

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 Individuals with Intellectual Disabilities (ICF/IID), 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/IID 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.

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 2010-2011, this index rose 218.210 percent.

Inflating the base period market value of \$15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2010-2011 is \$49,698 per bed and will be used in the determination of nursing facility rates beginning October 1, 2012.

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

participation will determine the allowable percentage of Medicaid depreciation and amortization costs to be used in determining total allowable Medicaid costs for any new beds coming on line on or after July 1, 1989. Furthermore, that portion of the cost of capital reimbursement applicable to these new beds will not be subject to the \$3.00 cap.

In order to determine cost of capital reimbursement for these facilities, two cost of capital computations will be completed (for existing and new beds). To determine an equitable capital reimbursement, a formula determination for the new beds utilizing annualized data will be computed and then weighted with the values calculated for the existing beds. The weights will be projected utilization of existing and new beds during the rate cycle, with minimum occupancy being 92%.

The actual cost of any additions to new beds after July 1, 1989 will be added to the Deemed Asset Value for the purpose of computing depreciation charges. For clarification purposes, any capital expenditures incurred after the certification date of the new beds during the initial cost report period will not be considered as improvements, but as part of actual construction costs.

For facilities where there are no historical costs available, the plan computes a Deemed Depreciated Value based on the Base Period Asset Cost, adjusted to the year of construction using the index for home owner's rent, spread over a depreciation period applicable to the year of construction under Medicare guidelines.

The allocation of the base 1981 nursing home bed cost (\$15,618) by component is as follows:

<u>Asset Component</u>	<u>Cost Per Bed</u>	<u>Percentage of Total</u>
Land	\$ 461	2.95%
Building	12,274	78.59%
Equipment and Other	2,883	18.46%
Total	<u>\$15,618</u>	<u>100.00%</u>

A useful life of 40 years will be assigned to the building and a composite useful life of 12 years will be assigned to the equipment and other.

4) Determination of the Market Rate of Return

The plan provides the lowest rate of return to investors that would provide incentives to keep the industry expanding sufficiently to meet the growing needs of Medicaid patients. The industry may need approximately three to four million dollars per year of new investments to keep up with the growing population and the demand for Medicaid services in the near future.

In determining that rate of return, the question is, "where can that money be raised and what rate of return will be necessary to raise 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 Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 2012, this rate is 4.08%.

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

average facility of 100 beds, based upon federal cost year 1987-1988, which is used for computing state fiscal year rates effective July 1, 1989. In this illustration, the average accumulated depreciation for the industry is used to compute an average Deemed Depreciated Value. Under the plan, each operator will use the accumulated depreciation applicable to his own facility to calculate the Deemed Depreciated Value of his facility. Beginning in federal cost year 1987-1988, which was used for computing state fiscal year 1989-1990 rates, the Deemed Asset Value was set at \$23,271 for each bed.

The Deemed Asset Value of the facility would be the fixed \$23,271 per bed multiplied by the number of beds, which would amount to \$2,327,100 for the average 100 bed facility. To determine the amount of Deemed Depreciated Value for an individual facility, the amount of depreciation costs the provider has reported in accordance with Medicare/Medicaid guidelines would be subtracted from the Deemed Asset Value of the facility and the value of improvements added to the Deemed Asset Value. The average amount of accumulated depreciation for a 100 bed facility is \$356,827.

The estimated Deemed Asset Value of the facility less the accumulated depreciation would yield an average Deemed Depreciated Value of \$1,970,273 for this average facility. In this example, improvements were assumed to be zero, but an operator would add on the value of any improvements.

At the July 1, 1989 market rate of return of 9.8 percent the annual return would be \$193,087. At July 1, 1989, the total capacity of 36,500 patient days for the facility less the two percent turnover factor, would yield a facility capacity factor of 35,770 patient days. Actual patient days will be used if actual occupancy exceeds 98 percent. Effective October 1, 1995, minimum occupancy is established at 97%. Effective October 1, 2000, the minimum occupancy is established at 96%. Effective October 1, 2012, the minimum occupancy is established at 92%. This would yield a payment by the State of \$5.40 per patient day for each day of Medicaid service. The annual return for the facility will replace facility lease costs and capital interest costs (excluding specialty vehicle interest which is directly charged to the appropriate cost center) reflected under the cost of capital cost center. Lease costs associated with equipment rentals (separate from a facility lease) will be reflected in the affected cost centers.

Table 1

METHOD FOR CALCULATING COST OF CAPITAL REIMBURSEMENT
EFFECTIVE JULY 1, 1989

Original Asset Cost 1980/1981	\$	15,618
<u>Inflation Adjustment to Cost Year 1987-1988</u>	X	1.49
Deemed Asset Value FY 87-88	\$	23,271
<u>Number of Beds</u>	X	100
Deemed Asset Value of Facility		2,327,100
Improvements Since 1981		0
<u>Accumulated Depreciation</u>		(356,827)
Deemed Depreciated Value		1,970,273
<u>Market Rate of Return</u>	X	9.8%
Annual Return for Facility		193,087
<u>Facility @ 98% Capacity*</u>		35,770
Return per Bed per Patient Day	\$	5.40

*Effective October 1, 1995, minimum occupancy is established at 97%.

*Effective October 1, 2000, minimum occupancy is established at 96%.

*Effective October 1, 2012, minimum occupancy is established at 92%.

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 92% 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 92% 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 92% 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: 10/01/10 through 09/30/11 DATE EFF. 10/01/12

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 @ 0.92 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	0.00%			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		3.805%		0.00
REIMBURSEMENT RATE				0.00

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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 92%).
- 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.

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 92%).]

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 92% occupancy, actual days will be adjusted to reflect 92% 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 2012 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 2012.
 - 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 2013 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 2013.
 - c. The percent change in the total proxy index during the third quarter of 2012 (as calculated in step a), to the total proxy index in the third quarter of 2013 (as calculated in step b), was 3.2%. Effective October 1, 2012 the inflation factor used was 0.0%.
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 92% occupancy, actual days will be adjusted to reflect 92% 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.

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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. Prior to the adjustment factor being applied, the reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive and profit.
11. For rates effective for services provided on and after October 1, 2012, the provider's reimbursement rate calculated in step 10 will be decreased by the 3.805% adjustment factor.

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-two percent (92%) 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.
- d) The Medicaid agency will determine the percent of Level A Medicaid patients serviced for a facility that changes its bed capacity by more than fifty percent (50%) 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.
- e) The Medicaid agency will determine the percent of Level A Medicaid patients served for a new facility based upon paid days during the last month of the initial cost report period as reflected on the SCDHHS Medstat report to establish rates.

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.

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 the compounding of two years of the Skilled Nursing Facility Market Basket Index utilized by Medicare 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 (including 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

II. Non-State Owned Governmental Nursing Facility Services

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.

L) Ancillary Services Reimbursement

Ancillary services provided to Medicaid recipients are allowable costs and thus are reimbursable under both the Medicare and Medicaid Programs. While Medicaid reimburses ancillary services as part of the overall routine per diem rate, Medicare reimburses the direct cost of ancillary services through either Part A consolidated billing or Part B. Therefore, in order to ensure that the Medicaid rate of each contracting nursing facility provides reimbursement for covered ancillary services provided solely to Medicaid eligible recipients residing in nursing facilities, the Medicaid Agency will include only the costs of the Medicaid recipients' ancillary services which are not reimbursed by Medicare consolidated billing, Medicare Part B, or other payors in the Medicaid reimbursement rate. Only the direct cost of ancillary services will be excluded from allowable Medicaid cost.

Examples of ancillary services include physical therapy, speech therapy, occupational therapy, specialty beds, and other special items and services for which charges are customarily made in addition to a routine service charge. For further clarification of routine services versus ancillary services, providers should refer to the Provider Reimbursement Manual HIM-15, Sections 2203 through 2203.2. However, please note that while the cost of diabetic testing supplies is categorized as an ancillary service per HIM-15, the Medicaid Agency will consider this cost to be a nursing supply for Medicaid rate setting purposes.

For state operated long term care facilities, 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 the agency will recoup all dually eligible covered Part B ancillary services billed and recovered during its annual cost report period which ends June 30.

Pursuant to the above, it shall be the responsibility of the provider to implement a uniform charge structure and bill Medicare and other payors for the reimbursement of covered ancillary services provided to Medicaid eligible recipients. Failure to implement billing procedures will result in a downward adjustment to allowable cost.

M) 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.

N) 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.

O) 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