Table of Contents

State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 17-0016

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

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

Financial Management Group

November 7, 2017

Ms. Deirdra T. Singleton
Acting Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: State Plan Amendment SC 17-0016

Dear Ms. Singleton:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 17-016. Effective October 1, 2017 this amendment modifies the State's reimbursement methodology for setting payment rates for Nursing Facilities. Specifically, this amendment will: update the cost center standards; update owner and relative compensation guidelines; increase payment rates by 2.9 percent; update the deemed asset value to $55,236 per bed; update the market rate of return factor to 2.92 percent; increase ventilator unit rates to $530 per day; and provide upper payment limit payments to nursing facilities that were mandated to move patients due to hurricane Matthew.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing 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, 2017. We are enclosing the CMS-179 and the amended approved plan pages.

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

Sincerely,

//s//

Kristin Fan
Director

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC-17-0016

2. STATE: South Carolina

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, 2017

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN x ☐ 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:
($15,600,00x.7158=$11,166,480
a. FFY2018 $11,166,480
b. FFY 2019 $Rates will be rebased

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages 2, 3, 6, 8, 14, 15, 17, 25, 25a, 26, 32, 34, 40a
(**Pages 26a and 26b will be deleted from the State Plan due to language shift because of deleted language**)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, pages 2, 3, 6, 8, 14, 15, 17, 25, 25a, 26, 32, 34, 40a

10. SUBJECT OF AMENDMENT:
Nursing Facility Rate Updates Effective October 1, 2017

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
x ☐ OTHER, AS SPECIFIED:
Mrs. Singleton was designated by Governor to review and approve all state plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Deirdra T. Singleton

14. TITLE:
Director

15. DATE SUBMITTED:
08/10/17

16. RETURN TO:
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
08/14/2017

18. DATE APPROVED: 11/07/17

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-01-17

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Kristin Fan

22. TITLE: Director , FMG

23. REMARKS: Approved with following changes to block # 8 and 9 as authorized by the state.

Block # 8 changed to read: pages 2,3,6,8,14,15,17,25a,26,32,34,26a,26b and 26c

Block # 9 changed to read: pages 2,3,6,8,14,15,17,25a,26,32,34,26a, and 26b

FORM HCFA-179 (07-92)

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.

E) All nursing facilities are required to retain all financial and statistical records for each cost reporting period, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least four (4) years following the end of the contract period for which the cost report was used to set this rate. These records must be made available upon demand to representatives of the Medicaid Agency, or the State Auditor, or the Centers for Medicare and Medicaid Services. The Medicaid Agency will retain all cost reports for four (4) years after the end of the contract period for which the cost report is used to set the rate. If any litigation, claim, negotiation, or other action involving the records has been started before the expiration of the four (4) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular four (4) year period, whichever is later.

F) Allowable costs shall include all items of expense which Providers must incur in order to meet the definition of nursing facility services as detailed in 42 CFR 440.40 and or 440.150 as promulgated under Title XIX of the Social Security Act, and in order to comply with standards for nursing facility care in 42 CFR 442 and in order to comply with requirements of the State Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 and in order to comply with any other requirements for nursing facility licensing under the State law.

1) Allowable costs are determined in accordance with Title XIX of the Social Security Act, 42 CFR USCA 1396, et seq. and Federal Regulations adopted pursuant to the Act; the Medicaid Agency regulations; Title XVIII of the Social Security Act, 42 CFR USCA 1395 et seq., Federal regulations adopted pursuant thereto and HIM-15, except those provisions which implement Medicare, retrospective, as opposed to Medicaid's prospective, reimbursement system or those provisions which concern the relationship between the provider and Medicare intermediary or are modified by this Plan.

2) Bad debts, charity and courtesy allowance shall not be included in allowable costs except that bad debts that are attributed to cost sharing amounts as defined in 42 CFR 447.50 and 447.59 shall be allowable.

3) Allowable cost shall be categorized as follows: (The application is defined in Section III, Payment Determination).

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 2015-2016, this index rose 253.669 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2015-2016 is $55,236 per bed and will be used in the determination of nursing facility rates beginning October 1, 2017.

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

that kind of money." Part of the funds 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 State of South Carolina Revenue and Fiscal Affairs Office, based on latest data published by the Federal Reserve. Effective October 1, 2017, this rate is 2.92%.

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

PROVIDER NAME: 0
PROVIDER NUMBER: 0
REPORTING PERIOD: 10/01/15 through 09/30/16 DATE EFF. 10/01/17

		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 @	0.90	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	2.90%				0.00
COST OF CAPITAL					0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)				3.50%	0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM					0.00
EFFECT OF $1.75 CAP ON COST/PROFIT INCENTIVES				$1.75	0.00
SUBTOTAL					0.00
ADJUSTMENT FACTOR			0.0000%		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. General Services cost center standards will be computed using private and non-state owned governmental free standing and hospital based nursing facilities. All other cost center standards will be computed using private for profit free standing nursing facilities. 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 (366 x 90%).

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. Effective December 31, 2011, nursing facility providers will no longer be allowed to appeal its acuity level (i.e. percent skilled) payment adjustment determination for any current or future year payment rates. 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.

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 Revenue and Fiscal Affairs Office 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 2016 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 2016.

   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 2017 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 2017.

   c. The percent change in the total proxy index during the third quarter of 2016 (as calculated in step a), to the total proxy index in the third quarter of 2017 (as calculated in step b), was 2.90%. Effective October 1, 2017 the inflation factor used was 2.90%.

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 90% occupancy, actual days will be adjusted to reflect 90% 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.

needs which fall within the higher ranges of disabilities in the criteria. To qualify as a Medicaid complex care beneficiary, the individual must meet the level of care for long-term care plus two or more of the following criteria:

- Wound/decubitus care - Stage 4 requiring wound vac treatment
- Tracheostomy Tube/Canula - sinus alone does not qualify, must have the following: tube/canula, need for aseptic care, need for tracheal aspiration
- Nasopharyngeal or suctioning - oral and pharyngeal aspiration does not apply
- Continuous parental fluids of extended duration of two weeks or more
- Continuous disruptive behavior at least 60% of the time in a 24/hr. day, 7 days a week resulting often from head trauma accidents, neuro deficits, bi-polar affective disorder and/or other chronic mental illnesses
- Diagnosis of HIV - usually related to drug costs and IV medications
- Morbid obesity/bariatric requiring special equipment such as beds, lifts, additional staff
- Medicaid only beneficiary who require goal directed therapies (occupational therapy, speech therapy, physical therapy) that addresses a recently diagnosed medical condition, within the last six (6) months
- Dialysis
- Total care as defined by the skilled long term care criteria

The Complex Care Program reimbursement rate effective October 1, 2011 will be $450.00 per patient day and was developed based upon an analysis of the Medicaid RUG scores developed from federal fiscal year 2011 Medicaid MDS assessments and federal fiscal year 2011 Medicare RUG rates. The complex care rate will be used to reimburse nursing facilities for their base operational costs as well as the additional costs incurred in providing services to the qualifying individuals such as:

1. Staff time (both by skilled professional and nurse aides) to perform actual procedures or provide additional care;
2. Necessary supplies, specialized equipment such as lifts, special beds, etc. needed to provide the care, and/or nutritional supplements; and
3. Staff education required to be able to provide for the beneficiary with complex care needs.

Nursing facilities that provide services to complex care individuals meeting the criteria defined above will be required to step down cost applicable to this service in accordance with Section I (C) of this plan upon submission of their annual cost report.

Ventilator Unit Reimbursement Program

Effective for services provided on or after October 1, 2017, the South Carolina Department of Health and Human Services will update its per diem payment for services provided to ventilator dependent Medicaid beneficiaries residing in a ventilator dependent wing of a contracting South Carolina Medicaid nursing facility. To qualify for this reimbursement, the wing must consist of a minimum of 20 nursing facility beds that are dedicated solely to the provision of ventilator dependent services. Effective for services provided on and after October 1, 2017, the vent rate will equal $530.00 per Medicaid patient day. This rate was determined based upon the Medicaid Agency's review of proposed Medicare FFY 2018 RUG rates associated with the provision of ventilator dependent services.

The ventilator unit rate will be used to reimburse nursing facilities for their base operational costs as well as the individual costs incurred in providing services to these individuals such as:

1. Staff time (both by skilled professional and nurse aides) to perform actual procedures or provide additional care;
2. Necessary supplies, specialized equipment such as lifts, special beds ventilators, etc. needed to provide the care, and/or nutritional supplements; and
3. Staff education required to be able to provide for the beneficiary with vent needs.

Nursing facilities that provide services to Ventilator Unit individuals will be required to step down cost applicable to this service in accordance with Section I (C) of Attachment 4.19-D 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. Upper Payment Limit Calculation

I. Private Nursing Facility Services

The following methodology is used to estimate the upper payment limit applicable to privately owned or operated nursing facilities (i.e. for profit and non-governmental nonprofit facilities):

The most recent FYE September 30 Medicaid nursing facility cost report serves as the base year cost report to be used for Medicaid rate setting and UPL calculations. In order to determine the Medicare allowable cost per patient day (i.e. upper payment limit), the SCDHHS:

(1) Adjusts each nursing facility's "desk audited" allowable cost (net of cost of capital expenses) to conform to the requirements of HIM-15 (i.e. the Provider Reimbursement Manual). This is done in order to ensure that allowable costs are determined in accordance with HIM-15, as some of our Medicaid allowable cost guidelines as defined in our state plan are more restrictive than Medicare.

(2) Desk audited cost of capital expenditures are reviewed and/or adjusted to ensure that, based upon the best information available, the capital costs reported by the provider reflect the historical costs of the prior owner in the event of a sale or lease of the nursing facility since December 15, 1981.

(3) Total allowable costs as defined in (1) are divided by the actual number of patient days served by the provider to determine the allowable cost per patient day of the provider (net of cost of capital). This allowable cost per patient day is then increased by employing the midpoint to midpoint trending methodology using the Global Insight CMS Nursing Home without Capital Market Basket Index in order to trend the base year cost to the Medicaid rate period.

(4) Total allowable cost of capital expenditures as defined in (2) are divided by the actual number of patient days served by the provider to determine the allowable cost of capital expense per patient day of the provider. No inflation trend is applied to the cost of capital per diem.

(5) The cost per diem as determined in (3) and (4) above are added together to determine the Medicaid rate per day based upon Medicare allowable cost definitions (i.e. HIM-15).

(6) Medicaid days paid (excluding NF days paid for recipients while under the Hospice Benefit) based upon the most recently completed state fiscal year are applied to the Medicaid cost based rate as defined in (5) above and the Medicaid rate as calculated in accordance with the state plan methodology to determine the annual Medicaid payments for each provider under each rate method described above.

(7) The annual Medicaid cost based rate expenditures and the annual Medicaid rate expenditures for all providers within the class are summed to determine the aggregate payments for each class.

(8) The Medicaid UPL compliance check is determined by comparing the aggregate amounts as determined in (7) above to ensure that Medicaid cost based rate expenditures are equal to or greater than Medicaid rate expenditures. In the event that aggregate Medicaid rate expenditures exceed aggregate Medicaid cost based rate expenditures, the Medicaid rate for each facility will be limited to the Medicaid cost based rate as determined in (5) above

(9) Due to the mandatory evacuation ordered by Governor Haley of South Carolina in regards to Hurricane Matthew, the following nursing facilities will receive quarterly private nursing facility UPL payments equating to Medicaid's share of its allowable Medicaid reimbursable evacuation related costs. In the determination of allowable Medicaid reimbursable evacuation costs, any insurance proceeds received by the impacted nursing facilities that relate to the residents' evacuation must be offset against the evacuation costs claimed for payment. The nursing facilities that qualify for this UPL payment are as follows:

Heartland of West Ashley, Johns Island Rehab and Healthcare, Life Care Center of Charleston, Mount Pleasant Manor, Riverside Health and Rehab, Sandpiper Rehab and Nursing, White Oak Manor - Charleston, Bayview, Life Care Center of Hilton Head, NHC of Bluffton, Hallmark Healthcare, Oakbrook Health and Rehab, Heartland Healthcare of Charleston (Hanahan), and Prince George.

The sum of the private UPL payments will not exceed the upper payment limit calculated under the FFY 2018 private nursing facility UPL demonstration.

II. Non-State Owned Governmental Nursing Facility

The following methodology is used to estimate the annual upper payment limit applicable to non-state owned governmental nursing facilities:

The three most recent quarterly nursing facility UPL payments paid during the preceding federal fiscal year serves as the base data used for the annual Medicaid UPL demonstration for this ownership class and is described below:

(1) Calculated Medicare upper payment limits for the December, March, and June quarters of the preceding federal fiscal year are determined in accordance with the Essential Public Safety Net Nursing Facility Payment Program as described in Section III(K) of Attachment 4.19-D. Additionally, the Medicaid paid days associated with each quarter are identified via MMIS and exclude hospice days.

(2) To estimate the calculated Medicare upper payment limit for the September quarter, the payments for the three preceding quarters are summed and divided by three for each nursing facility. The estimated Medicaid paid days for the September quarter are also determined using the same methodology.

(3) The calculated quarterly Medicare upper payment limits identified in (1) above are added to the estimated September quarter Medicare upper payment limit as identified in step (2) to determine the annual estimated Medicare upper payment limit for the preceding federal fiscal year for each nursing facility. Annual estimated Medicaid paid days for the preceding federal fiscal year are also determined using the same methodology.

(4) In order to estimate the annual Medicare upper payment limit for the upcoming federal fiscal year which begins October 1st, the annual estimated Medicare upper payment limit of the preceding federal fiscal year as determined in step (3) above is multiplied by the applicable Medicare SNF PPS Market Basket Rate (net of the Productivity Adjustment) applicable to the next federal fiscal year.

(5) In order to estimate the annual Medicaid rate payments for each nursing facility for the next federal fiscal year, the Medicaid adjusted per diem rate applicable to the next federal fiscal year (which includes the base Medicaid per diem rate, the Medicaid per patient day pharmacy cost, and the Medicaid per diem lab, x-ray, and ambulance cost) is multiplied by the estimated Medicaid paid days as determined in step (3) above.

(6) The Medicaid UPL compliance check is determined for the non-state owned governmental nursing facility class by comparing the aggregate amounts as determined in (4) above to ensure that the projected Medicare upper payment limit is equal to or greater than projected Medicaid nursing facility expenditures determined in step (5).

III. 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, 2011, 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.

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)	$77,771	$82,347	$102,482
RN	$58,822	$59,592	$62,816
LPN	$48,006	$48,006	$50,149
CNA	$24,336	$24,336	$26,000
SOCIAL SERVICES DIRECTOR	$39,874	$41,434	$51,522
SOCIAL SERVICES ASSISTANT	$34,050	$34,050	$39,790
ACTIVITY DIRECTOR	$33,030	$33,883	$36,795
ACTIVITY ASSISTANT	$22,027	$22,464	$24,586
DIETARY SUPERVISOR	$40,456	$44,762	$55,245
DIETARY WORKER	$19,781	$20,966	$23,754
LAUNDRY SUPERVISOR	$29,099	$29,099	$29,099
LAUNDRY WORKER	$17,597	$19,344	$21,590
HOUSEKEEPING SUPERVISOR	$28,746	$34,674	$38,438
HOUSEKEEPING WORKER	$18,366	$19,282	$20,987
MAINTENANCE SUPERVISOR	$38,355	$42,848	$50,773
MAINTENANCE WORKER	$28,018	$28,122	$31,429
ADMINISTRATOR	$89,752	$101,213	$131,581
ASSISTANT ADMINISTRATOR	$65,644	$77,958	$77,958
BOOKKEEPER / BUSINESS MGR	$45,302	$45,302	$47,715
SECRETARY / RECEPTIONIST	$28,413	$28,704	$30,035
MEDICAL RECORDS SECRETARY	$36,192	$36,192	$36,192

Note: Based upon payroll surveys sent during the FYE 10/1/15 to 9/30/16

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	$89,752	$101,213	$131,581	130%* 100+ admin. Guidelines	$171,055
ASST CEO CONTROLLER CORPORATE SECRETARY CORPORATE TREASURER ATTORNEY	75%	$67,314	$75,910	$98,686		$128,291
ACCOUNTANT BUSINESS MGR PURCHASING AGENT REGIONAL ADMINISTRATOR REGIONAL V-P REGIONAL EXECUTIVE	70%	$62,826	$70,849	$92,107		$119,739
CONSULTANTS: SOCIAL ACTIVITY DIETARY (RD) PHYSICAL THER (RPT) MEDICAL RECORDS (RRA) NURSING (BSRN)	65%	$58,339	$65,788	$85,528		$111,186
SECRETARIES	see nh	$28,413	$28,704	$30,035		$30,035
BOOKKEEPERS	see nh	$45,302	$45,302	$47,715		$47,715
MEDICAL DIRECTOR	90%	$80,777	$91,092	$118,423		53,950
NOTE: there are no home offices in the 0-60 bed group						

Note: Based upon payroll surveys sent during the FYE 10/1/15 to 9/30/16

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.