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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

SEP 30 2016

RECEIVED
OCT 04 2016
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Christian L. Soura
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: State Plan Amendment SC 16-0006

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 16-0006. Effective October 1, 2016 this amendment modifies the state's reimbursement methodology for setting payment rates for nursing facility services. Specifically, this amendment updates the deemed asset value and market rate of return used in the determination of the fair rental value rates for capital reimbursement, updates the per diem rates by 2.4%, revises the minimum occupancy rate from 92% to 90%, and adjusts the payment for professional liability claims that exceed $50,000 from 97% to 100%.

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 found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2016. 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,

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 16-0006

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, 2016

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:
a. FFY 2017 $3.9 Million
b. FFY 2018 $Rates will be rebased

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, pages 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 19, 21, 22, X, 33, & 40a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, pages 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 19, 21, 22, X, 33, & 40a

10. SUBJECT OF AMENDMENT:
Nursing Facility Rate Updates Effective October 1, 2016

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. Soura was designated by the Governor to review and approval all state plans.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Christian L. Soura

14. TITLE:
Director

15. DATE SUBMITTED:
August15, 2016

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:

18. DATE APPROVED: SEP 30 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMCo

23. REMARKS:

FORM HCFA-179 (07-92)

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 2014-2015, this index rose 243.533 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2014-2015 is $53,653 per bed and will be used in the determination of nursing facility rates beginning October 1, 2016.

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. **Effective for services provided on or after October 1, 2016, the Medicaid Agency will no longer establish a separate bed class for a minor bed addition that results from the conversion of private rooms into semi private rooms for cost of capital reimbursement purposes. In this scenario, the additional beds will be reflected within the bed group class where the beds were added and the capitalized costs associated with the addition of the beds will be reflected within this bed group. The only exception to this criteria will be when the additional beds result in the creation of a new wing. Under this scenario, a new bed group class will be created for cost of capital reimbursement purposes. In order to receive Medicaid reimbursement for these beds under either scenario, the beds must be certified for Medicaid participation.** 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 90%.

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:

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

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 State of South Carolina Revenue and Fiscal Affairs Office, based on latest data published by the Federal Reserve. Effective October 1, 2016, this rate is 3.21%,which is a reduction from the previously supplied market rate of 3.24% that was erroneously reported as 3.00% effective October 1, 2015.

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%. Effective October 1, 2016, the minimum occupancy is established at 90%. 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
Inflation Adjustment to Cost Year 1987-1988	X 1.49
Deemed Asset Value FY 87-88	$ 23,271
Number of Beds	X 100
Deemed Asset Value of Facility	2,327,100
Improvements Since 1981	0
Accumulated Depreciation	(356,827)
Deemed Depreciated Value	1,970,273
Market Rate of Return	X 9.8%
Annual Return for Facility	193,087
Facility @ 98% Capacity*	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%.
*Effective October 1, 2016, minimum occupancy is established at 90%.

7) Income Offsets

Income offset adjustments as defined in HIM-15, section 202.2 will continue to be made, except that income adjustments will be limited to the amount of the annual return per facility (see Table 1), plus working capital and specialty vehicle interest, in lieu of actual interest expense.

8) Limit on Cost of Capital Reimbursement

Cost of capital reimbursement effective July 1, 1989 cannot exceed the audited cost of capital and return on equity per diem payment reimbursed prior to July 1, 1989 (i.e., cost of capital and return on equity per diem payment on June 30, 1989) by more than $3.00 per patient day. The $3.00 cap is applicable only to those beds that were being reimbursed on June 30, 1989. Any new beds coming on line on or after the cost reporting period used to set the June 30, 1989 Medicaid payment rate will not be subject to the $3.00 cap. In order for nursing facilities to recognize the increase in the Deemed Asset Value in future years, the $3.00 limit on the capital per diem payment will be inflated each year by the index for the rental value of a home computed as part of the CPI (i.e., the same index used to determine the Deemed Asset Value each year). This rate (rental value index) will be supplied by the Budget and Control Board's Division of Research and Statistical Services each year. The cap effective October 1, 1995, inflated by 4.2% is $3.99. Effective October 1, 1996, the cap will be frozen at $3.99. Effective October 1, 2016, the cap is $5.00.

State operated facilities will continue to be reimbursed their actual capital costs (depreciation, interest, lease, and amortization costs).

a) Lease and Sales

The South Carolina Department of Health and Human Services will treat any new lease or sale of a facility executed after December 15, 1981, as a related party transaction. Therefore, in the event of a sale after December 15, 1981, the provider's capital related cost will be limited to the lower of the sales price or the historical cost of the prior owner. In the event of a lease executed after December 15, 1981, the provider's capital related cost will be limited to the lower of the lease cost or the historical cost of the owner (lessor). The historical costs of the prior owner would include:

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 90% are currently being utilized for Medicaid rate setting purposes. For clarification purposes, nursing facility beds that are taken off-line due to renovation/construction issues relating to unsafe building conditions and considered unusable to meet the SC Department of Health and Environmental Control survey and certification guidelines will be temporarily excluded from the minimum occupancy computation for Medicaid rate setting purposes. Effective on and after October 1, 2013, Medicaid rates for nursing facilities located in counties where the county occupancy rate is less than 85% based upon the FYE September 30 cost report information will be established using the following policy:

- The SCDHHS will waive the 90% minimum occupancy requirement used for rate setting purposes for those nursing facilities located in counties whose occupancy is less than 85%. However, standards will remain at the 90% 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. However, the SCDHHS will not participate in establishing payment rates using an occupancy rate of less than eighty-five percent (85%).

PROVIDER NAME:	0				
PROVIDER NUMBER:	0				
REPORTING PERIOD:	10/01/14	through	09/30/15	DATE EFF.	10/01/16

		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 2.40%				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

SC 16-0006
EFFECTIVE DATE: 10/01/16
RO APPROVED: SEP 30 2016
SUPERSEDES: SC 15-008

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 (365 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.

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. Total patient days are determined by taking maximum bed days available from each bed group, subtracting complex care days associated with each bed group, and multiplying the net amount by 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%.

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 90% occupancy, actual days will be adjusted to reflect 90% 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 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 2.40%. Effective October 1, 2015 the inflation factor used was 2.40%.

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.

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 percent (90%) 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 (1^{st}) day of the seventh (7^{th}) 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.

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

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

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

A change in ownership will be defined as a transaction (i.e. a sale or lease of fixed assets) that results in a new operating entity and occurs between unrelated parties. 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. Nursing facilities in the process of obtaining a certificate of need due to a sale or lease between unrelated parties prior to October 1, 2014 will be grandfathered in under the prior system.

Purchase of Fixed Assets

For a change in ownership due to a purchase of fixed assets, the new owner will receive the prior owner's most recent Medicaid rate upon the effective date of the change in ownership (purchase) and subsequent Medicaid reimbursement rates will be based upon the most recently filed fiscal year end September 30 cost report of the prior owner adjusted for any industry wide inflation trend or industry wide add-on until the new owner files a minimum nine month cost report which ends September 30. For clarification purposes, the new owner's rate will not be subject to the effect of any audits performed on the prior owners rate.

Lease of Fixed Assets

For a change in ownership due to a lease of fixed assets, the new owner will receive the prior owner's most recent Medicaid rate upon the effective date of the change in ownership (lease) and subsequent Medicaid reimbursement rates will be based upon the most recently filed fiscal year end September 30 cost report of the prior owner adjusted for any industry wide inflation trend or industry wide add-on until the new owner files a minimum nine month cost report which ends September 30. For clarification purposes, the new owner's rate will not be subject to the effect of any audits performed on the prior owners rate.

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

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

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

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

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

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

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

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

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

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

6. For clarification purposes, owners and/or relatives will be defined as an individual, individuals, or any legal entity with ownership or equity of at least five percent (5%) in the provider.

This payment will be made via a gross adjustment and Medicaid's portion of this payment will be determined based upon the Medicaid occupancy of the nursing facility during the cost-reporting period in which the claim is paid. Effective for professional liability claim payments made on and after April 8, 2011, only 97% of the Medicaid allowed amount will be paid. Effective October 1, 2016, 100% of the Medicaid allowed amount will be paid. Payments made under this method will be for those claims that have a final settlement date within the corresponding cost reporting period. For example, claims with a final settlement date occurring between October 1, 2005 through September 30, 2006 will be eligible for payment on or after October 1, 2007. The final settlement between the plaintiff and the nursing facility should indicate the amount of the payment for compensatory or actual damages and the amount of the payment for punitive damages. Professional liability punitive damage awards are not considered an allowable cost for South Carolina Medicaid reimbursement purposes. This payment will not be subject to the lower of cost or charges compliance test.