DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	1-9-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000444	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

Mr. Robert M. Kerr
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

DEC 19 2006

Log- Wells
"Nec. Action"

RE: South Carolina 06-013

Dear Mr. Kerr:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 06-013. This amendment modifies the State's payment methodology for setting payment rates for nursing facility services. Specifically, this amendment incorporates the adjustments made to the State's nursing facility rate setting methodology and allowable cost definitions based on the annual rebasing of rates effective on or after October 1, 2006.

We conducted our review of your submittal according to Medicaid statutory requirements in sections 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and implementing Federal regulations at 42 CFR Part 447. I am pleased to inform you that South Carolina State plan amendment 06-013 is approved effective October 1, 2006.

If you have any questions related to this letter, please call Venesa Johnson at (410)-786-8281.

Sincerely,

Dennis G. Smith

Dennis G. Smith
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 06-013

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, 2006

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: $25,000 x 69.54%

a. FFY 2007 $17,385
b. FFY 2008 Rates will be rebased.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Pages 1, 2, 6, 8, 13 thru 17, 19, 26, 29, 30, 32, and 34, 23, 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Pages 1, 2, 6, 8, 13 thru 17, 19, 26, 29, 30, 32, and 34

10. SUBJECT OF AMENDMENT:
Nursing Facility rate update effective October 1, 2006 based upon annual rebasing.

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:
Mr. Kerr was designated by the Governor to review and approve all State Plans.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert M. Kerr

13. TYPED NAME:
Robert M. Kerr

14. TITLE:
Director

15. DATE SUBMITTED:
September 27, 2006

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
December 19, 2006

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis G Smith

21. TYPED NAME: Dennis G Smith

22. TITLE: Director, CMSO

23. REMARKS:
Per e-mail change to block # 8

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, 2006, nursing facilities which have an annual Medicaid utilization of 1,500 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) All 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. [Effective October 1, 2006, nursing facilities which have an annual Medicaid utilization of 1,500 days or less will not be required to file an annual financial and statistical report.]

C) All 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. For rates effective January 1, 1988, a facility which participates in the Medicaid program for the first time on and after July 1, 1987 will not be required to prepare a step-down cost allocation if the facility has a private pay wing(s). However, if a facility participating in the Medicaid program for the first time on and after July 1, 1987 adds a private pay wing subsequent to that date, then a step-down allocation of cost as previously described will be required.

D) All 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, all 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.

Effective October 1, 2006, nursing facilities which have an annual Medicaid utilization of 1,500 days or less will not be required to file an annual financial and statistical report.

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 2003-2004, this index rose 177.878 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2004-2005 is $43,399 per bed and will be used in the determination of nursing facility rates beginning October 1, 2006.

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. Furthermore, that portion of the cost of

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 (through 2001) and the long-term average of Treasury rates longer than 25 years (effective 2002) 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, 2006, this rate is 4.90%.

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, 2006, nursing facilities which do not incur an annual Medicaid utilization in excess of 1,500 patient days will receive a prospective payment rate which will represent the average industry rate at the beginning of each rate cycle. The average industry rate is determined by summing the October 1 rate of each nursing facility and dividing by the total number of nursing facilities. 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%.

ATTACHMENT 4.19-D
Page 14
Revised 10/01/06

PROVIDER NAME:	0			
PROVIDER NUMBER:	0			
REPORTING PERIOD:	10/01/04	through	09/30/05	DATE EFF. 10/1/2006

		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 @	0.95	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 4.60%				0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 9.5% OF ALLOWABLE COST)				0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LNM				0.00
EFFECT OF $1.75 CAP ON COST/PROFIT INCENTIVES			$0.00	0.00
REIMBURSEMENT RATE				0.00

SC 06-013
EFFECTIVE DATE: 10/01/06
RO APPROVED:
SUPERSEDES: MA 05-008

DEC 19 2006

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 2006 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 2006.

   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 2007 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 2007.

   c. The percent change in the total proxy index during the third quarter of 2006 (as calculated in step a), to the total proxy index in the third quarter of 2007 (as calculated in step b), was 4.6%. Effective October 1, 2006 the inflation factor used was 4.6%.

7. The per patient day cost of capital will be calculated by dividing capital cost as determined under IF(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.

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.

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 P (A) through P (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.

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

An enhanced rate of $180 per patient day may be available for nursing facility 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.

This rate will be adjusted as follows:

Intensive Technical Services Reimbursement Rate	
Effective Date	Reimbursement Rate
10/01/2003	$188.00
10/01/2004	$197.00
10/01/2005	$206.00
10/01/2006	$215.00

The initial rate was determined through an analysis of costs of 1) a small rural hospital located in South Carolina who would set up a small ward to provide this level of service and 2) contracting with an out-of-state provider which has established a wing in a nursing facility to deliver this type of service. Future reimbursement rates for this service may be adjusted to account for inflationary trends and/or reviews of participating nursing facilities costs of providing the service. 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. 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 IV of this attachment.

L. 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.

However, if by audit it is determined that the portion of dues expended on lobbying, entertaining legislators and legal action against state agencies exceeds 10% of the dues, that amount will be disallowed. The per diem rate for each nursing home that claims association dues will be adjusted at the time costs are determined to be nonallowable and such per diem rate adjustments will be effective for the entire contract period.

A) 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.

B) 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.

C) 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)	$49,264	$51,915	$59,779
RN	$40,374	$41,688	$42,802
LPN	$30,613	$30,613	$32,018
CNA	$17,179	$17,313	$18,427
SOCIAL SERVICES DIRECTOR	$25,267	$26,425	$30,659
SOCIAL SERVICES ASSISTANT	$17,780	$22,526	$24,241
ACTIVITY DIRECTOR	$20,767	$22,014	$23,774
ACTIVITY ASSISTANT	$17,202	$17,202	$17,202
DIETARY SUPERVISOR	$20,142	$26,381	$30,703
DIETARY WORKER	$15,262	$15,708	$16,109
LAUNDRY SUPERVISOR	$23,395	$23,395	$23,395
LAUNDRY WORKER	$13,614	$14,171	$14,883
HOUSEKEEPING SUPERVISOR	$17,891	$20,676	$23,663
HOUSEKEEPING WORKER	$14,460	$14,571	$15,084
MAINTENANCE SUPERVISOR	$29,032	$29,032	$33,088
MAINTENANCE WORKER	$20,142	$21,790	$21,992
ADMINISTRATOR	$53,563	$67,288	$82,484
ASSISTANT ADMINISTRATOR	$50,066	$50,066	$50,066
BOOKKEEPER / BUSINESS MGR	$26,937	$28,742	$34,290
SECRETARY / RECEPTIONIST	$21,813	$21,813	$21,813
MEDICAL RECORDS SECRETARY	$21,612	$21,612	$21,612

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	$53,563	$67,288	$82,484	1.30%* 100+ admin. Guidelines	$107,230
ASST CEO CONTROLLER CORPORATE SECRETARY CORPORATE TREASURER ATTORNEY	75%	$40,172	$50,466	$61,863		$80,423
ACCOUNTANT BUSINESS MGR PURCHASING AGENT REGIONAL ADMINISTRATOR REGIONAL V-P REGIONAL EXECUTIVE	70%	$37,494	$47,102	$57,739		$75,061
CONSULTANTS: SOCIAL ACTIVITY DIETARY (RD) PHYSICAL THER (RPT) MEDICAL RECORDS (RRA) NURSING (BSRN)	65%	$34,816	$43,737	$53,615		$69,700
SECRETARIES	see nh	$21,813	$21,813	$21,813		$21,813
BOOKKEEPERS	see nh	$26,937	$28,742	$34,290		$34,290
MEDICAL DIRECTOR	90%	$48,207	$60,559	$74,236		$96,507

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

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.

SC 06-013
EFFECTIVE DATE: 10/01/06
RO APPROVED: DEC 19 2006
SUPERSEDES: MA 05-008

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.