 1.0%--the state employee pay increase effective 07/01/08

1. The above are maximum limits of allowable compensation to owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed on percentage of time spent. No individual will have more than one full time equivalent (40 hours per week) job recognized in the Medicaid program.

2. If the facility has under 60 beds, only (1) Administrator and/or Business Manager is allowed.

3. Allowances for any position not specifically listed herein will be based on comparable positions.

4. Other items of consideration to be used in adjustments to these maximum allowances are:

    a. Determination that the job is necessary and that the person is actually there 40 hours per week. (The owner/lessee must document that the job is necessary, and the relative actually worked on the premises the number of hours claimed.)

    b. The time period during which these duties were performed.

    c. Accounting period bed changes based on dates of change.

5. Allowable compensation amounts shown above will be adjusted annually by annual cost of living raises provided to state employees.

G) ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED BY PARENT COMPANIES:

JOB TITLE	% - CEO Compensation	0-60 BEDS	61-99 BEDS	100-257 BEDS	258 + BEDS	
CEO	see nh admin. Guidelines	$66,700	$81,112	$101,237	130%* 100+ admin. Guidelines	$131,608
ASST CEO CONTROLLER CORPORATE SECRETARY CORPORATE TREASURER ATTORNEY	75%	$50,025	$60,834	$75,928		$98,706
ACCOUNTANT BUSINESS MGR PURCHASING AGENT REGIONAL ADMINISTRATOR REGIONAL V-P REGIONAL EXECUTIVE	70%	$46,690	$56,778	$70,866		$92,126
CONSULTANTS: SOCIAL ACTIVITY DIETARY (RD) PHYSICAL THER (RPT) MEDICAL RECORDS (RRA) NURSING (BSRN)	65%	$43,355	$52,723	$65,804		$85,545
SECRETARIES	see nh	$20,650	$21,806	$25,398		$25,398
BOOKKEEPERS	see nh	$32,352	$32,751	$39,768		$39,768
MEDICAL DIRECTOR	90%	$60,030	$73,001	$91,113		$118,447

****NOTE: there are no home offices in the 0-60 bed group**

Note: Last year guidelines were increased by 1.0%--the state employee pay increase effective 07/01/08

1. The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent. No individual will have more than one full time equivalent (40 hour per week) job recognized in the Medicaid program.

2. No assistant operating executive will be authorized for a chain with 257 beds or less.

3. Allowable compensation amounts shown above will be adjusted annually by annual cost of living raises provided to state employees.

H) Management Fee

Only reasonable management fees which result in lower total costs shall be included in allowable costs. Each centrally managed facility shall submit a home office cost report which separately identifies each cost by cost categories. The costs so identified will be individually tested for reasonableness and then assigned to the appropriate line item in the individual facility's cost report.

For purposes of setting the current administrative cost standards, the administrative costs of those centrally managed facilities that reported their management fee as a single line item among administrative costs in their cost report shall be excluded from the computation of the administrative standard. Those centrally managed facilities which identified their management fee as a single line item among administrative costs shall have the management fee included in administrative cost for the purpose of rate calculation.

I) Other Benefits

The other benefits such as pensions, group life insurance, and health insurance can be recognized if these benefits are provided in accordance with sound financial/management practices by the provider. This excludes from allowable cost Key Man Life Insurance and benefits made available only to an exclusive number of employees, including the owner of the facility. Other benefits are accumulated to applicable cost centers.

J) Payroll Taxes and Benefits

Payroll taxes and benefits should be reported in the cost center applicable for the salaries to which they relate. Payroll taxes and benefits will be limited in the same proportion that compensation is limited.

K) Routine Laundry Services

Effective October 1, 1993, basic personal laundry services are to be provided to all patients of the facility free of charge. All laundry costs associated with basic patient personal laundry will be included in allowable costs in the laundry cost center. Therefore, for clarification purposes, there should be no reduction in allowable costs via a step-down or income offset for the provision of basic personal laundry services regardless of whether or not a charge is made for this service. Basic personal laundry does not include dry cleaning, mending, hand washing or other specialty services; these services need not be provided and residents may be charged for such services if they request them.

L) Specialty Bed Expense

Specialty beds are defined as air fluidized therapy beds and low air loss beds. For rates effective October 1, 1994, specialty bed costs that will be reimbursable under the South Carolina Medicaid nursing facility reimbursement rate will consist of only specialty bed costs for Medicaid recipients in which the nursing facility did not receive reimbursement from the Medicare Program for this service. The specialty bed costs that will be excluded from allowable costs will consist of direct costs only. No indirect costs associated with the removal of specialty bed expense will be removed from allowable costs in order to encourage Medicare participation.

M) Ancillary Services Reimbursement

Ancillary services provided to Medicaid recipients are allowable costs, and thus, reimbursable under both the Medicare and Medicaid Programs. Medicare reimburses these costs outside of the overall routine per diem rate while Medicaid reimburses these costs as a part of the overall routine per diem rate. Ancillary services which are reimbursed by Medicare include: physical therapy, speech therapy, oxygen therapy, occupational therapy, medical supplies, PEN therapy and other special services. Effective January 1, 1995, in order to avoid dual reimbursement of these costs from both the Medicare and Medicaid Programs, the SCDHHS will only include the costs of the Medicaid recipients' ancillary services which are not reimbursed by the Medicare Program in the facility's Medicaid reimbursement rate. However, when ancillary service costs are reimbursed as part of routine costs by Medicare (e.g. PEN Therapy), these costs will continue to be treated as allowable costs in the facility's Medicaid reimbursement rate. Therefore, only those costs which are reimbursed outside of the overall routine per diem rate by Medicare will be removed from allowable costs for Medicaid rate setting purposes. The ancillary services costs that will be excluded from allowable costs will consist of direct costs only. No indirect costs associated with the removal of ancillary services will be removed from allowable costs in order to encourage Medicare participation. Effective January 1, 2003, Part B coinsurance payments applicable to dual eligibles will no longer be reimbursed through the per diem rate.

For state operated long term care facilities which are reimbursed retrospectively their total allowable costs, no adjustment to the Medicaid rate will be made to ancillary services (including specialty beds) to adjust for dual reimbursement by both the Medicare and Medicaid Programs. Instead, Medicare Part A and Part B ancillary services cost settlements will be made upon submission of the annual FYE June 30 cost reports in accordance with the cost reporting schedules.

Pursuant to the above, it shall be the responsibility of the provider to bill the Medicare Program for the reimbursement of covered ancillary services provided to dual eligible recipients. Failure to implement billing procedures by January 1, 1995 could result in an adjustment to allowable cost.

N) Eden Alternative Expenses

The costs incurred by nursing facilities which participate in adopting the Eden Alternative concept will be considered an allowable cost for Medicaid rate setting purposes. The goals of the Eden Alternative are to improve the quality of life in nursing facilities, and transform the conventional nursing facility into a vibrant human habitat for its residents. The incorporation of gardens, animals, birds, and children into the daily activities of the nursing facility residents assists in meeting these goals.

As with all other allowable Medicaid costs, these costs will be subject to reasonableness and must be related to patient care. Additionally, Eden Alternative expenses must be offset by grant income. Costs associated with fund raising activities applicable to the Eden Alternative concept or any other fund raising program will not be considered an allowable cost for Medicaid rate setting purposes.

O) Quality Initiatives Grant Awards

The goal of the Quality Initiatives Grant Award Program administered by the Medicaid Agency is to enhance the quality of care and quality of life for nursing facility residents and staff through initiatives that focus on education. Nursing facilities that participate in this Quality Initiative Program will receive grant funding that must be used to fund one of the approved quality enhancing initiative items: (1) subscription costs related to "My Inner View", an independent survey and benchmarking company measuring quality in long-term care and assisted living facilities; (2) Bladder Scanner, or (3) Electronic Medical Records System. While the costs of the items listed above will be included as an allowable cost for Medicaid rate setting, nursing facilities must offset the costs of these items by the amount of the grants award received from the Medicaid Agency.

P) Professional Liability, Workers' Compensation, and Health Insurance Costs

A provider participating in the South Carolina Medicaid Program is expected to follow sound and prudent management practices, including the maintenance of an adequate insurance program to protect itself against likely losses, particularly losses so great that the provider's financial stability would be threatened. There are various types of insurance coverage that are allowable costs for South Carolina Medicaid reimbursement purposes and they, as well as their allowable cost requirements, are defined in the Provider Reimbursement Manual HIM-15, sections 2161 through 2162.14. However, due to recent questions relating to providers' treatment of professional liability, workers' compensation, and health insurance costs, the South Carolina

Department of Health and Human Services (SCDHHS) is providing the following clarification/new policy to address the questions raised for the three insurance programs.

The provider may choose to protect itself against professional liability, workers' compensation, and health insurance costs through the use of one of the following methods:

1. Insurance purchased from a commercial insurance company which provides coverage after a deductible or coinsurance provision has been met;

2. Insurance purchased from a limited purpose insurance company (captive);

3. Total self insurance; or

4. A combination of purchased insurance and self-insurance.

In order for the losses and the costs associated with the purchase of insurance coverage to be considered as an allowable cost for South Carolina Medicaid reimbursement purposes, all pertinent provisions of the Provider Reimbursement Manual HIM-15 must be met. This would include those sections of HIM-15 relating to losses arising from other than sale of assets (i.e. all sections of 2160 through 2160.5) and those sections of HIM-15 relating to insurance (i.e. all sections of 2161 through 2162.14). In addition, the state will clarify existing requirements and impose new requirements effective October 1, 2007:

- No more than twelve months of claims expense will be allowed during a full cost reporting period;

- Professional liability punitive damage awards are not considered an allowable cost for South Carolina Medicaid reimbursement purposes.

- Effective October 1, 2007, free standing nursing facilities as well as chain nursing facilities must ensure that South Carolina specific data is used in claiming allowable insurance costs for its South Carolina nursing facilities.

- For cost reporting periods beginning on or after October 1, 2007, when a change is made from commercial insurance to one of the alternatives listed above or from one alternative to another, the provider must document and submit to the SCDHHS a comparative analysis which shows that the provider's choice results in a reasonable cost for the coverage offered and that the extent of the coverage is consistent with sound management practices. The provider's comparative analysis must be performed every three (3) years to assure consistent

application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider must provide these analyses for review by the SCDHHS and/or the Office of the State Auditor (SAO). The analyses must include the information as reflected in HIM-15, section 2162.C.

- Providers that are currently operating under insurance coverage other than commercial insurance are required to perform a comparative analysis every three (3) years to assure consistent application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider must provide these analyses for review by the SCDHHS and/or the SAO. The analyses must include the information as reflected in HIM-15, section 2162.C. An insurance survey will be mailed to all contracting providers no later than March 31, 2008 to determine those providers that will be required to perform the comparative analysis and when it will be due.

- Effective October 1, 2007, providers cannot switch between claims paid and claims paid with incurred but not reported expenses (IBNR) factor without prior authorization from the SCDHHS.

Insurance Purchased from a Commercial Insurance Company

The reasonable costs of insurance purchased from a commercial carrier are allowable if the type, extent, and cost of coverage are consistent with sound management practice (HIM-15, sections 2161.A., 2162.1, 2160.B). The premiums paid under this coverage will be an allowable cost for South Carolina Medicaid reimbursement purposes using GAAP and HIM -15 reimbursement principles to allocate the expense between cost reporting periods.

Insurance Purchased from a Limited Purpose Insurance Company (Captive)

See HIM-15, section 2162.2 for South Carolina Medicaid allowable cost reimbursement requirements.

Total Self-Insurance

A provider must meet all of the conditions set forth in HIM-15, section 2162.7 to be designated as "self-insured" by the South Carolina Medicaid Program. Under this designation, providers will be required to claim as cost the actuarial determined amount to be paid into the fund in accordance with HIM-15. Expenses related to losses paid out of the self-insurance fund as described in HIM-15, section 2162.8 will be considered an allowable cost for South Carolina Medicaid reimbursement purposes. Those expenses specifically identified in section 2162.8 will become part of the cost of the particular insurance coverage that meets the self-

insurance test while those not specifically identified will be considered an administrative cost. In the event that the provider does not meet all of the "self-insurance" criteria as established

in HIM-15, section 2162.7, the provider's allowable Medicaid reimbursable costs associated with insurance coverage will be limited to one of the following options:

a) actual claims paid during the cost reporting period; or

b) actual claims paid with a year end accrual for incurred but not reported (IBNR) expenses applicable to the cost reporting period. The IBNR factor will be determined based upon experience occurring during the three month period immediately following the end of the cost reporting period.

Allowability of actual loses related to deductibles or co-insurance will be determined in accordance with HIM-15, Section 2162.5.

Professional Liability Expense Only - Pool Payments

Effective October 1, 2007, providers will be reimbursed outside of their Medicaid reimbursement rate for Professional Liability claims that exceed $50,000 on an individual claim-by-claim basis. When a claim for payment is made under this provision, the provider will be required to submit to the SCDHHS a copy of the final settlement agreement and/or court or jury decision. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the provider's policy, as well as the reasonable cost of any legal assistance connected with the settlement or award will be considered an allowable Medicaid reimbursable cost, provided the provider submits evidence to the satisfaction of the SCDHHS and/or the SAO that the insurance coverage carried by the provider at the time of the loss reflected the decision of prudent management (HIM-15, section 2160.2).The reasonable legal costs associated with this claim will be reimbursed via the nursing facility's Medicaid per diem rate.

This payment will be made via a gross adjustment and Medicaid's portion of this payment will be determined based upon the Medicaid occupancy of the nursing facility during the cost-reporting period in which the claim is paid. Payments made under this method will be for those claims that have a final settlement date within the corresponding cost reporting period. For example, claims with a final settlement date occurring between October 1, 2005 through September 30, 2006 will be eligible for payment on or after October 1, 2007. The final settlement between the plaintiff and the nursing facility should indicate the amount of the payment for compensatory or actual damages and the amount of the payment for punitive damages. Professional liability punitive damage awards are not considered an allowable cost for South Carolina Medicaid reimbursement purposes. This payment will not be subject to the lower of cost or charges compliance test.