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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable Deborah Brooks Durden, Administrative Law Judge

Appellate Case No. 2015-001986

Countrywood Nursing, LLC, ... Appellant,

v.

South Carolina Department of Health and Human Services, ... Respondent.

RECORD ON APPEAL
VOLUME I
Pages 1-372

NICKLES LAW FIRM, LLC.

W. Allen Nickles, III
wanickles@nickleslaw.com
1122 Lady Street, Suite 610
Columbia, SC 29201
(803) 799-8080

*Attorney for Respondent, South Carolina
Department of Health and Human Services*

**NELSON MULLINS RILEY &
SCARBOROUGH LLP**

Daniel J. Westbrook
S. C. Bar No. 012939
Dan.westbrook@nelsonmullins.com
Alice V. Harris
S. C. Bar No. 066223
Alice.harris@nelsonmullins.com
1320 Main Street, 17th Floor
Post Office Box 11070 (29211-1070)
Columbia, SC 29201
(803) 799-2000

*Attorneys for Appellant Countrywood Nursing,
LLC.*

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**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Countrywood Nursing, LLC,

Appellant,

vs.

South Carolina Department of Health and
Human Services,

Respondent.

Docket No. 15-ALJ-08-0014-AP

ORDER

This matter comes before the Administrative Law Court (ALC or Court) pursuant to the appeal of Countrywood Nursing, LLC (Countrywood or Appellant) from a decision of the South Carolina Department of Health and Human Services (DHHS or Department) to recoup overpayments for Medicaid benefits based on certain audits performed by the South Carolina State Auditor's Office (SAO).

BACKGROUND

Appellant is a thirty-eight bed nursing facility in Hopkins, South Carolina. It provides services under the South Carolina Medicaid program, which is administered by DHHS. DHHS has a contract with SAO to conduct audit reviews of facilities like Appellant. SAO is to identify costs reported by a facility that do not meet Medicaid program requirements. On November 22, 2011, SAO issued final audit reports on Appellant. Appellant filed an appeal of these final audit reports on December 16, 2011. On September 17, 2014, an evidentiary hearing was held before DHHS Hearing Officer Betsy Schindler. On December 16, 2014, the Hearing Officer issued an order which concluded DHHS was entitled to recoup overpayments for Medicaid benefits it had made to Appellant. Appellant filed a motion to alter or amend on December 29, 2014, which the Hearing Officer denied on January 23, 2015. On January 20, 2015, Appellant filed an appeal with this Court.

ISSUE

Did the Hearing Officer err in her December 16, 2014 decision holding that DHHS was entitled to recoup overpayments for Medicaid benefits made to Appellant?

FILED
August 19, 2015

SC ADMIN. LAW COURT

STANDARD OF REVIEW

The ALC hears appeals from decisions of DHHS pursuant to the Administrative Procedures Act (APA). S.C. Code Ann. § 44-6-190 (2002 & Supp. 2014); Estate of Nicholson ex rel. Nicholson v. S.C. Dept. of Health and Human Servs., 377 S.C. 590, 660 S.E.2d 303 (Ct. App. 2008). Accordingly, the APA's standard of review as set forth in § 1-23-380 governs these appeals. See S.C. Code Ann. § 1-23-600(D) (Supp. 2014). That section states:

The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

- (a) in violation of constitutional or statutory provisions;
- (b) in excess of the statutory authority of the agency;
- (c) made upon unlawful procedure;
- (d) affected by other error of law;
- (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
- (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(5) (Supp. 2014).

A decision is supported by substantial evidence when the record as a whole allows reasonable minds to reach the same conclusion as the agency. Friends of the Earth v. Pub. Serv. Comm'n of S.C., 387 S.C. 360, 366, 692 S.E.2d 910, 913 (2010). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's findings from being supported by substantial evidence. Waters v. S.C. Land Res. Conservation Comm'n, 321 S.C. 219, 226, 467 S.E.2d 913, 917 (1996). In applying the substantial evidence rule, "a reviewing court will not overturn a finding of fact by an administrative agency 'unless there is no reasonable probability that the facts could be as related by a witness upon whose testimony the finding was based.'" Sea Pines Ass'n for Prot. of Wildlife, Inc. v. S.C. Dept. of Natural Res., 345 S.C. 594, 603-04, 550 S.E.2d 287, 292 (2001) (quoting Lark v. Bi-Lo, Inc., 276 S.C. 130, 136, 276 S.E.2d 304, 307 (1981)). However, the ALC may reverse or remand a decision which is affected by an error of law. Gilliam v. Woodside Mills, 312 S.C. 523, 435 S.E.2d 872 (Ct. App. 1993). An error of law occurs when the lower court is vested with discretion but the order reveals the lower court did not exercise that discretion. Fontaine v. Peitz, 291 S.C. 536, 354 S.E.2d 565 (1987).

DISCUSSION

Under the South Carolina Medicaid plan (State Plan), all nursing home facilities must maintain accurate and detailed financial records that are subject to on-site audit. DHHS has a contract with SAO (SAO Contract) to perform these audits. After purchasing an existing nursing facility in 2007, Appellant entered the South Carolina Medicaid program and accepted assignment of the contract between DHHS and the facility it purchased (Facility Contract). Under the terms of the Facility Contract, Appellant was to file initial and annual cost reports to DHHS, which were subject to audit by SAO.

In 2011, SAO audited three of Appellant's cost reports: November 29, 2007 to May 31, 2008; November 29, 2007 to September 30, 2008; and October 1, 2008 to September 30, 2009. The first cost reporting period was an initial cost report that covered a portion of the same dates as the second cost reporting period. On November 22, 2011, SAO issued the final audit reports and determined that Appellant had to repay DHHS \$546,968 in overpayments for Medicaid services. Following the issuance of the final audit reports, SAO continued to receive and consider additional information from Appellant through at least August 6, 2012. Appellant filed a timely appeal of these final audit reports, which resulted in the September 17, 2014 hearing at which the Hearing Officer upheld the SAO's findings and determined that DHHS was entitled to recoupment of the disputed Medicaid payments made to Appellant.

In this appeal, Countrywood argues that DHHS should be barred from recouping the overpayments identified in the audit reports for two reasons. First, Appellant argues that because DHHS's contract with SAO limits audits to two periods, the initial cost report at issue here was not a proper subject for audit. Second, Countrywood argues that the audit reports were not issued within the three-year time period required by the Facility Contract and so recovery of the overpayments is barred.

Initial Cost Report

At the September 17, 2014 hearing, Appellant argued that the SAO Contract limited the audit review to two cost reporting periods. DHHS argued that Appellant did not have the standing necessary to challenge the language of the SAO Contract. Appellant argued it had standing to enforce this reading of the SAO Contract as a third-party beneficiary. Appellant stated that Medicaid nursing homes, like its own facility, were the intended beneficiaries of DHHS' statutory

duty to ensure equitable administration of the South Carolina Medicaid program and the corollary duty to equitably administer Medicaid audits.

The Hearing Officer correctly determined that Appellant was not a third-party beneficiary to the SAO Contract. Generally, a "third person not in privity of contract with the contracting parties has no right to enforce a contract." Goode v. St. Stephens United Methodist Church, 329 S.C. 433, 445, 494 S.E.2d 827, 833 (Cl. App. 1997) (citing Bob Hammond Constr. Co. v. Banks Constr. Co., 312 S.C. 422, 440 S.E.2d 890 (Ct. App. 1994)). However, when a contract is "made for the benefit of the third person, that person may enforce the contract if the contracting parties intended to create a direct, rather than an incidental or consequential, benefit to such third person." Id. As noted by the Hearing Officer, the purpose of the SAO Contract is to formalize the relationship between two state agencies and not, as Appellant argues, to benefit nursing home facilities. Therefore, the Hearing Officer correctly found that Appellant did not have standing to enforce the SAO Contract as a third-party beneficiary.

Appellant also argues it has standing to enforce the agreement between DHHS and SAO under the public importance doctrine. Appellant alleges that failure to adopt its interpretation of the effect of the SAO Contract language would have an impact on the entire Medicaid program. The Hearing Officer correctly determined that the public interest doctrine does not confer standing to enforce the SAO Contract upon Appellant. Under the public importance doctrine, a party can have standing to litigate "when an issue is of such public importance as to require its resolution for future guidance." Sloan v. Dept. of Transportation, 365 S.C. 299, 618 S.E.2d 876 (2005). Whether a resolution is needed for future guidance is the key to public importance analysis. ATC S., Inc. v. Charleston Cnty., 380 S.C. 191, 199, 669 S.E.2d 337, 341 (2008). Appellant failed to prove facts or cite any authority demonstrating that its case rose to the level of public importance necessary to establish standing under this doctrine. As the Hearing Officer noted, public interest does not favor Appellant's position that audits of cost reporting periods related to Medicaid reimbursement should be restricted. On the contrary, the State Plan provides that all nursing facilities must maintain accurate and detailed financial records for at least six years following the end of the contract period, and that such records must be made available upon demand to DHHS or the State Auditor. See, State Plan at Attachment 4.19-D,I(C). It is axiomatic that the public interest does not favor a result that contradicts the express provisions of the State Plan.

Even setting aside the issue of whether Countrywood has standing to enforce a provision of a contract between SAO and DHHS, there is no support for Appellant's argument that DHHS is contractually barred from examining more than two cost reporting periods. Appellant believes that language in both the SAO Contract and Facility Contract that references when the SAO must issue a final audit report creates a ceiling and restricts the number of cost reporting periods that SAO can audit. However, Appellant's position is not supported by case law or evidence in the record. Under the State Plan, with which both the SAO Contract and Facility Contract must comply, Medicaid service providers like Appellant must always make records available to the SAO. The Hearing Officer correctly found that the plain language of both contracts clearly leads to the conclusion that the two cost reporting periods are not intended as a limitation on SAO's ability to perform audits. If the language was as a ceiling rather than a floor, words of limitation, such as "only," would have been included.

Timeliness of Audit Reports

Appellant next argues that DHHS is barred from recovering overpayments identified in report AC# 3-RDM-E8 because the audit report was not issued timely. The Facility Contract states, "Any disallowance made pursuant to an on-site audit shall be made in the final audit report which shall be issued within three years of the close of the contract period." The Facility Contract provides that, "the contract period will be the rate period as defined by the South Carolina State Plan." The issue in this case turns upon the meaning of the term "rate period."¹

DHHS presented testimony from an expert on the State Plan that a "rate period" was the time frame determined by the information contained in a cost report and was not limited to the report period itself. It was within the Hearing Officer's discretion to believe this expert testimony over evidence presented by Appellant. See, Kearse v. State Health & Human Servs. Fin. Comm'n, 318 S.C. 198, 200, 456 S.E.2d 892, 893 (1995) (The findings of an administrative agency are presumed correct and will only be set aside if not supported by substantial evidence.) Here, the testimony of DHHS' witness was supported by substantial evidence and it was within the Hearing

¹ Appellant argues that C.A.N. Enterprises, Inc. v. S. Carolina Health & Human Servs. Fin. Comm'n, 296 S.C. 373, 373 S.E.2d 584 (1988), requires a finding that DHHS is barred from recouping funds disallowed by the audit reports related to the November 29, 2007 to May 31, 2008 cost reporting period. In C.A.N., the court examined language in a contract between the former state Medicaid agency and a provider of services. However, as the Hearing Officer pointed out, the C.A.N. decision dealt with a different deadline than the one at issue here. Therefore, nothing in the C.A.N. decision offers any guidance on the interpretation of the term "rate period."

Officer's purview to weigh the witnesses' credibility. DHHS went on to present evidence and testimony that showed Appellant's initial report, which ran from November 29, 2007 to May 31, 2008, set the base for reimbursement through September 30, 2009 and should be considered a part of that extended rate period. Therefore, DHHS argues, the SAO's final audit report that was issued on November 22, 2011 was made well within the three-year period that began on September 30, 2009.

Appellant argues that because the State Plan offers no express definition, the term "rate period" means any time a rate changes, regardless of the reason. Appellant presented correspondence from a DHHS employee in support of its position that the parties all understood "rate periods" to be any time a reimbursement rate changed. Under South Carolina law, even if a public employee is acting in the scope of their employment, they cannot make representations that alter controlling provisions of law or regulation. Ahrens v. State, 392 S.C. 340, 351, 709 S.E.2d 54, 59, (2011). In other words, representations made by a DHHS employee in correspondence with Appellant, do not control the interpretation of the language of the State Plan. Moreover, while the correspondence in question contains a heading "rate period," it does not purport to address the definition of that term as used in the Facilities Contract or State Plan. The Hearing Officer rightly focused her analysis on construing the term using the relevant principles of statutory construction, giving deference to the consistently-applied interpretation of the Department.

In construing a term in a statute, regulation or other public document an interpretation that leads to an absurd result must be rejected. Peake v. S.C. Dept. of Motor Vehicles, 375 S.C. 589, 599, 654 S.E.2d 284, 289 (Ct. App. 2007). The interpretation is

not to be governed by the apparent meaning of words found in one clause, sentence, or part of the act, but by a consideration of the whole act, read in the light of the conditions and circumstances as we may judicially know they appeared to the Legislature, and the purpose sought to be accomplished.

State v. Sawyer, 104 S.C. 342, 88 S.E. 894, 895 (1916). The State Plan makes a distinction between an initial cost report, which in this case ran from November 29, 2007 to May 31, 2008, and an annual report. The initial reports are filed after a change in ownership and allow a new owner the chance to obtain a new prospective rate until such a time as they are required to file an annual report. Under Appellant's interpretation of the term "rate period," the State Plan's distinction between initial and annual cost reports is rendered meaningless. The Hearing Officer

correctly found that Appellant's interpretation of the "rate period" would not be consistent with the purpose of Medicaid or the State Plan as a whole and, therefore, must be rejected.

The Hearing Officer's December 16, 2014 decision is supported by substantial evidence and does not exhibit any errors of law or abuse of discretion.

IT IS HEREBY ORDERED that the decision finding DHHS was entitled to recoup \$546,968 in Medicaid reimbursement payments from Appellant is **AFFIRMED**.

AND IT IS SO ORDERED.

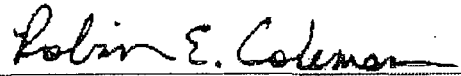


Deborah Brooks Durden
Administrative Law Judge

August 19, 2015
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, Robin E. Coleman, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail to the address provided by the party(ies) and/or their attorney(s).



Robin E. Coleman
Judicial Aide to Deborah Brooks Durden

August 19, 2015
Columbia, South Carolina

FILED

August 19, 2015

SC ADMIN. LAW COURT

STATE OF SOUTH CAROLINA)

COUNTY OF RICHLAND)

Countrywood Nursing, LLC)

Petitioner,)

v.)

South Carolina Department of Health
and Human Services,)

Respondent.)

BEFORE THE DIVISION OF
APPEALS AND HEARINGS
SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

**ORDER DENYING PETITIONER'S
MOTION TO ALTER OR AMEND**

12-AUD-010/AC#3-RDM-J9

12-AUD-011/ AC#3-RDM-J8

12-AUD-012/AC #3-RDM-E8

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (SCDHHS) to administer various programs and grants. See e.g., S.C. Code Ann. § 44-6-5, et seq. This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of SCDHHS (S.C. Code Ann. R. 126-150 et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. § 1-23-310 et seq.)

STATEMENT OF THE CASE

Petitioner, Countrywood Nursing Center, LLC (Countrywood), is a 38-bed nursing facility in Hopkins, South Carolina. Countrywood provides services under the South Carolina Medicaid program administered by the Respondent, SCDHHS. SCDHHS contracts with the South Carolina State Auditor's Office (SAO) to conduct audit reviews and identify reported costs that do not meet program requirements. On November 22, 2011, SAO issued the final audit reports identified above.

Petitioner filed a timely appeal for the audit reports AC#3-RDM-J9, cost report period 10/1/08 to 9/30/09 (Appeal Case 12-AUD-010); AC#3-RDM-J8, cost report period 11/29/07 to 9/30/08 (Appeal Case 12-AUD-011); and AC#3-RDM-E8, cost report period 11/29/07 to 5/31/08 (Appeal Case 12-AUD-012). Petitioner's appeal included its opposition to Respondent's recoupment

notice requesting repayment of \$546,968 resulting from the cost report audits. Petitioner and Respondent participated in a prehearing conference, exchanged documents, conducted depositions and filed prehearing briefs. A motion for summary judgment filed by Petitioner was denied by order dated December 19, 2012 with permission to raise the issues presented in the hearing.

A Hearing was convened on September 17, 2014, in Columbia, South Carolina. Petitioner was represented by Daniel Westbrook, Esq. Also present for Petitioner was Alice Harris, Esq., Terry Schnoyer, CPA and Tammie Pope. Allen Nickles, III, Esq. represented Respondent and Jeff Saxon and Jay Von Kannel, CPA were Respondent witnesses.

A Final Administrative Decision for these appeals was issued on December 17, 2014. This Hearing Officer found Respondent is entitled to recoup overpayments identified in the challenged audit reports. On December 29, 2014, Petitioner filed a Motion to Alter or Amend that proposed additional factual findings be included or addressed in the Decision.

ISSUE

The immediate determinative issue is whether this Hearing Officer should modify the Final Administrative Decision of December 17, 2014.

APPLICABLE LAW & CONCLUSIONS OF LAW

Department of Health and Human Services' regulations on Appeals and Hearings §126-154 states: "A Hearing Officer has the authority, among other things, to: direct all procedures, issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or conclusions of law; call witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with the requirements of this subarticle."

DECISION

After careful consideration of Petitioner's Motion to Alter or Amend, Respondent's Reply to Motion to Alter or Amend and the entire record in this matter, I find the finding of facts set forth in the Final Administrative Decision sufficient to address the issues on appeal. Therefore, Petitioner's Motion to Alter or Amend is **denied**.

AND IT IS SO ORDERED.

Betsy Schindler
Betsy Schindler, Hearing Officer
Division of Appeals and Hearings

Columbia, South Carolina

January 23, 2015

STATE OF SOUTH CAROLINA)

COUNTY OF RICHLAND)

Countrywood Nursing, LLC)

Petitioner,)

v.)

South Carolina Department of Health
and Human Services,)

Respondent.)

BEFORE THE DIVISION OF
APPEALS AND HEARINGS
SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

**FINAL ADMINISTRATIVE
DECISION**

12-AUD-010/AC#3-RDM-J9

12-AUD-011/ AC#3-RDM-J8

12-AUD-012/AC #3-RDM-E8

Hearing Date September 17, 2014

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (SCDHHS) to administer various programs and grants. See e.g., S.C. Code Ann. § 44-6-5, et seq. This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of SCDHHS (S.C. Code Ann. R. 126-150 et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. § 1-23-310 et seq.)

STATEMENT OF THE CASE

Petitioner, Countrywood Nursing Center, LLC (Countrywood), is a 38- bed nursing facility in Hopkins, South Carolina. Countrywood provides services under the South Carolina Medicaid program administered by the Respondent, SCDHHS. SCDHHS contracts with the South Carolina State Auditor's Office (SAO) to conduct audit reviews and identify reported costs that do not meet program requirements. On November 22, 2011, SAO issued the final audit reports identified above.

Petitioner filed a timely appeal for the audit reports AC#3-RDM-J9, cost report period 10/1/08 to 9/30/09 (Appeal Case 12-AUD-010), AC#3-RDM-J8, cost report period 11/29/07 to 9/30/08 (Appeal Case 12-AUD-011) and AC#3-RDM-E8, cost report period 11/29/07 to 5/31/08 (Appeal Case 12-AUD-012). Petitioner's appeal included its opposition to Respondent's recoupment notice requesting repayment of \$546,968 resulting from the cost report audits. Petitioner and Respondent participated in a prehearing conference, exchanged documents, conducted depositions and filed prehearing briefs. A motion for summary judgment filed by Petitioner was denied by order dated December 19, 2012 with permission to raise the issues presented in the hearing.

A Hearing was convened on September 17, 2014, in Columbia, South Carolina. Petitioner was represented by Daniel Westbrook, Esq. Also present for Petitioner was Alice Harris, Esq., Terry Schmoyer, CPA and Tammie Pope. Allen Nickles, III, Esq. represented Respondent and Jeff Saxon and Jay Von Kannel, CPA were Respondent witnesses.

ISSUES

This appeal is comprised of two issues. The first issue contends that the contract between SCDHHS and SAO limits audit reviews to two cost report periods. Petitioner asserts that it is a third-party beneficiary of the contract between SCDHHS and the SAO. Petitioner further asserts that "public interest" confers standing to enforce the contract between SCDHHS and the SAO. The second issue claims that the contract between SCDHHS and the Petitioner bars recovery of disallowances in audit report AC #3-RDM-E8. Petitioner maintains that certain disallowances identified in this report were issued more than three years following the close of the contract period under review and that SCDHHS is barred from recovering identified overpayments for the period

November 29, 2007 through September 30, 2008. Based upon these claims, Petitioner seeks to retain \$546,968 in identified overpayments for Medicaid services.¹

As to Petitioner's first issue, Respondent asserts that Petitioner is not a beneficiary and has no standing to raise claims relating to the contract between SCDHHS and the SAO. Respondent further asserts that the contract between SCDHHS and the SAO does not limit the SAO to review of two cost reports. As to Petitioner's second issue, Respondent asserts that reviews were conducted and final audit reports were issued in a timely fashion.

INFORMATION BEFORE THE HEARING OFFICER

The information presented for review in this appeal includes testimony by Terry Schmoyer, CPA, offered as an expert on behalf of the Petitioner and testimony by Jeff Saxon, a Program Manager for SCDHHS, offered as an expert on behalf of Respondent. In addition to testimony provided at the hearing, the depositions of Mr. Schmoyer and Mr. Saxon are part of the record. Both parties presented documents that were marked as exhibits.

Respondent raised an objection to Mr. Schmoyer's participation as an expert on grounds that he is employed as an advocate by the Petitioner. Respondent argued that Mr. Schmoyer's opinion concerning the proposed limit on audit reviews and untimeliness of audit reports seeks to prevent the State from recouping unearned Medicaid payments based on reports that he submitted on behalf of Petitioner. I have considered Respondent's objections and have determined that issues raised challenging Mr. Schmoyer's impartiality go to the weight of his testimony rather than admissibility.

¹ The cost report for the period November 29, 2007 through May 31, 2008 alone resulted in an overpayment of \$292,592.00.

Respondent has also raised an objection to hearsay testimony offered by Mr. Schmoyer concerning communications between representatives of SCDHHS and Nursing Home Association representatives during the 1990s regarding the number of cost reports to be reviewed by the SAO. I agree that hearsay testimony is not admissible in this proceeding but also find admission of Mr. Schmoyer's testimony not to be determinative.

FINDINGS OF FACT

Based upon the documents and testimony presented at the hearing, I make the following findings of fact:

1. Providers of Medicaid services are reimbursed for their allowable costs in accordance with Medicare principles as found in the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (HIM-15), unless modified by the State Plan.
2. Costs that are reasonable, necessary and related to patient-care are allowable, reimbursable costs under State Plan and HIM-15.
3. As a condition of participation in seeking Medicaid reimbursement, providers must follow the rules set forth in the HIM-15 and State Plan.
4. HIM-15-1, Section 2304 (Adequacy of Cost Information) states in part: "Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning cost, etc.), which pertain to the determination of reasonable cost, capable of being audited. . ."

5. The State Plan is an agreement between South Carolina and the Federal government describing how the state administers its Medicaid program. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The State Plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.

6. The State Plan provides that: "All nursing facilities are required to detail their cost for the entire reporting period..." Attachment 4.19-D, I. (B)

7. The State Plan provides that cost reports submitted by nursing facilities: "shall be certified by the operator..." Attachment 4.19-D, I. (D)

8. The State Plan provides that all nursing facilities must maintain accurate and detailed financial records for "at least six (6) years following the end of the contract period for which the cost report was used to set this rate..." and that such records "must be made available upon demand to representatives of the Medicaid Agency [SCDHHS], or the State Auditor..." Attachment 4.19-D, I. (E)

9. The State Plan provides that: "All cost reports are subject to on-site audit." If there is a dispute about audit findings, "[t]he provider has the right to appeal..." through the present process. Attachment 4.19-D, II. (H)

10. Petitioner entered the South Carolina Medicaid program on November 29, 2007, having obtained an existing nursing facility (Ridgeview Manor). Petitioner accepted assignment of the contract for Medicaid services entered between Ridgeview Manor and SCDHHS.

11. As a "new facility" Petitioner filed an initial cost report for the period November, 29, 2007 through May 31, 2008, rather than the usual annual cost report filed by facilities operating

in South Carolina for a year or more. Attachment 4.19-D, III. (E) This initial cost report set the Petitioner's reimbursement rates through September 30, 2009.

12. The contract assumed by Petitioner provides that: "For purposes of Article V, Section F only [Time Limit on Issuance of the Final Audit Report], the contract period will be the rate period as defined by the South Carolina State Plan." Petitioner Contract Article II

13. The contract assumed by Petitioner "expressly incorporates" a number of governing laws, regulations and guidelines, including the State Plan. Petitioner Contract Article III

14. The contract assumed by Petitioner provides for audits and appeal from audit disallowances. Petitioner Contract Article V (A) and (B)

15. The contract assumed by Petitioner provides that final audit reports "shall be issued within three (3) years of the close of the contract period..." Petitioner Contract Article V (F)

16. The contract assumed by Petitioner provides that all cost reports "shall be certified as true, accurate, and complete..." and shall not include claims for payment that the provider "knows, or has reason to know, are not properly prepared or payable..." Petitioner Contract Article V (G)

17. The contract assumed by Petitioner provides that financial records shall be maintained for the same six year period designated in the State Plan and that such records are subject to inspection "at any time" by SCDHHS, the SAO and other identified agencies. Petitioner Contract Article V (G)(1) and (2)

18. The contract assumed by Petitioner provides that it "shall be construed to be the complete integration of all understandings between the parties hereto." Petitioner Contract Article IX (L)

19. SCDHHS and the SAO have entered a contract for "Agreed -Upon Procedure Activities Related To Medicaid Institutional Providers." This contract provides that the parties "have a common and concurrent interest in ascertaining that the expenditure of Medicaid funds is in accordance with the Provider contracts and the State Plan." SCDHHS/SAO Contract, p.1.

20. The SAO contract provides that: "The SAO will perform agreed-upon procedures involving two cost report periods." The contract further provides that for non-hospital based/related nursing facilities [such as Petitioner], the SAO will be required to issue the final reports of the two cost report periods no later than three (3) years after the end of the closed rate period that is associated with the preceding cost report period." SCDHHS/SAO Contract Article IV (D)(1).

21. The periods relevant to this matter were identified as three periods. The first time period was a portion of the second period.

Appeal No./Audit No.	Period Start Date	Period End Date
12-AUD-012/AC#3-RDM-E8	11/29/2007	5/31/2008
12-AUD-011/AC#3-RDM-J8	11/29/2007	9/30/2008
12-AUD-010/AC#3-RDM-J9	10/1/2008	9/30/2009

26. The SAO initiated field work on the challenged cost reports on August 10, 2011.

27. The SAO issued final audit reports on the challenged cost reports on November, 22, 2011.

28. Following issuance of the final audit reports, the SAO continued to receive and consider additional information from Petitioner through at least August 6, 2012. (Warrington email to Schmoyer, dated August 1, 2012)

CONCLUSIONS OF LAW

1. In a contest involving review of a statute, regulation or other public document, the plain language of the document in question controls and there is no need for explanation by way of testimony. See Paschal v. State Election Comm'n., 317 S.C. 434, 436, 454 S.E.2d 890, 892 (1995).

2. If there is any question about the meaning or intent of a public document, it is the responsibility of the reviewing body to ascertain the public interest at stake and to rule in a manner that serves that interest. Kiriakides v. United Artists Communications, Inc., 312 S.C. 271, 440 S.E.2d 364 (1994) (an interpretation that leads to an unintended result must be rejected).

3. In determining intent, the reviewing body may consider the interpretation and application of the agency responsible for execution of the legislation. See, Nucor Steel v. South Carolina Public Serv. Comm'n., 310 S.C. 539, 426 S.E. 2d 319 (1992).

4. Where an administrative agency has consistently applied a statute or regulation in a particular manner, its construction may not be overturned absent cogent reasons. S.C. Cable Television Ass'n. v. Southern Bell Tel. & Tel. Co., 308 S.C. 216, 417 S.E.2d 586 (1992); Emerson Electric Co. v. Wasson, 278 S.C. 394, 339 S.E.2d 118 (1986).

5. The words used in a statute or regulation should be given their ordinary and common meaning, consistent with their manifest purpose. See, Floyd v. Nationwide Mut. Ins. Co., 367 S.C. 253, 260, 626 S.E.2d 6, 10 (2005). A construction or interpretation that leads to an absurd or unintended result must be rejected. Peake v. S.C. Dept. of Motor Vehicles, 375 S.C. 589, 599, 654 S.E.2d 284, 289 (Ct. App. 2007); Jones v. State Farm Mut. Auto Ins. Co., 364 S.C. 222, 232, 612 S.E.2d 719, 724 (Ct. App. 2005).

6. There is no need to interpret the contract between DHHS and the SAO. See, Lee v. University of South Carolina, 407 S.C. 512, 517, 757 S.E.2d 394, 397 (2014) (Contractual language is to be construed according to its plain terms and courts are not at liberty to consider unexpressed or secret intentions).

7. Petitioner is not an intended beneficiary of the contract between DHHS and SAO. Instead, this contract is for the purpose of formalizing the relationship between two agencies of the State. Additionally, Petitioner has identified no legal basis to support a private cause of action or remedy arising out of this document. See, Wogan v. Kunze, 366 S.C. 583, 604, 623 S.E.2d 107, 118 (Ct. App. 2007) (a third party has no right to enforce a contract absent a showing that the contract is intended to create a direct rather than incidental or consequential benefit to the third person).

8. Petitioner contends that "public interest" supports its intervention in the contract between SCDHHS and the SAO. No authority offered by Petitioner supports this argument. For example, in Sloan Construction Co., Inc. v. Southco Grassing, Inc., 377 S.C. 108, 659 S.E.2d 158 (2008), the South Carolina Supreme Court determined that a third party breach of contract claim applies against a public entity only if supported by an expression of legislative intent. In Sloan, the Court found the required intent in a statute requiring contractors to maintain bonds protecting the interest of subcontractors on public projects. No such expression of intent is contained in the contract between SCDHHS and the SAO. To the contrary, the public interest in confining Medicaid payments to costs documented as reasonable and necessary to achieve program purposes would be undermined by allowing providers to limit audit reviews in a manner inconsistent with the State Plan and controlling law. The limit proposed by Petitioner would also subvert legislation

incorporated in the SCDHHS/SAO contract authorizing the SAO to review Medicaid costs to the full extent available under state and federal law. (SCDHHS/SAO Contract, "Recitals") (p. 1))

9. Petitioner has no standing to intervene in the contractual relationship between SCDHHS and the SAO under the "public importance" exception addressed in ATC South, Inc. v. Charleston County, 380 S.C. 191, 669 S.E.2d 337 (2008). As stated above, Petitioner's private interest in maintaining unearned public funds does not satisfy the "level of public importance" necessary to establish standing.

10. Petitioner contends that C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission, 296 S.C. 373, 373 S.E.2d 584 (S.C. 1988), requires a finding that audit report AC #3-RDM-E8 (addressing the cost report for the period November 29, 2007 through May 31, 2008 used to set the reimbursement rate through September 30, 2009) was issued in an untimely fashion as it relates to the period November 29, 2007 through September 30, 2008. The C.A.N. opinion addressed former contract language that required audits to be conducted "during the contract period and . . . after termination of this contract and for a period of three years thereafter." The Supreme Court held that the former contract language required audit reports to be issued within three years of the contract ending date. The audit periods applicable to current contracts are governed by the "rate period as defined by the South Carolina State Plan." (Petitioner Contract Art. II, Definitions "Contract Period"). The deadline for issuance of the challenged audit reports differs from deadline addressed in the C.A.N. opinion. As addressed below the language of the controlling State Plan establishes that the audit reports on appeal were issued timely. Accordingly, disallowances identified in the challenged reports are subject to recoupment.

DISCUSSION

I. Petitioner's initial cost report was subject to review by the SAO.

Petitioner's argument that the SAO is contractually barred from examining more than two cost reports for purposes of issuing final audit reports is not supported by the record or controlling law. For example, the SCDHHS/SAO contract provides that the SAO shall conduct "all engagements to determine if the reimbursement rate or amount is in accordance with the provision of the provider contracts, State Plan, and all state and federal laws and regulations." (SCDHHS/SAO Contract Art. III, ¶ B.3 (p. 3)) Limiting audit reviews in a manner inconsistent with governing law would be improper and exceed the authority of this Hearing Officer.

The SCDHHS/SAO contract states that it is the complete integration of all understandings between the parties. (SCDHHS/SAO Contract Art. IX, ¶ H (p. 10)) The contract's express purpose is to serve a "common and concurrent interest in ascertaining that the expenditure of Medicaid funds is in accordance with the Provider contracts and the State Plan." Even without this language, the controlling State Plan makes all records required to be maintained by Medicaid providers available on demand to the SAO. (State Plan Attachment 4.19-D, ¶ I (E) (p. 3))

If the two reporting periods referenced in the contract were intended to limit audit reviews, a construction denied by SCDHHS, the review language would contain limiting terms such as "only." This limitation is not stated in the contract and may not be added to alter the agreement between the parties. See (SCDHHS/SAO Contract Art. III, ¶ D.1 (p. 4). Petitioner was not a party to the SCDHHS/SAO contract, and its agreement acknowledges that: "All decisions and determinations regarding the administration of the Medicaid program shall be made by SCDHHS." (Petitioner Contract Art. IX, ¶ GG "Single State Agency Responsible for Medicaid"). Petitioner's agreement also makes clear that the SAO shall have access to Petitioner's records for a period of

six years following any contract, including amendments or extensions. See Petitioner Contract Art. V, ¶ G.2 (p. 9). This is consistent with the State Plan section on "Auditing" authorizing on site audit of "all cost reports." (State Plan Attachment 4.19-D ¶ II (H) "Auditing" (p. 12)).

Petitioner's reading of the contract between SCDHHS and the SAO would result in restricting the SAO from examining available records and prohibiting recovery of unnecessary and undocumented costs even when the provider reports and certifies costs without required documentation. Neither the plain language of the contract nor the State Plan supports such an outcome. Moreover, there is no evidence that Petitioner relied on the alleged limitation or has suffered any prejudice (apart from repaying unearned funds). As in any contractual relationship, it is for the parties to determine the nature of their agreement. Absent a dispute between SCDHHS and the SAO or a statutory mandate, there is no basis to impose a limit on auditors' access to information or issuance of reports.² Accordingly, Petitioner's assertion of its right to intervene in the contractual relationship between SCDHHS and the SAO is not supportable.

II. SCDHHS is not barred from recovering overpayments to Petitioner.

Petitioner argues that SCDHHS is barred from recovering identified overpayments in report AC #3-RDM-E8 (addressing the cost report for the period November 29, 2007 through May 31, 2008 used to set the reimbursement rate through September 30, 2009) as it relates to the period November 29, 2007 through September 30, 2008. Petitioner contends that the language of its contract with SCDHHS supports this position.

² Jeff Saxon is the person responsible for drafting both the SCDHHS/SAO contract and the contract assumed by Petitioner. In addition, Mr. Saxon is responsible for State Plan provisions. Any question concerning the construction of contractual or Plan language must take into account Mr. Saxon's testimony that, read together, these provisions are intended to allow the SAO full access to Medicaid provider records.

The contract assumed by Petitioner specifies that "the contract period will be the rate period as defined by the South Carolina State Plan." The State Plan identifies both initial cost reports (commonly called "six month reports" although the periods of less than a year may vary) and annual cost reports. Six month reports follow a change of ownership and allow the new owner an opportunity to obtain a new prospective reimbursement rate. The initial report set the rates for extended periods of time, here November 29, 2007 through September 30, 2009. Differences in reimbursements during this extended period are based on inflation and amendments to the State Plan, not changes in Petitioner's costs. Because the "rate period" determined by Petitioner's initial report extended far beyond the period reported and reviewed, Petitioner enjoyed significantly enhanced reimbursements.

Petitioner further argues that because the State Plan offers no express definition, the term "rate period" means any time a rate changes, regardless of the reason. Petitioner offers correspondence from SCHDDS using the term "rate period" in this fashion as evidence that the SAO exceeded its authority and that SCDHHS is barred from recouping overpayments. (Letter from Debra Myers to Joseph Hunt dated December 16, 2011). It is well established, however, that the representations of public employees, even acting in the scope of employment, cannot alter controlling provisions of law or regulation. Ahrens v. State, 392 S.C. 340, 351, 709 S.E.2d 54, 59 (2011) (Retirement Systems' agents cannot alter benefits). Moreover, the correspondence offered by Petitioner is countered by Mr. Saxon, author and recognized expert on the State Plan. Mr. Saxon testified that a "rate period" is the time frame determined by information contained in a cost report and is not limited to the report period itself. Petitioner's witness, Mr. Schmoyer, acknowledged that the State Plan must be read in its entirety if questions arise as to its application. Mr. Schmoyer also agreed that Petitioner's initial cost report set the base for reimbursement through September

30, 2009. The challenged audit report was issued on November 22, 2011, well within the three year period following September 30, 2009.

A reading of the State Plan, without reference to testimony from Mr. Saxon or Mr. Schmoeyer, confirms that a "rate period" is the period used to establish the foundation for a provider's reimbursement. The differing treatment afforded initial cost reports in setting extended rates and annual reports setting rates for one year only would not make sense as constructed by Petitioner. For example, applying Petitioner's interpretation of "rate period" would lead to the absurd result of setting different limitations periods for the same costs. Indeed, Petitioner admits that the costs addressed in AC #3-RDM-E8 and AC #3-RDM-J8 overlap, each starting on November 29, 2007. Petitioner does not contest the timeliness of AC #3-RDM-J8, so that overpayments identified in that report are subject to recovery by SCDHHS. Petitioner argues, however, that AC #3-RDM-E8 has three reporting deadlines that would render some of the same overpayments shielded from recovery by SCDHHS.

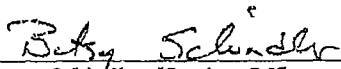
Petitioner's construction of the term "rate period" renders the distinction between initial and annual cost reports contained in the State Plan meaningless, ignores the benefits enjoyed by Petitioner due to the extended application of its initial report, and undermines the public interest in maintaining the fiscal integrity of the Medicaid program. In the absence of a definition section in the State Plan addressing the term "rate period," the meaning of this term must be ascertained by the purpose of the South Carolina Medicaid program and must take into account the whole of the State Plan. The meaning of "rate period" offered by Petitioner is not consistent with the purpose of the Medicaid program or the State Plan as a whole and must be rejected. See, Gaffney v. Mallory, 186 S.C. 337, 195 S.E. 840, 845 (1938) (The meaning of statutory language is not governed by words found in one clause, sentence or part, but by consideration of the whole and

the public purpose sought to be accomplished). For all of these reasons, Petitioner's objections to recoupment of funds disallowed in the final audit reports on appeal are denied.³

DECISION

Having considered all of the evidence and testimony presented for review, and having weighed the credibility and relevance of the evidence presented, for the following reasons, I find Respondent is entitled to recoup overpayments identified in the challenged audit reports.

AND IT IS SO ORDERED.


Betsy Schindler, Hearing Officer
Division of Appeals and Hearings

Columbia, South Carolina

December 16, 2014

³ Any equitable claim asserted by Petitioner also fails because the alleged "delay" in issuing audit reports was neither unreasonable nor prejudicial to Petitioner. See generally, Emery v. Smith, 361 S.C. 207, 603 S.E.2d 598 (2004) (delay alone does not establish a right to relief from payment of monies due).

THE STATE OF SOUTH CAROLINA

In The Court of Appeals

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SEP 18 2015

SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

The Honorable Deborah Brooks Durden, Administrative Law Judge

Docket No. 15-ALJ-08-0014-AP

South Carolina Department of Health and Human
Services, ...

Respondent,

v.

Countrywood Nursing, LLC.....

Appellant.

NOTICE OF APPEAL

Daniel J. Westbrook
SC Bar No: 12939
dan.westbrook@nelsonmullins.com
Alice V. Harris
SC Bar No. 66223
alice.harris@nelsonmullins.com
1320 Main Street, 17th Floor
Post Office Box 11070
Columbia, SC 29201
(803) 799-2000

Attorneys for Appellant Countrywood Nursing, LLC

W. Allen Nickles, III, Esq.
Nickles Law Firm, LLC
1122 Lady Street, Suite 610
Columbia, SC 29201

Attorney for Respondent

FILED

SEP 18 2015

SC ADMIN. LAW COURT

R0027

Countrywood Nursing, LLC, appeals the Final Order of the Honorable Deborah Brooks Durden, dated August 19, 2015. Appellant received written notice of this decision August 19, 2015.

NELSON MULLINS RILEY & SCARBOROUGH LLP

By: 

Daniel J. Westbrook

SC Bar No. 12939

dan.westbrook@nelsonmullins.com

Alice V. Harris

SC Bar No. 66223

alice.harris@nelsonmullins.com

1320 Main Street, 17th Floor

Post Office Box 11070

Columbia, SC 29201

(803) 799-2000

Attorneys for Appellant Countrywood Nursing, LLC

Columbia, South Carolina

Sept. 18, 2015

THE STATE OF SOUTH CAROLINA

In The Court of Appeals

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SEP 18 2015

APPEAL FROM THE ADMINISTRATIVE LAW COURT

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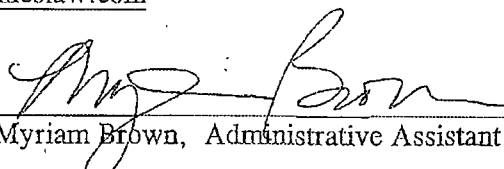
Respondent.

CERTIFICATE OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Countrywood Nursing, LLC, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by mailing a copy of the same by United States Mail, postage prepaid, to the following address(es):

Pleadings: Notice of Appeal

Counsel Served: W. Allen Nickles, III, Esq.
Nickles Law Firm, LLC
1122 Lady Street, Suite 610
Columbia, SC 29201
wanickles@nickleslaw.com


Myriam Brown, Administrative Assistant

Sept. 18, 2015

FILED

SEP 18 2015

SC ADMIN. LAW COURT

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Countrywood Nursing, LLC,

Appellant,

vs.

South Carolina Department of Health and
Human Services,

Respondent.

Civil Action No. 15-ALJ-08-0014-AP

APPELLANT'S REPLY

Daniel J. Westbrook
dan.westbrook@nelsonmullins.com
Alice V. Harris
alice.harris@nelsonmullins.com
1320 Main Street, 17th Floor
Post Office Box 11070
Columbia, SC 29201
(803) 799-2000

*Attorneys for Appellant Countrywood
Nursing, LLC*

FILED

MAY 27 2015

SC ADMIN. LAW COURT

INTRODUCTION

Appellant Countrywood Nursing Center, LLC ("Appellant" or "Countrywood") submits this Reply to Respondent's Brief. Countrywood appeals the decision by the South Carolina Department of Health & Human Services ("DHHS") to recoup Medicaid reimbursement based on certain audits proposed by the South Carolina State Auditor's Office ("SAO"). This Reply incorporates by reference the Issues on Appeal and Statement of the Case set forth in Appellant's Initial Brief.

ARGUMENT

I. The SAO Contract Prohibits the SAO from Auditing Countrywood's First Cost Report Period.

A. The Plain Language of the Contract Restricts the SAO to Auditing Two Cost Report Periods.

Countrywood is a non-hospital based nursing home in Hopkins, South Carolina. This appeal arises out of the SAO's audit of three of Countrywood's cost report periods.

- 1) Audit E-8: 11/29/07-5/31/08 (the "First Cost Report Period");
- 2) Audit J-8: 11/29/07-9/30/08 (the "Second Cost Report Period"); and
- 3) Audit J-9: 10/1/08-9/30/09 (the "Third Cost Report Period").

R. 396-409.

DHHS is party to a contract with the SAO (the "SAO Contract") that provides:

The SAO will provide agreed-upon procedures¹ involving two cost report periods. For non-hospital based/related

¹ "Agreed-upon procedures" include audits and audit reports. R. 108:24-26.

nursing facilities, the periods will be defined as the cost report period which was used to set the provider's Medicaid rate in effect at the time the field work for the engagement is initiated, plus the preceding cost report period.

R. 418 (Article III(D)(1)). Pursuant to this provision, the SAO was restricted to auditing Countrywood's Second and Third Cost Report Periods. R. 112:19-27.

The Respondent wishes to alter the plain language of the contract, suggesting that the key sentence from Article III(D) of the SAO Contract – “The SAO will provide agreed-upon procedures involving two cost report periods” – is ambiguous or does not mean what it says. Respondent's Brief at 14. Respondent argues that Countrywood's construction of the language, restricting the SAO to auditing two cost report periods, would be justified only if the contractual provision contained “limiting terms.” *Id.* First, Respondent's position ignores the fact that Article III(D) *does* contain a “limiting term,” referring to its requirements as “restrictions.” R. 418 (Art. III (D)(4)). Second, Respondent's position is inconsistent with legal maxims cited in Respondent's own brief. *See id.* at 10, ¶ 6, citing *Lee v. Univ. of South Carolina*, 407 S.C. 512, 517, 757 S.E.2d 394, 397 (2014) (“Contractual language is to be construed according to its plain terms”); *see also id.* at 10, ¶¶ 7-8.

Respondent relies on the cost report retention provision of the State Health Plan (the “Plan”), which requires DHHS to retain cost reports for six years, or, in the event of legal actions involving cost reports, even longer. R. 233. Facility contracts between Medicaid nursing homes and DHHS have a similar requirement for nursing homes. R. 284. The requirements are consistent, however, with Article III(D)(4),

which provides: "These restrictions do not apply in relation to any procedures initiated *subsequent to or in relation to* any investigation of fraud." R. 418. (emphasis added).

These audits were not initiated subsequent to or in relation to any fraud investigation. R. 149:15-17 (testimony of DHHS's Jeff Saxon).² At the final hearing, Countrywood acknowledged that, through an unintentional oversight, it had improperly omitted listing in cost reports certain related-party costs. R. 163:16-165:5; 181:28-29. Respondent states that Countrywood knew of these related party omissions before the audit review, Respondent's Brief at 16, citing R. 161-62, 174-78, 181, but nothing in the record supports this allegation. Terry Schmoyer, the accountant who prepared Countrywood's cost reports, testified he first became aware of the related party omission the day before the DHHS final hearing, when DHHS first raised the issue. R. 163:16-164:2. He further testified that the omission "did not impact the amount of money that Countrywood was paid by Medicaid." R. 165:15-17. As Mr. Schmoyer explained:

If you look at the related party, there's columns for how much the cost that the provider paid for the service, how much the cost is that the related party incurred and then if the costs are different, you reduce the costs down or bring the costs up. As you look through the provider to whatever the related party paid for the service so if the, if we bought the equipment for \$68,000 and the provider - and the client tells me that is the cost that they paid for it then there's no adjustment, there's no profit in the transaction and it's just disclosure.

R. 166:3-10. Respondent states the related party purchases had a "reimbursement impact" of over \$130,000, Respondent's Brief at 8, but points to nothing in the record

² Mr. Saxon oversees Medicaid rates and activities for all Medicaid contracting in South Carolina. R. 106:25-27.

that disputes Mr. Schmoyer's testimony that, in this case, the disclosure omission did not affect the amount of reimbursement Countrywood actually received. R. 165:15-17. In other words, the \$130,000 would have been paid even if the related-party disclosures had been made.

B. Countrywood Has a Right to Enforce the SAO Contract.

A third party whom the parties to a contract intend to be beneficiary has a right to enforce the contract. *Wise v. Picow*, 232 S.C. 237, 244, 101 S.E.2d 651, 655 (1958). The intent of the parties to establish a contractual beneficiary need not be express, but may be implied from circumstances. *Wise*, 232 S.C. at 244, 101 S.E.2d at 655; *E. B. Roberts Constr. Co. v. Concrete Contractors, Inc.*, 704 P.2d 859, 865 n. 7 and accompanying text (1985), citing Restatement (Second) of Contracts § 302 (1981) (the "Restatement") (attached as Exhibit A). It is not necessary that a contract be exclusively for the benefit of a third person to give such person a right of enforcement.³ 17A Am. Jur. 2d *Contracts* § 436, citing *American Trust Co. v. Catawba Sales & Processing Co.*, 242 N.C. 370, 88 S.E.2d 233 (1955). It is sufficient for the third party to show it was a member of a class of intended beneficiaries. *Id.*, citing *Shell v. Schmidt*, 126 Cal. App. 279 (1954).

The circumstances surrounding the two cost report restriction in Article III(D) strongly imply an intent to directly benefit South Carolina nursing homes. The restriction resulted directly from negotiations between DHHS and the South Carolina Health Care Association (the "Association"), a professional organization of nursing

³ This is the majority rule. Appellant is unaware of any South Carolina decision addressing this precise question.

homes whose members include Countrywood. R. 108:22-109:18; 169:25; 170:7; 191:17-20; 1799:24-1800:16; 1803:18-1804:15; 1805:7-1806:25. Under these circumstances, it would clearly be reasonable for a member of the Association, such as Countrywood, to rely on the revision to Article III(D). See Restatement § 302 (Ex. A) at 3, Illustration 9(d) ("if the beneficiary would be reasonable in relying on the promise as manifesting an intention to confer a right on him, he is an intended beneficiary"). The circumstances of the present case are analogous to Illustration 14 in the Restatement:

A, a labor union, enters into a collective bargaining agreement with B, an employer, in which B promises not to discriminate against any employee because of his membership in A. All B's employees who are members of A are intended beneficiaries of the promise.

Ex. A. at 4, Ill. 14. Similarly, all members of the Association who contract with DHHS are intended beneficiaries of DHHS's promise to restrict SAO audits to two cost report periods.

Respondent argues that the separation of powers doctrine prevents this Court from "intervening" in a matter involving two executive agencies. Respondent's Brief at 13 n. 2 and accompanying text. Countrywood, however, is not an executive agency, but a private, third party beneficiary to the SAO Contract with statutory and contractual rights to appeal audit disallowances. S.C. Code Ann. § 1-23-380; R. 282, Art. V (B). The separation of powers doctrine "is not fixed and immutable." *State v. Langford*, 400 S.C. 421, 434, 735 S.E.2d 471, 478 (2012). On the contrary, the doctrine contains "grey areas" and an "overlap of authority" among governmental branches. *Id.*

"Separation of powers does not require that the branches of government be hermetically sealed; the doctrine of

separation requires a cooperative accommodation among the three branches of government; a rigid and inflexible classification of powers would render government unworkable." At its core the doctrine therefore "is directed only to those powers which belong *exclusively* to a single branch of government."

Id. (quoting 16A Am. Jur. 2d, *Constitutional Law* § 244, 246) (emphasis added). The resolution of third party beneficiary claims involving public contracts is not a power belonging exclusively to the executive branch. It is well established that a private third party beneficiary can sue to enforce a contract between public entities. *Touchberry v. City of Florence*, 295 S.C. 47, 367 S.E.2d 149 (1988).

Even if Countrywood were not a third party beneficiary, it would have standing to enforce the SAO Contract under the public importance doctrine. *See ATC South, Inc. v. Charleston County*, 380 S.C. 191, 198, 669 S.E.2d 337, 341 (2008). Respondent argues that the public importance doctrine should not apply to what it characterizes as Countrywood's "private interest" in this matter. Respondent's Brief at 12, ¶ 14. Far from being a private matter, Medicaid audits and reimbursement are of enormous public importance, affecting nursing homes, hospitals, and other healthcare facilities, as well as their patients. Of equal public importance is the extent to which state agencies may disregard the requirements of public contracts to which they are parties. These are clearly matters that need resolution for future guidance. *See Sloan v. School Dist of Greenville Co.*, 342 S.C. 515, 537 S.E.2d 299 (holding that plaintiff had standing through the public importance exception to challenge the validity of public contracts entered into by defendants); *Baird v. Charleston County*, 333 S.C. 519, 511

S.E.2d 69 (1999) (holding that plaintiff had standing under the public importance exception to challenge county issuance of hospital bonds).

II. The SAO Failed to Issue Timely Audit Reports for Countrywood's First Two Cost Report Periods.

Article V, Section 7 of the contract between Countrywood and DHHS (the "Facility Contract") provides: "Any disallowance made pursuant to an on-site audit shall be made in the final audit report, which shall be issued within three (3) years of the close of the contract period" R.449. The Facility Contract defines "contract period" as "the rate period as defined by the South Carolina Health Plan." R. 443. The Plan, however, does not define "rate period." R. 463-503.

Countrywood's Medicaid rate from 11/29/07-5/31/08 was \$129.21. From 6/1/08-9/30/08 its rate was \$134.74. From 10/1/08-9/30/09 its rate was \$135.11. R. 505-06, 121:27-123:3. The SAO's desk audits and final audits and the DHHS's recoupment letter specifically identified these as Countrywood's rate periods. R. 505-06, 511, 520, 361. The SAO did not issue its final audit reports until 11/22/11, over three years from the close of the first two rate periods.

Respondent argues that Countrywood's initial cost report established rates for an extended period of time, but concedes this "established" rate was subject to modification by the State Health Plan. R. 652. It is undisputed that Countrywood's initial rates were, in fact, modified by the Plan, first on June 1, 2008, when it increased from \$129.21 to \$134.74, and again on October 1, 2008, when it increased to \$135.11. R. 121:27-124:6, 361, 505-06, 511- 520.

Respondent asserts that the rate period is "the time frame determined by information contained in a cost report and is not limited to the report period itself." Respondent's Brief at 17. Alternatively, Respondent states the rate period is "the period used to establish the foundation for a provider's reimbursement." *Id.* at 18. Mr. Schmoyer, the only CPA to testify, gave a more specific and common sense definition: a rate period is the period of time where "the payment stays the same." R. 172:25-26. It is clear that Mr. Schmoyer's definition of rate period – the period when a specific rate remains in effect – is the definition routinely used by SAO and DHHS. R. 505-06, 511, 520, 361. Respondent argues that representations of DHHS and SAO employees cannot alter controlling law, but here there is no controlling law on the definition of "rate period." Respondent argues that deference should be given to the Hearing Officer, but the Hearing Officer made no factual finding on the definition of rate period. There is only the consistent practice, evidenced in SAO audit reports and in the recoupment demand authored by Mr. Saxon's "right hand person," R. 120:19-26, that "rate period" means what it says – the period a provider's rate remains in effect.

C.A.N. Enterprises v. S.C. Health and Human Services Finance Comm'n, 296 S.C. 373, 373 S.E.2d 584 (1988) involved a contract between DHHS's predecessor agency ("HHSFC") and Oakmont Nursing Centers ("Oakmont"). The contract required that Medicaid audits be completed within three years of the contract's termination. 296 S.C. at 376, 373 S.E.2d at 585. HHSFC audited Oakmont, completing its on-site reviews within three years, but not issuing final audit reports until after three years had passed. *Id.* at 377, 373 S.E.2d at 586. The contract defined

“audit” as “[t]o examine for the purpose of authentication and to adjust, disallow or reject an account of the provider.” *Id.* at 376, 373 S.E.2d 585. HHSFC argued that an audit, as defined, included only on-site reviews, but not final audit reports. *Id.* at 377, 373 S.E.2d at 586.

The supreme court rejected HHSFC’s position, despite acknowledging that Oakmont would thereby receive a windfall. *Id.* at 377, 373 S.E.2d at 586. First, the court noted that the drafter of the contract was HHSFC. *See Plantation A.D., LLC v. Gerald Bldrs of Conway, Inc.*, 386 S.C. 198, 205, 687 S.E.2d 714, 718 (Ct. App. 2009), (“Any ambiguity in a contract should be resolved against the party who prepared the contract”) Second, the court observed that HHSFC “had every opportunity to protect itself by completing the audit process within the time specified in the contract.” *Id.* Finally, the court relied on some well-established principles of contract construction:

Common sense and good faith are the leading touchstones of construction of the provisions of a contract; where one construction makes the provisions unusual or extraordinary and another construction which is equally consistent with the language employed, would make it reasonable, fair and just, the latter construction must prevail. In construing terms in contracts, this Court must first look at the language of the contract to determine the intentions of the parties.

When a contract is unambiguous, clear and explicit, it must be construed according to the terms the parties have used, to be taken and understood in their plain, ordinary, and popular sense. Extrinsic evidence giving the contract a different meaning from that indicated by its plain terms is inadmissible.

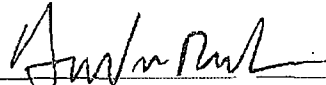
Id. at 377-78, 373 S.E.2d at 586 (citations omitted).

In the present case, as in *C.A.N. Enterprises*, the drafter of the contract is the state agency arguing to extend a contractual limitations period that it missed. Here, as in *C.A.N.*, the agency had every opportunity to issue its audit reports in a timely fashion. Here, as in *C.A.N.*, the agency wishes to impose a construction that is "unusual or extraordinary", while Countrywood urges a construction based on common sense and common usage.

CONCLUSION

For all the reasons set forth above and in Appellant's Initial Brief, Appellant respectfully requests the decision of the DHHS Hearing Officer be reversed.

NELSON MULLINS RILEY & SCARBOROUGH LLP

By: 

Daniel J. Westbrook

dan.westbrook@nelsonmullins.com

Alice V. Harris

alice.harris@nelsonmullins.com

1320 Main Street, 17th Floor

Post Office Box 11070

Columbia, SC 29201

(803) 799-2000

Attorneys for Appellant Countrywood Nursing, LLC

Columbia, South Carolina

May 27, 2015

CERTIFICATE OF SERVICE

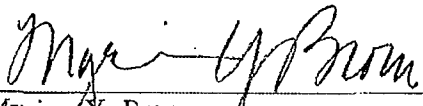
I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Countrywood Nursing, LLC, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by email and by mailing a copy of the same by United States Postal Service, postage prepaid, to the following address(es):

Pleadings:

APPELLANT'S REPLY

Counsel Served:

W. Allen Nickles, III, Esq.
Nickles Law Firm, LLC
1122 Lady Street, Suite 610
Columbia, SC 29201
wanickles@nickleslaw.com


Myriam Y. Brown
Administrative Assistant

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EXHIBIT

A

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Restatement 2d, Contracts - Rule Sections » Chapter 14- Contract Beneficiaries

§ 302 Intended and Incidental Beneficiaries

(1) Unless otherwise agreed between promisor and promisee, a beneficiary of a promise is an intended beneficiary if recognition of a right to performance in the beneficiary is appropriate to effectuate the intention of the parties and either

(a) the performance of the promise will satisfy an obligation of the promisee to pay money to the beneficiary; or

(b) the circumstances indicate that the promisee intends to give the beneficiary the benefit of the promised performance.

(2) An incidental beneficiary is a beneficiary who is not an intended beneficiary.

COMMENTS & ILLUSTRATIONS**Comment:**

a. Promisee and beneficiary. This Section distinguishes an "intended" beneficiary, who acquires a right by virtue of a promise, from an "incidental" beneficiary, who does not. See §§ 304, 315. Section 2 defines "promisee" as the person to whom a promise is addressed, and "beneficiary" as a person other than the promisee who will be benefitted by performance of the promise. Both terms are neutral with respect to rights and duties: either or both or neither may have a legal right to performance. Either promisee or beneficiary may but need not be connected with the transaction in other ways: neither promisee nor beneficiary is necessarily the person to whom performance is to be rendered, the person who will receive economic benefit, or the person who furnished the consideration.

b. Promise to pay the promisee's debt. The type of beneficiary covered by Subsection (1)(a) is often referred to as a "creditor beneficiary." In such cases the promisee is surety for the promisor, the promise is an asset of the promisee, and a direct action by beneficiary against promisor is normally appropriate to carry out the intention of promisor and promisee, even though no intention is manifested to give the beneficiary the benefit of the promised performance. Promise of a performance other than the payment of money may be governed by the same principle if the promisee's obligation is regarded as easily convertible into money, as in cases of obligations to deliver commodities or securities which are actively traded in organized markets. Less liquid obligations are left to Subsection (1)(b).

A suretyship relation may exist even though the duty of the promisee is voidable or is unenforceable by reason of the statute of limitations, the Statute of Frauds, or a discharge in bankruptcy, and Subsection (1)(a) covers such cases. The term "creditor beneficiary" has also sometimes been used with reference to promises to satisfy a supposed or asserted duty of the promisee, but there is no suretyship if the promisee has never been under any duty to the beneficiary. Hence such cases are not covered by Subsection (1)(a). The beneficiary of a promise to discharge a lien on the promisee's property, or of a promise to satisfy a duty of a third person, is similarly excluded from Subsection (1)(a). Such beneficiaries may, however, be "intended beneficiaries" under Subsection (1)(b).

Illustrations:

1. A owes C a debt of \$ 100. The debt is barred by the statute of limitations or by a discharge in bankruptcy, or is unenforceable because of the Statute of Frauds. B promises A to pay the barred or unenforceable debt. C is an intended beneficiary under Subsection (1)(a).

2. B promises A to furnish support for A's minor child C, whom A is bound by law to support. C is an intended beneficiary under Subsection (1)(a).

3. B promises A to pay whatever debts A may incur in a certain undertaking. A incurs in the undertaking debts to C, D and E. If the promise is interpreted as a promise that B will pay C, D and E, they are intended beneficiaries under Subsection (1)(a); if the money is to be paid to A in order that he may be provided with money to pay C, D and E, they are at most incidental beneficiaries.

c. Gift promise. Where the promised performance is not paid for by the recipient, discharges no right that he has against anyone, and is apparently designed to benefit him, the promise is often referred to as a "gift promise." The beneficiary of such a promise is often referred to as a "donee beneficiary"; he is an intended beneficiary under Subsection (1)(b). The contract need not provide that performance is to be rendered directly to the beneficiary: a gift may be made to the beneficiary, for example, by payment of his debt. Nor is any contact or communication with the beneficiary essential.

Illustrations:

4. A, an Insurance company, promises B in a policy of insurance to pay \$ 10,000 on B's death to C, B's wife. C is an intended beneficiary under Subsection (1)(b).

5. C is a troublesome person who is annoying A. A dislikes him but, believing the best way to obtain freedom from annoyance is to make a present, secures from B a promise to give C a box of cigars. C is an intended beneficiary under Subsection (1)(b).

6. A's son C is indebted to D. With the purpose of assisting C, A secures from B a promise to pay the debt to D. Both C and D are intended beneficiaries under Subsection (1)(b).

7. A owes C \$ 100 for money lent. B promises A to pay C \$ 200, both as a discharge of the debt and as an indication of A's gratitude to C for making the loan. C is an intended beneficiary under Subsection (1)(a) as to the amount of the debt and under Subsection (1)(b) as to the excess.

8. A conveys land to B in consideration of B's promise to pay \$ 15,000 as follows: \$ 5,000 to C, A's wife, on whom A wishes to make a settlement; \$ 5,000 to D to whom A is indebted in that amount, and \$ 5,000 to E, a life insurance company, to purchase an annuity payable to A during his life. C is an intended beneficiary under Subsection (1)(b); D is an intended beneficiary under Subsection (1)(a); E is an incidental beneficiary.

9. A owes C \$ 100. Not knowing of any such debt, B promises A to pay \$ 100 to C. C is an intended beneficiary under Subsection (1)(a) if A manifests an intention that the payment is to satisfy the debt, an intended beneficiary under Subsection (1)(b) if A manifests an intention to make a gift of \$ 100, leaving outstanding the original debt.

d. Other intended beneficiaries. Either a promise to pay the promisee's debt to a beneficiary or a gift promise involves a manifestation of intention by the promisee and promisor sufficient, in a contractual setting, to make reliance by the beneficiary both reasonable and probable. Other cases may be quite similar in this respect. Examples are a promise to perform a supposed or asserted duty of the promisee, a promise to discharge a lien on the promisee's property, or a promise to satisfy the duty of a third person. In such cases, if the beneficiary would be reasonable in relying on the promise as manifesting an intention to confer a right on him, he is an intended beneficiary. Where there is doubt whether such reliance would be reasonable, considerations of procedural convenience and other factors not strictly dependent on the manifested intention of the parties may affect the question whether under Subsection (1) recognition of a right in the beneficiary is appropriate. In some cases an overriding policy, which may be embodied in a statute, requires recognition of such a right without regard to the intention of the parties.

Illustrations:

10. A, the operator of a chicken processing and fertilizer plant, contracts with B, a municipality, to use B's sewage system. With the purpose of preventing harm to landowners downstream from its system, B obtains from A a promise to remove specified types of waste from its deposits into the system. C, a downstream landowner, is an intended beneficiary under Subsection (1)(b).

11. A, a corporation, contracts with B, an insurance company, that B shall pay to any future buyer of a car from A the loss he may suffer by the burning or theft of the car within one year after sale. Later A sells a car to C, telling C about the insurance. C is an *intended beneficiary*.

12. B contracts to build a house for A. Pursuant to the contract, B and his surety S execute a payment bond to A by which they promise A that all of B's debts for labor and materials on the house will be paid. B later employs C as a carpenter and buys lumber from D. C and D are intended beneficiaries of S's promise to A, whether or not they have power to create liens on the house.

13. C asserts that A owes him \$ 100. A does not owe this money, or think that he owes it, but rather than engage in litigation and in order to obtain peace of mind A secures a promise from B to pay C \$ 100. C is an *intended beneficiary*.

14. A, a labor union, enters into a collective bargaining agreement with B, an employer, in which B promises not to discriminate against any employee because of his membership in A. All B's employees who are members of A are intended beneficiaries of the promise.

15. A buys food from B, a grocer, for household use, relying on B's express warranty. C, A's minor child, is injured in person by breach of the warranty. Under Uniform Commercial Code § 2-318, without regard to the intention of A or B, the warranty extends to C.

e. Incidental beneficiaries. Performance of a contract will often benefit a third person. But unless the third person is an intended beneficiary as here defined, no duty to him is created. See § 315.

Illustrations:

16. B contracts with A to erect an expensive building on A's land. C's adjoining land would be enhanced in value by the performance of the contract. C is an *incidental beneficiary*.

17. B contracts with A to buy a new car manufactured by C. C is an *incidental beneficiary*, even though the promise can only be performed if money is paid to C.

18. A, a labor union, promises B, a trade association, not to strike against any member of B during a certain period. One of the members of B charts a ship from C on terms under which such a strike would cause financial loss to C. C is an *incidental beneficiary* of A's promise.

19. A contracts to erect a building for C. B then contracts with A to supply lumber needed for the building. C is an *incidental beneficiary* of B's promise, and B is an *incidental beneficiary* of C's promise to pay A for the building.

f. Trust and agency. Where money or property is transferred from one person to another with an intention to benefit a third person, the manifested intention of the parties determines whether the transferee is an agent for the transferor or the third person or a trustee for the third person or whether the third person is the beneficiary of a promise

made by the transferee. See Restatement, Second, Agency §§ 14B, 14L; Restatement, Second, Trusts §§ 8, 14. Similarly, an agreement between two parties may constitute one the agent of the other to confer a benefit on a third person, or the promise of one may be made to the other as trustee for a third person, or a third person may be the beneficiary of a promise of either or both; the manifested intention of the parties determines which of these possible relations is created for the particular purpose involved. There is a fiduciary relation between agent and principal or between trustee and beneficiary, but not between promisor or promisee and beneficiary of a contract. Agency requires the consent of the principal and the agent; a trust or a contract for the benefit of a third person does not require the consent of the beneficiary. Either the promisee or the beneficiary of a promise may be made a trustee of rights arising by virtue of the promise; although the beneficiary of such a trust is a beneficiary of the promise under this Section, his rights must be enforced in accordance with the law of Trusts. See Restatement, Second, Trusts §§ 26, 177, 199.

Illustration:

20. A, an insurance company, promises B in a policy of insurance to pay \$ 10,000 on B's death to C as trustee for B's wife D. C is an intended beneficiary and may enforce his rights as trustee; D's rights as beneficiary of the trust and the contract are enforceable only in the manner in which rights of other trust beneficiaries are enforced.

REPORTER'S NOTES

The definition of "intended beneficiary" is new; it comprehends all those included as "donee" and "creditor" beneficiaries in former § 133. For the reasons stated in the Introductory Note to this Chapter, the terms "donee beneficiary" and "creditor beneficiary" are not used. In addition, the word "donee" was not entirely appropriate to the beneficiary of an executory gift promise; it was sometimes entirely inappropriate where "the purpose of the promise," under Subsection (1)(a) of former § 133 was not "to make a gift" but "to confer a right." See Note, The Third Party Beneficiary Concept: A Proposal, 57 Colum. L. Rev. 406, 423-25 (1957). The new language in the preamble of Subsection (1) takes account of factors not dependent on intention, as stated in Comment d. Subsections (2) and (3) of former § 133 are deleted; Subsection (3) is replaced by Comment f.

See 2 Williston, Contracts §§ 347-56 (3d ed. 1959); 4 Corbin, Contracts §§ 772-81 (1951 & Supp. 1980).

The text of this Section (as § 133) was revised several times, and appeared in different forms in Tentative Draft No. 3 (1967), Tentative Draft No. 4 (1968) and the Revised and Edited version of Tentative Drafts Nos. 1-7 (1973). The 1973 text is identical to that shown here. Cases and articles discussing the text of the tentative drafts of this Section often are referring to earlier versions. See, e.g., Note, 27 Hastings L.J. 137, 144 (1975), quoting the text of Tentative Draft No. 4, but making no reference to the 1973 published version.

Comment a. For discussions of the parties' intention as a key factor in third party beneficiary contract analysis, see Note, Third Party Beneficiaries and the Intention Standard: A Search for Rational Contract Decision-Making, 54 Va. L. Rev. 1166 (1968); Note, Martinez v. Socoma Companies: Problems In Determining Contract Beneficiaries' Rights, 27 Hastings L.J. 137 (1975); Costanza v. Costanza, 346 So.2d 1133 (Ala. 1977). See also Jones, Legal Protection of Third Party Beneficiaries: On Opening Courthouse Doors, 46 U. Cinn. L. Rev. 313 (1977). A court in determining the parties' intention should consider the circumstances surrounding the transaction as well as the actual language of the contract. See Cutler v. Hartford Life Ins. Co., 22 N.Y.2d 245, 292 N.Y.S.2d 430, 239 N.E.2d 361 (1968) (citing the 1973 Tentative Draft of this Section and Comments); CF Indus. v. Transcontinental Gas Pipe Line Corp., 448 F. Supp. 475 (W.D.N.C. 1978); Gilbert Fin. Corp. v. Steelform Contracting Co., 82 Cal. App.3d 65, 145 Cal. Rptr. 448 (1978); Ross v. Imperial Constr. Co., 572 F.2d 518 (5th Cir. 1978); American Elec. Power Co. v. Westinghouse Elec. Corp., 418 F. Supp. 435 (S.D.N.Y. 1976). Republic Nat'l Bank v. National Bankers Life Ins. Co., 427 S.W.2d 76, 81 (Tex. Civ. App. 1968), ref. n.r.e., is a leading exponent of the view that a court should not go beyond "the four corners of [the] instrument." (See also American Elec. Power Co. v. Westinghouse Elec. Corp., supra, at 447, discussing the similar Pennsylvania rule.) Nonetheless, a later Texas case considered the surrounding circumstances at some length, Suthers v. Booker Hosp. Dist., 543 S.W.2d 723, 727-29 (Tex. Civ. App. 1976), ref. n.r.e.; in the dissent in that case, id. at 731, 733-34, Chief Justice Ellis also examined the circumstances, although he drew a different conclusion as to the parties' intentions. See also Texas Bank & Trust Co. v. Lone Star Life Ins. Co., 565 S.W.2d 353 (Tex. Civ. App. 1978), in which the court purported to apply the rule of Republic Nat'l Bank, supra, but examined the circumstances to see if a mortgage commitment letter was assignable. See also Comment d.

Comment b. Illustration 1 is based on Illustration 6 to former § 133. Illustration 2 is based on Illustration 8 to former § 133; contrast Spates v. Spates, 267 Md. 72, 296 A.2d 581 (1972). Illustration 3 is based on Illustration 9 to former § 133; see also Hurley v. Lano Int'l, Inc., 569 S.W.2d 602 (Tex. Civ. App. 1978), ref. n.r.e., citing this Illustration in Tentative Draft. On whether an interim lender is an intended beneficiary of a long term mortgage commitment (a "takeout" mortgage), see, e.g., Texas Bank & Trust Co. v. Lone Star Life Ins. Co., 565 S.W.2d 353 (Tex. Civ. App. 1978); Republic Nat'l Bank v. National Bankers Life Ins. Co., 427 S.W.2d 76 (Tex. Civ. App. 1968), ref. n.r.e.

Comment c. Illustration 4 is new. Illustration 5 is based on Illustration 2 to former § 133. Illustration 6 is new. Illustrations 7-9 are based on Illustrations 1, 5 and 7 to former § 133.

Comment d. Situations in which neither a debt analysis nor a gift analysis is satisfactory include the takeout mortgage commitment, discussed in the Reporter's Note to Comment b. The reliance analysis discussed in this Comment appears more useful, but would raise issues of the reasonableness and probability of the reliance by the interim lender. Since the interim lender may require a long term mortgage commitment before making the

Interim loan, a reliance analysis would appear to require a change in the result of the cases cited. This could be avoided by an express statement in the long term mortgage commitment letter disclaiming any intention to create third party beneficiary rights in interim lenders. On reliance, see *Commercial Ins. Co. v. Pacific-Peru Constr. Corp.*, 558 F.2d 948 (9th Cir. 1977), citing this Comment in Tentative Draft; Note, 54 Va. L. Rev. 1166 (1968), *supra*. Cases in which there was an element of reasonable and probable reliance by a third party, but in which this factor was not discussed include *Suthers v. Booker Hosp. Dist.*, 543 S.W.2d 723 (Tex. Civ. App. 1976), *ref. n.r.e.* (finding no third party beneficiary contract); and *CF Indus. v. Transcontinental Gas Pipe Line Corp.*, 448 F. Supp. 475 (W.D.N.C. 1978) (finding that plaintiffs stated a claim as intended beneficiaries); cf. *H. R. Moch Co. v. Rensselaer Water Co.*, 247 N.Y. 160, 159 N.E. 896 (1928).

Illustration 10 is based on *Ratzlaff v. Franz Foods*, 250 Ark. 1003, 468 S.W.2d 239 (1971). Illustrations 11-13 are based on Illustrations 3, 4 and 10 to former § 133. As to Illustration 12, see *Ross v. Imperial Constr. Co.*, 572 F.2d 518 (5th Cir. 1978); *Ceco Corp. v. Plaza Point, Inc.*, 573 S.W.2d 92 (Mo. Ct. App. 1978) (discussing both payment and performance bonds and citing this Comment in Tentative Draft); *Town & Country Bank v. James M. Canfield Contracting Co.*, 55 Ill. App.3d 91, 12 Ill. Dec. 826, 370 N.E.2d 630 (1977) (discussing differing lines of authority). Illustration 14 is new and is suggested by *Smith v. Evening News Ass'n*, 371 U.S. 195 (1962); cf. *Charles Dowd Box Co. v. Courtney*, 368 U.S. 502 (1962). Illustration 15 is new; in *Rhodes Pharmacal Co. v. Continental Can Co.*, 72 Ill. App.2d 362, 219 N.E.2d 726 (1966), it was held that Uniform Commercial Code § 2-318 did not exclude other seller's warranties to non-consumer third parties.

Comment e. Illustrations 16 and 17 are based on Illustrations 11 and 12 to former § 133. Illustration 18 is based on *Isbrantsen Co. v. Local* 1291, 204 F.2d 495 (3d Cir. 1953). Illustration 19 is based on Illustration 1 to former § 147.

Comment f. Illustration 20 is based on Illustration 13 to former § 133. On the status of an injured party under the tortfeasor's liability insurance policy, see *Chitlik v. Allstate Ins. Co.*, 34 Ohio App.2d 193, 299 N.E.2d 295 (1973).

Cross Reference

ALR Annotations:

Third-party beneficiaries of warranties under UCC § 2-318. 100 A.L.R.3d 743.

Right of architect to compensation under contractual provision that fee is to be paid from construction loan funds. 92 A.L.R.3d 509.

Tenant's capacity to sue independent contractor, as third-party beneficiary, for breach of contract between landlord and such contractor for repair or remodeling work. 46 A.L.R.2d 1210.

Right of owner's employee, injured by subcontractor, to recover against general contractor for breach of contract between latter and owner requiring contractor and subcontractors to carry insurance. 22 A.L.R.2d 647.

Right of third person not named in bond or other contract conditioned for support of, or services to, another, to recover thereon. 11 A.L.R.2d 1010.

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IN THE STATE OF SOUTH CAROLINA
In The Administrative Law Court

APPEAL FROM
THE SOUTH CAROLINA DIVISION OF APPEALS AND HEARINGS
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 15-ALJ-08-0014-AP

Countrywood Nursing, LLC,

Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

RESPONDENT'S BRIEF

W. Allen Nickles, III
Nickles Law Firm, LLC
1122 Lady Street, Suite 610
Columbia, South Carolina 29201
803-779-8080
wanickles@nickleslaw.com

Attorney for Respondent

STATEMENT OF ISSUES ON APPEAL

1. Whether Appellant's initial cost report was subject to review by the SAO.

Appellant claims that the contract between the South Carolina Department of Health and Human Services ("SCDHHS") and the State Auditor's Office ("SAO") limits audit reviews to two cost report periods. Appellant asserts that it is a third-party beneficiary of the contract between SCDHHS and the SAO. Appellant further asserts that "public interest" confers standing to enforce the contract between SCDHHS and the SAO.

2. Whether SCDHHS is barred from recovering overpayments to Appellant identified by the SAO

Appellant claims that the contract between SCDHHS and the Appellant bars recovery of disallowances in audit report AC #3-RDM-E8 (addressing the cost report for the period November 29, 2007 through May 31, 2008 and the rate period through September 30, 2009). Appellant asserts that certain disallowances identified in this report were issued more than three years following the close of the contract period under review, thereby preventing SCDHHS from recovering identified overpayments for the period November 29, 2007 through September 30, 2008. Based upon these claims, Appellant seeks to retain \$546,968 in identified overpayments for Medicaid services.¹

¹ The cost report for the period November 29, 2007 through May 31, 2008 alone resulted in an overpayment of \$292,592.00.

STATEMENT OF THE CASE

Appellant, Countrywood Nursing Center, LLC, is a 38-bed nursing facility in Hopkins, South Carolina. Appellant provides services under the South Carolina Medicaid program administered by Respondent, SCDHHS.

SCDHHS contracts with SAO to conduct audit reviews and identify reported costs that do not meet program requirements. On November 22, 2011, SAO issued the final audit reports that are subject to this appeal. Appellant filed a timely appeal for the audit reports AC#3-RDM-J9, cost report period 10/1/08 to 9/30/09 (Appeal Case 12-AUD-010), AC#3-RDM-J8, cost report period 11/29/97 to 9/30/08 (Appeal Case 12-AUD-011) and AC#3-RDM-E8, cost report period 11/29/07 to 5/31/08 (Appeal Case 12-AUD-012). Appellant's appeal included its opposition to a recoupment notice requesting repayment of \$546,968 resulting from the cost report audits. Appellant and SCDHHS participated in a prehearing conference, exchanged documents, conducted depositions and filed prehearing briefs. A motion for summary judgment filed by Appellant was denied by order dated December 19, 2012 with permission to raise the issues presented in the hearing.

The hearing was convened on September 17, 2014, in Columbia, South Carolina. The Hearing Officer issued the agency's Final Administrative Decision on December 16, 2014. (R. pp. 8-22) This appeal followed.

STANDARD OF REVIEW

This appeal is governed by the Administrative Procedures Act ("APA"). Under the APA, a reviewing court:

[M]ay not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of

fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

- (a) in violation of constitutional or statutory provisions;
- (b) in excess of the statutory authority of the agency;
- (c) made upon unlawful procedure;
- (d) affected by other error of law;
- (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
- (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(5)

This standard of review is commonly referred to as the substantial evidence rule. Under the substantial evidence rule, a reviewing court "may reverse or modify an administrative decision if such decision is affected by errors of law, characterized by an abuse of discretion, or clearly erroneous in view of the substantial evidence on the whole record." Todd's Ice Cream, Inc. v. S. Carolina Employment Sec. Comm'n, 281 S.C. 254, 258, 315 S.E.2d 373, 375 (Ct. App. 1984)

"Substantial evidence" is something less than the weight of the evidence; it is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached in order to justify its action. The substantial evidence rule does not allow judicial fact-finding, or the substitution of judicial judgment for agency judgment.

Id.; see also, Friends of Earth v. Pub. Serv. Comm'n of S.C., 387 S.C. 360, 366, 692 S.E.2d 910, 913 (2010) (Substantial evidence is "evidence which, considering the record

as a whole, would allow reasonable minds to reach the same conclusion as the agency") Furthermore, "[t]he findings of the agency are presumed correct and will be set aside only if unsupported by substantial evidence." Kcarse v. State Health & Human Servs. Fin. Comm'n, 318 S.C. 198, 200, 456 S.E.2d 892, 893 (1995) The possibility of drawing two inconsistent conclusions from the evidence does not mean the agency's conclusion is unsupported by substantial evidence. Waters v. S.C. Land Res. Conservation Comm'n, 321 S.C. 219, 226, 467 S.E.2d 913, 917 (1996) Appellant bears the burden "to prove convincingly that the agency's decision is unsupported by the evidence." Id.

RELEVANT FACTS

The following facts contained in the record and relied upon by the Hearing Officer provide substantial support for the decision on appeal:

1. Providers of Medicaid services are reimbursed for their allowable costs in accordance with Medicare principles as found in the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (HIM-15), unless modified by the State Plan.
2. Costs that are reasonable, necessary and related to patient-care are allowable, reimbursable costs under State Plan and HIM-15.
3. As a condition of participation in seeking Medicaid reimbursement, providers must follow the rules set forth in the HIM-15 and State Plan.
4. HIM-15-1, Section 2304 (Adequacy of Cost Information) states in part: "Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions,

purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning cost, etc.), which pertain to the determination of reasonable cost, capable of being audited. . .”

5. The State Plan governs delivery of Medicaid services in South Carolina. (R. pp. 231-270) Appellant concedes that the State Plan is an “organic” document that must be read as a whole. (R. p. 617)

6. The State Plan provides that: “All nursing facilities are required to detail their cost for the entire reporting period...” (R. p. 231, Attachment 4.19-D, I. (B))

7. The State Plan provides that cost reports submitted by nursing facilities: “shall be certified by the operator...” (R. p. 232, Attachment 4.19-D, I. (D))

8. The State Plan provides that all nursing facilities must maintain accurate and detailed financial records for “at least six (6) years following the end of the contract period for which the cost report was used to set this rate...” and that such records “must be made available upon demand to representatives of the Medicaid Agency [SCDHHS], or the State Auditor...” (R. p. 233, Attachment 4.19-D, I. (C))

9. The State Plan provides that: “All cost reports are subject to on-site audit.” If there is a dispute about audit findings, “[t]he provider has the right to appeal...” through the present process. (R. p. 242, Attachment 4.19-D, II. (F))

10. Appellant entered the South Carolina Medicaid program on November 29, 2007, having obtained an existing nursing facility (Ridgeview Manor). Appellant accepted assignment of the contract for Medicaid services entered between Ridgeview Manor and SCDHHS. (R. p. 272)

11. As a "new facility" Appellant filed an initial cost report for the period November, 29, 2007 through May 31, 2008, rather than the usual annual cost report filed by facilities operating in South Carolina for a year or more. (R. p. 248, Attachment 4.19-D, III. (E)) This initial cost report set the Appellant's reimbursement rates through September 30, 2009. (R. pp. 181-182, 612-613)

12. The contract assumed by Appellant provides that: "For purposes of Article V, Section F only [Time Limit on Issuance of the Final Audit Report], the contract period will be the rate period as defined by the South Carolina State Plan." (R. p. 277, Appellant Contract Article II)

13. The contract assumed by Appellant "expressly incorporates" designated governing laws, regulations, guidelines, and amendments including the State Plan. (R. p. 279, Appellant Contract Article III)

14. The contract assumed by Appellant provides for audits and appeal from audit disallowances. (R. pp. 282-283, Appellant Contract Article V (A) and (B))

15. The contract assumed by Appellant provides that final audit reports "shall be issued within three (3) years of the close of the contract period..." (R. p. 283, Appellant Contract Article V (F))

16. The contract assumed by Appellant provides that all cost reports "shall be certified as true, accurate, and complete..." and shall not include claims for payment that the provider "knows, or has reason to know, are not properly prepared or payable..." (R. pp. 283-284, Appellant Contract Article V (G))

17. The contract assumed by Appellant provides that financial records shall be maintained for the same six year period designated in the State Plan and that such records

are subject to inspection "at any time" by SCDHHS, the SAO and other identified agencies. (R. pp. 283-284, Appellant Contract Article V (G)(1) and (2))

18. The contract assumed by Appellant provides that it "shall be construed to be the complete integration of all understandings between the parties hereto." (R. p. 291, Appellant Contract Article IX (L))

19. SCDHHS and SAO have entered contracts for "Agreed -Upon Procedure Activities Related To Medicaid Institutional Providers." These contracts provide that the parties "have a common and concurrent interest in ascertaining that expenditures of Medicaid funds is in accordance with the Provider contracts and the State Plan." (R. p. 300, SCDHHS/SAO Contract)

20. The cost reports submitted by Appellant contain the following certification: "Under penalties of perjury, I declare that I have examined this cost report, including any accompanying schedule and/or statement, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of the preparer (other than facility owner/personnel) is based on all information of which the preparer has knowledge)" (R. pp. 759, 799)

21. Appellant's initial cost report, for the period November 29, 2007 through May 31, 2008, was signed by its representative on February 11, 2009. (R. pp. 759-798) This cost report did not disclose related party transactions involving the purchase of more than \$60,000.00 in "minor equipment." (R. p. 788)

22. Appellant's second cost report, for the period November 29, 2007 through September 30, 2008 was signed by its representative on May 12, 2009. (R. pp. 799-839) Like Appellant's initial report, this second cost report did not disclose related party

transactions involving the purchase of more than \$60,000.00 in "minor equipment." (R. p. 828)

23. Because Appellant's initial cost report was used to set the reimbursement rates through September 30, 2009, non-recurring expenses, including disallowed "minor equipment" purchases, had a reimbursement impact of \$131,665.00. (R. pp. 651-652)

24. Terry Schmoyer, prepared the cost reports for Appellant. Mr. Schmoyer admitted that the "minor equipment" reported by Appellant was obtained through a related party that was not disclosed as required and certified. Mr. Schmoyer further admitted that Appellant did not retain records of this transaction. Such records are required as a condition of reimbursement by contract, State Plan and controlling guidelines. (R. pp. 157, 161-162, 174-178)

25. The SAO requested documentation relating to the challenged cost reports on July 15, 2011. (R. p. 328)

26. The SAO issued final audit reports to Appellant on November, 22, 2011. (R. pp. 359, 380, 396) The reports identified overpayments of \$546,968. (R. pp. 505-506)

27. Following issuance of the final audit reports, SAO continued to receive and consider additional information from Appellant through at least August 6, 2012. (R. pp. 187-188, 542)

GOVERNING LAW

This appeal centers upon the terms of contracts and the State Plan that address review of costs associated with providing Medicaid services by nursing facilities in South Carolina. SCDHHS is the agency designated by the State to administer this program and to hear reimbursement appeals. (R. pp. 922-925) SCDHHS contracts with facilities such

as Appellant to provide services and with SAO to review the costs claimed by facilities for delivering the services to eligible recipients. The following legal principles govern the issues presented for review.

1. In a contest involving review of a statute, regulation or other public document, the plain language of the document in question controls and there is no need for explanation by way of testimony. See, Paschal v. State Election Comm'n., 317 S.C. 434, 436, 454 S.E.2d 890, 892 (1995)

2. If there is any question about the meaning or intent of a public document, it is the responsibility of the reviewing body to ascertain the public interest at stake and to rule in a manner that serves that interest. Kiriakides v. United Artists Communications, Inc., 312 S.C. 271, 440 S.E.2d 364 (1994) (an interpretation that leads to an unintended result must be rejected)

3. In determining intent, the reviewing body may consider the interpretation and application of the agency responsible for execution of the legislation. See, Nucor Steel v. South Carolina Public Serv. Comm'n., 310 S.C. 539, 426 S.E. 2d. 319 (1992)

4. Where an administrative agency has consistently applied a statute or regulation in a particular manner, its construction may not be overturned absent cogent reasons. S.C. Cable Television Ass'n. v. Southern Bell Tel. & Tel. Co., 308 S.C. 216, 417 S.E.2d 586 (1992); Emerson Electric Co. v. Wasson, 278 S.C. 394, 339 S.E.2d 118 (1986)

5. The words used in a statute or regulation should be given their ordinary and common meaning, consistent with their manifest purpose. See, Floyd v. Nationwide Mut. Ins. Co., 367 S.C. 253, 260, 626 S.E.2d 6, 10 (2005) A construction or interpretation

that leads to an absurd or unintended result must be rejected. Peake v. S.C. Dept. of Motor Vehicles, 375 S.C. 589, 599, 654 S.E.2d 284, 289 (Ct. App. 2007); Jones v. State Farm Mut. Auto Ins. Co., 364 S.C. 222, 232, 612 S.E.2d 719, 724 (Ct. App. 2005)

6. Contractual language is to be construed according to its plain terms and courts are not at liberty to consider unexpressed or secret intentions. Sec. Lee v. University of South Carolina, 407 S.C. 512, 517, 757 S.E.2d 394, 397 (2014)

7. Courts are without authority to alter a contract by construction or to make new contracts for the parties. C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission, 296 S.C. 373, 378, 373 S.E.2d 584, 587 (1988), *citing* Gilstrap v. Culpepper, 283 S.C. 83, 320 S.E.2d 445 (1984)

8. In construing the terms in contracts, courts "must first look to the language of the contract to determine the intentions of the parties." 296 S.C. at 377, 373 S.E.2d at 586, *citing* Superior Automotive Insurance Co. v. Maners, 261 S.C. 257, 263, 199 S.E.2d 719, 722 (1973)

9. Parole or other extrinsic evidence may be considered only if a contract is ambiguous and the evidence may be admitted only to show the intent of the parties. Hawkins v. Greenwood Dev. Corp., 328 S.C. 585, 592, 493 S.E.2d 875, 888-89 (Ct. App. 1997)

10. Appellant contends that the C.A.N. Enterprises opinion requires a finding that audit report AC #3-RDM-E8 (addressing the cost report for the period November 29, 2007 through May 31, 2008 used to set the reimbursement rate through September 30, 2009) was issued in an untimely fashion as it relates to the period November 29, 2007 through September 30, 2008. (Appellant Brief pp. 9-11) The C.A.N. opinion addressed

language in a **former** contract between the **former** state Medicaid agency and a provider of services. The opinion does not involve interpretation of any agreement between state agencies. Accordingly, C.A.N. has no application to this appeal.

11. Should the court wish to examine the C.A.N. holding, the Hearing Officer correctly observed that the **former** Medicaid services contract contested in C.A.N. required audits to be conducted “during the contract period and . . . after termination of this contract and for a period of three years thereafter.” 266 S.C. at 376, 373 S.E.2d at 585 The Supreme Court held this **former** Medicaid services contract language required audit reports to be issued within three years of the contract ending date. The audit periods applicable to current contracts are governed by the “**rate period** as defined by the South Carolina State Plan.” (R. p. 277, Appellant Contract Art. II, Definitions “Contract Period”)) The deadline for issuance of the challenged audit report differs from deadline addressed in the C.A.N. opinion. Additionally, the SCDHHS/SAO contract provides that reports shall be issued no later than three (3) years **after the end of the closed rate period that is associated with the preceding cost report period.**” (R. p. 301, SCDHHS/SAO Contract Article III (D)(1)) (emphasis added) The challenged report was issued within three years of the rate period “associated with” Appellant’s initial audit report.

12. Appellant contends that it has third party beneficiary standing to challenge the SCDHHS/SAO. (Appellant Brief pp. 5-6) A third party has no right to enforce a contract absent a showing that the contract is intended to create a direct rather than incidental or consequential benefit to the third person. See, Wogan v. Kunze, 366 S.C. 583, 604, 623 S.E.2d 107, 118 (Ct. App. 2007)

13. Appellant contends that “public interest” supports its intervention in the contract between SCDHHS and the SAO. (Appellant Brief pp. 6-7) No authority offered by Appellant supports this argument. For example, Sloan Construction Co., Inc. v. Southco Grassing, Inc., 377 S.C. 108, 659 S.E.2d 158 (2008) holds that a third party breach of contract claim may apply against a public entity only if supported by an expression of legislative intent. In Sloan, the required intent was expressed in a statute requiring contractors to maintain bonds protecting the interest of subcontractors on public projects. No such expression of intent is contained in the contract between SCDHHS and SAO. To the contrary, the public interest in confining Medicaid payments to costs documented as reasonable and necessary to achieve program purposes would be undermined by allowing providers to limit audit reviews in a manner inconsistent with the State Plan and controlling law. The limit proposed by Appellant would also subvert legislation incorporated in the SCDHHS/SAO contract authorizing the SAO to review Medicaid costs to the full extent available under state and federal law. (R. p. 300, SCDHHS/SAO Contract, “Recitals”))

14. Appellant contends that the need for “future guidance” supports standing to intervene in the contractual relationship between SCDHHS and the SAO, citing ATC South, Inc. v. Charleston County, 380 S.C. 191, 669 S.E.2d 337 (2008) (Appellant Brief p.6-7) Appellant’s private interest in maintaining unearned public funds does not satisfy the “level of public importance” necessary to establish standing. Additionally, SCDHHS and the SAO may modify their contractual agreement at any time without participation by Appellant or other providers of Medicaid services. Accordingly there is no public

interest or future guidance to be served by allowing Appellant to intervene in the relationship between two executive branches of government.

15. The task of the judicial system is to administer judicial functions only. Intervention in legislative, policy or executive functions is both unwarranted and in violation of the constitution. See, State ex rel. McLeod v. Younce, 274 S.C. 81, 261 S.E.2d 303, 306 (1979)

16. The General Assembly "may direct, by law, in what manner claims against the State may be established and adjusted." S.C. Const. art. X § 10.12

17. A ruling on appeal may be affirmed on any ground supported by the record. P'On L.L.C. v. Town of Mt. Pleasant, 338 S.C. 406, 417, 526 S.E.2d 716, 722 (2000); Dreher v. S.C. Dept. of Health and Environmental Control, 2015 WL 1223709 (S.C. March 18, 2015)

LEGAL ARGUMENT

I. Appellant's initial cost report was subject to review by the SAO.

Appellant's argument that the SAO is contractually barred from examining more than two cost reports for purposes of issuing final audit reports is not a matter of controversy for disposition by this court.² Should the court wish to consider Appellant's argument, neither the record nor controlling law provide a basis for returning the overpayments requested. For example, the SCDHHS/SAO contract provides that the SAO shall conduct "all engagements to determine if the reimbursement rate or amount is in

² Appellant's request that this court intervene in an agreement between two executive agencies is inconsistent with the constitutional separation of powers jealously guarded by all branches of government. See, S.C. Const. art. 1 § 8; Hampton v. Haley, 403 S.C. 395, 743 S.E.2d 258 (2013) (General Assembly plenary power to legislate and executive branch tasked with faithful execution). There being no contest between SCDHHS and the SAO, and no violation of law, there is no justiciable controversy requiring intervention by this court in the relationship between two executive branches of government.

accordance with the provision of the provider contracts, State Plan, and all state and federal laws and regulations.” (R. p. 302, SCDHHS/SAO Contract Art. III, ¶ B.3)) Limiting audit reviews in a manner inconsistent with governing law would be improper and exceed the authority of this court.

The SCDHHS/SAO contract states that it is the complete integration of all understandings between the parties. (R. p. 309, SCDHHS/SAO Contract Art. IX, ¶ H)) The contract’s express purpose is to serve a “common and concurrent interest in ascertaining that the expenditure of Medicaid funds is in accordance with the Provider contracts and the State Plan.” Even without this language, the controlling State Plan makes all records required to be maintained by Medicaid providers available on demand to the SAO. (R. p. 233, State Plan Attachment 4.19-D, ¶ I (E))

If the two reporting periods referenced in the contract were intended to limit audit reviews, a construction denied by SCDHHS, the audit review language would contain limiting terms such as “only.” This limitation is not stated in the contract and may not be added to alter the agreement between the parties. (R. p. 303, SCDHHS/SAO Contract Art. III, ¶ D.1); See also, Lee v. University of South Carolina, 407 S.C. 512, 517, 757 S.E.2d 394, 397 (2014); C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission, 296 S.C. 373, 378, 373 S.E.2d 584, 587 (1988), citing Gilstrap v. Culpepper, 283 S.C. 83, 320 S.E.2d 445 (1984)

Appellant is not a party to the SCDHHS/SAO contract. Moreover its agreement with SCDHHS acknowledges that: “All decisions and determinations regarding the administration of the Medicaid program shall be made by SCDHHS.” (R. p. 294, Appellant Contract Art. IX, ¶ GG “Single State Agency Responsible for Medicaid”)

Appellant's agreement also makes clear that SAO shall have access to Appellant's records for a period of six years following any contract, including amendments or extensions. (R. p. 284, Appellant Contract Art. V, ¶ G.2) This is consistent with the State Plan section on "Auditing" authorizing on site audit of "all cost reports." (R. p. 242, State Plan Attachment 4.19-D ¶ II (F) "Auditing")

Appellant's reading of the contract between SCDHHS and SAO would lead to the absurd result of restricting SAO from examining available records and prohibiting recovery of unnecessary and undocumented costs even when the provider reports and certifies costs without required documentation. Neither the plain language of the contract nor the State Plan supports such an outcome. Moreover, there is no evidence that Appellant relied on the alleged limitation or has suffered any prejudice (apart from repaying unearned funds). As in any contractual relationship, it is for the parties to determine the nature of their agreement. Absent a dispute between SCDHHS and SAO or a statutory mandate, there is no basis to impose a limit on auditors' access to information or issuance of reports.³ Accordingly, Appellant's attempt to intervene in the contractual relationship between SCDHHS and SAO is not supportable.

Appellant is responsible for documenting costs sufficient to demonstrate that purchases were made, used for patient care and meet all requirements for reimbursement. All transactions between related parties (entities that share common ownership or control) must be documented and limited to actual costs. Reporting undocumented

³ Jeff Saxon is the person responsible for drafting both the SCDHHS/SAO contract and the contract assumed by Petitioner. In addition, Mr. Saxon is responsible for State Plan provisions. (R. pp. 190, 651-652) Any question concerning the construction of contractual or Plan language must take into account Mr. Saxon's testimony that, read together, these provisions are intended to allow the SAO full access to Medicaid provider records.

related party costs is an irregularity warranting further review, even if the report related to a period outside the review process.

Terry Schmoyer testified as Appellant's expert and was responsible for preparing Appellant's cost reports. Mr. Schmoyer admitted that undocumented, undisclosed related party transactions were reported for reimbursement. Mr. Schmoyer further admitted that the related party and undocumented nature of these costs were known before the audit review. (R. pp. 161-162, 174-178, 181) Submitting costs that a provider knows or has reason to know are not "true, correct and accurate" violates the cost report certification required as a condition of obtaining reimbursement for Medicaid services. (R. pp. 759, 799) The reporting of undocumented costs authorized review of Appellant's initial report, regardless of the number or the timing of the report. (R. p. 306, SCDHHS/SAO Contract Art. VI. 6, ¶ A(2); R. pp. 283-284, Provider Contract Art. V, ¶ G; R. pp. 231-233, State Plan 4.19-D) Based upon this record, the Hearing Officer correctly determined that Appellant has no enforceable claim to maintain unearned public funds.

II. SCDHHS is not barred from recovering overpayments to Appellant.

Appellant further argues that SCDHHS is barred from recovering identified overpayments in report AC #3-RDM-E8 (addressing the cost report for the period November 29, 2007 through May 31, 2008 used to set the reimbursement rate through September 30, 2009) as it relates to the period November 29, 2007 through September 30, 2008. Appellant contends that the language of its contract with SCDHHS supports this position.

The contract assumed by Appellant specifies that "the contract period will be the rate period as defined by the South Carolina State Plan." The State Plan identifies both

initial cost reports (commonly called "six month reports" although the periods of less than a year may vary) and annual cost reports. Six month reports follow a change of ownership and allow the new owner an opportunity to obtain a new prospective reimbursement rate. The initial report set the rates for extended periods of time, here November 29, 2007 through September 30, 2009. Differences in reimbursements during this extended period are based on inflation and amendments to the State Plan, not changes in Appellant's costs. Because the "rate period" determined by Appellant's initial report extended far beyond the period reported and reviewed, Appellant enjoyed significantly enhanced reimbursements.

Appellant argues that because the State Plan offers no express definition, the term "rate period" means any time a rate changes, regardless of the reason. Appellant offers correspondence from SCHDDS using the term "rate period" in this fashion as evidence that the SAO exceeded its authority and that SCDHHS is barred from recouping overpayments. (R. pp. 321-322) It is well established, however, that the representations of public employees, even acting in the scope of employment, cannot alter controlling provisions of law or regulation. Ahrens v. State, 392 S.C. 340, 351, 709 S.E.2d 54, 59 (2011) (Retirement Systems' agents cannot alter benefits) Moreover, the correspondence offered by Appellant is countered by Mr. Saxon, author and recognized expert on the State Plan. Mr. Saxon testified that a "rate period" is the time frame determined by information contained in a cost report and is not limited to the report period itself. (R. pp. 124-128, 134-135, 651-652) Appellant's witness, Mr. Schmoyer, acknowledged that the State Plan must be read in its entirety if questions arise as to its application. (R. pp. 190, 617) Mr. Schmoyer also agreed that Appellant's initial cost report set the base for

reimbursement through September 30, 2009. (R. pp. 181-182, 612-613) The challenged audit report was issued on November 22, 2011, well within the three year period following September 30, 2009.

Under the controlling standard of review, it was for the Hearing Officer to weigh the credibility of witnesses and to resolve factual disputes. Under this standard, Appellant cannot prevail by arguing that the Hearing Officer should have chosen to accept Mr. Schmoyer's opinion over that of Mr. Saxon. See, Kearse v. State Health & Human Servs. Fin. Comm'n, 318 S.C. 198, 200, 456 S.E.2d 892, 893 (1995); Waters v. S.C. Land Res. Conservation Comm'n, 321 S.C. 219, 226, 467 S.E.2d 913, 917 (1996)

Reading the State Plan without reference to testimony from Mr. Saxon or Mr. Schmoyer confirms that a "rate period" is the period used to establish the foundation for a provider's reimbursement. The differing treatment afforded initial cost reports in setting extended rates and annual reports setting rates for one year only would make no sense under Appellant's interpretation. For example, applying Appellant's interpretation of "rate period" would lead to the absurd result of setting different limitations periods for the same costs. Indeed, Appellant admits that the costs addressed in AC #3-RDM-E8 and AC #3-RDM-J8 overlap, each starting on November 29, 2007. Appellant does not contest the timeliness of AC #3-RDM-J8, so that overpayments identified in that report are subject to recovery by SCDHHS. Appellant argues, however, that AC #3-RDM-E8 has three reporting deadlines that would render some of the same overpayments shielded from recovery by SCDHHS.

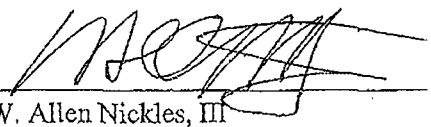
Appellant's construction of the term "rate period" renders the distinction between initial and annual cost reports contained in the State Plan meaningless, ignores the

advantages accepted by Appellant due to the extended application of its initial report, and undermines the public interest in maintaining the fiscal integrity of the Medicaid program. In the absence of a definition section in the State Plan addressing the term "rate period," the meaning of this term must be ascertained by the purpose of the South Carolina Medicaid program and must take into account the whole of the State Plan. This exercise confirms that the meaning of "rate period" offered by Appellant is not consistent with the purpose of the Medicaid program or the State Plan as a whole and must be rejected. See, Gaffney v. Mallory, 186 S.C. 337, 195 S.E. 840, 845 (1938) (The meaning of statutory language is not governed by words found in one clause, sentence or part, but by consideration of the whole and the public purpose sought to be accomplished)

CONCLUSION

For the reasons stated in the Final Administrative Decision of the Division of Appeals and Hearings and addressed above, the substantial evidence of record and controlling law of this State establishes that Appellant is not entitled to retain identified overpayments for Medicaid services. Accordingly, the Final Administrative Decision issued December 16, 2014 must be affirmed.

Respectfully submitted,

By: 

W. Allen Nickles, III
Nickles Law Firm, LLC
1122 Lady Street, Suite 610
Columbia, South Carolina 29201
(803) 779-8080
wanickles@nickleslaw.com

Attorney for Respondent

May 12, 2015
Columbia, South Carolina

IN THE STATE OF SOUTH CAROLINA
In The Administrative Law Court

APPEAL FROM
THE SOUTH CAROLINA DIVISION OF APPEALS AND HEARINGS
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 15-ALJ-08-0014-AP

Countrywood Nursing, LLC,

Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

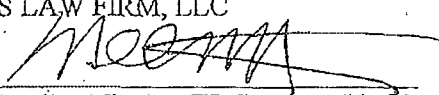
CERTIFICATE OF SERVICE

The undersigned hereby certifies that he has served the foregoing Respondent's Brief by depositing a copy of same in the United States Mail, postage prepaid and addressed as follows:

Daniel J. Westbrook, Esquire
Alice V. Harris, Esquire
Post Office Box 11070
Columbia, South Carolina 29201

This 12th day of May, 2015.

NICKLES LAW FIRM, LLC

By: 

W. Allen Nickles, III, S.C. Bar #4226
1122 Lady Street, Suite 610
Columbia, South Carolina 29201
(803) 779-8080
wanickles@nickleslaw.com

Attorney for Appellant

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Countrywood Nursing, LLC,	)	Civil Action No. 15-ALJ-08-0014-AP
	)	
Appellant,	)	
	)	
vs.	)	
	)	
South Carolina Department of Health and	)	<u>BRIEF OF APPELLANT</u>
Human Services,	)	
	)	
Respondent.	)	

Pursuant to S. C. Code Ann. § 1-23-380 and Rule 33 of the Rules of Procedure for the Administrative Law Court, Appellant Countrywood Nursing Center, LLC ("Countrywood") appeals the decision by the South Carolina Department of Health and Human Services ("DHHS") to recoup Medicaid reimbursement based on certain audits performed by the South Carolina State Auditor's Office ("SAO").

ISSUES ON APPEAL

1. Can DHHS recoup funds from Countrywood based on audits of three cost report periods, when DHHS's contract with the SAO limits such audits to two periods, given that Countrywood is a third-party beneficiary to the contract and has standing to assert rights under the contract under the public importance exception?
2. Can DHHS recoup funds from Countrywood when the SAO failed to issue timely audit reports in violation of both the DHHS-SAO contract and the contract between DHHS and Countrywood?

STATEMENT OF THE CASE

On December 16, 2011 DHHS established an accounts receivable to recoup Medicaid funds from Countrywood based on three audit reports from the SAO. R. 505. Pursuant to S.C. Code Ann. § 1-23-310, *et seq.* and S. C. Code Ann. R. 126-150, *et seq.*, Countrywood filed an administrative appeal with DHHS on December 16, 2011. R. 209-215. An evidentiary hearing was held before a DHHS Hearing Officer on September 17, 2014. R. 83. The Hearing Officer

issued an order denying the appeal on December 16, 2014. R. 8-22. Countrywood filed a motion to alter or amend on December 29, 2014, R. 28-31, which the Hearing Officer denied on January 23, 2015. R. 4-6. Countrywood filed the present appeal on January 20, 2015.

ARGUMENT

I. Except for Fraud Investigations, the SAO Contract Prohibits Audits of Three Cost Report Periods.

A. Statement of Facts

DHHS is the state agency charged with administering the South Carolina Medicaid program. DHHS contracts with the SAO to audit Medicaid providers. On November 22, 2011 the SAO issued three final Medicaid audit reports to Countrywood: AC#3-RDM-E8, based on cost report period 11/29/07-5/31/08, R. 359-377; AC#3-RDM-J8, based on cost report period 11/29/07-9/30/08, R. 380-393; and AC#3-RDM-J9, based on cost report period 10/1/08-9/30/09, R. 396-409. Relying on these three audit reports, DHHS demands a recoupment from Countrywood of \$546,968 in Medicaid reimbursement. R. 505.

DHHS is party to a contract with the SAO “for the Purchase and Provision of Agreed-Upon Procedure Activities Related to Medicaid Institutional Providers” (“SAO Contract”). R. 412-434. “Agreed-upon procedure activities” includes audits and audit reports, such as the November 22, 2011 final audit reports SAO issued on Countrywood. R. 108:24-26; 409. DHHS’s Jeff Saxon is a program manager who oversees Medicaid rates and activities for all Medicaid contracting in South Carolina. R. 106:25-27. Mr. Saxon testified that several years ago DHHS entered into a series of discussions with the South Carolina Health Care Association (the “Association”) concerning the number of cost report periods the SAO could audit. R. 108:27-109:1. The Association is a nonprofit, professional association whose members include most of the state’s nursing homes, including Countrywood. R. 109:2-5. According to Mr. Saxon,

both DHHS's Director and Deputy Director participated in these discussions, which lasted for weeks or months and involved both face-to-face meetings and telephone conferences. R. 109:6-14. As a result of these discussions Article II, Section D(1) of the SAO Contract was revised to its present form: "The SAO will perform agreed-upon procedures involving *two* cost report periods." R. 108:22-23; 109:15-18; 169:27-170:7 (emphasis added). Before this revision, the SAO Contract did not contain the two cost report limitation.¹ R. 1799:24-1800:7, R. 1803:18-1804:15, R. 1805:7-1806:25, R. 169:25-170:7.

Article III, Section D (1) of the SAO Contract specifies which two cost report periods the SAO may audit:

For non-hospital based/related nursing facilities, the periods will be defined as the cost report period which was used to set the provider's Medicaid rate in effect at the time the field work for the engagement is initiated, plus the preceding cost report period.

R. 418; *see* R. 868 (Article III, Section E(1) of 1998 SAO Contract identifies the same two cost report periods).

The SAO initiated the field work for the Countrywood audits on August 10, 2011. R. 436; R. 111:23-112:7. The cost report period used to set Countrywood's Medicaid rate in effect when field work was initiated was the period of 10/1/08-9/30/09. R.112:19-24. The preceding cost report period was 11/29/07-9/30/08. R. 112:25-27.

¹ Mr. Saxon could not remember when DHHS's discussions with the Association occurred, only that it was "several years ago," R. 1800:5-10, "maybe, early 2000s, I'm guessing. I don't know." R. 1800:15-16. Countrywood's expert witness, accountant Terry Schnoyer, also recalled these negotiations, but testified that they occurred in "the late 1990s." R. 191:17-20. The 1997 SAO Contract had no limitation on the number of cost reports the SAO could audit, R. 852-861, while the 1998 SAO Contract limited the SAO to auditing two cost report periods, R. 868, consistent with Mr. Schnoyer's testimony.

The only limitation the SAO Contract imposes on the two-cost report restriction is set forth in Article III, Section D(4): "These restrictions do not apply in relation to any procedures initiated subsequent to or in relation to any investigation of fraud." R. 418. On the day before the final hearing, in an email from DHHS's counsel to Countrywood's counsel, DHHS raised for the first time an allegation that Countrywood had improperly omitted listing in a cost report certain related-party costs. R. 163:16-164:2. Mr. Schmoyer testified at the hearing that this omission was an unintentional mistake that had no impact on the amount of reimbursement Countrywood received. R. 163:16-166:10. DHHS offered nothing to rebut Mr. Schmoyer's testimony, presented no evidence that the SAO audits were based on or related to such omissions, and presented no evidence that any of the audits at issue were initiated subsequent to or in relation to any investigation of fraud.

B. Argument

1. The SAO Contract Prohibits Audits of Three Cost Report Periods, Absent Allegations of Fraud.

Article III, Section D(1) of the SAO Contract states in plain terms that the SAO "will perform agreed-upon procedures involving *two* cost report periods." R. 418 (emphasis added). DHHS argues that this language should somehow be construed as allowing the SAO to perform agreed-upon procedures involving "a minimum" of two cost report periods, but the word "minimum" is not to be found in Section D(1). Rather than a "minimum," Article III, Section D(4) of the SAO Contract characterizes the two cost report provision as a "restriction," which applies in all cases except those involving allegations of fraud. R. 418. Section D(1) even specifies which two cost report periods the SAO may audit: (1) the one used to set the rate in effect at the time the field work is initiated; and (2) the preceding cost report period. R. 418. To drive home the point, a few lines later in the same section the contract states "the SAO will be

required to issue the final reports for *the two cost report periods* no later than three (3) years after the end of the closed rate period that is associated with the preceding cost report period.”

R. 418 (emphasis added).

In this case, the SAO audited three cost report periods:

1. 11/29/07-5/31/08 (the “First Cost Report Period”);
2. 11/29/07-9/30/08 (the “Second Cost Report Period”); and
3. 10/1/08-9/30/09 (the “Third Cost Report Period”).

R. 505. The SAO did not initiate field work until August 10, 2011. The cost report period used to set the rate in effect in August 2011 was the Third Cost Report Period (10/1/08-9/30/09). R. 112:19-24. The preceding period was the Second Cost Report Period (11/29/07-9/30/08). R. 112:25-27. Under the plain terms of the SAO Contract, the SAO had no right to audit the First Cost Report Period (11/29/07-5/31/08).

Mr. Saxon testified that the SAO routinely audits six-month cost reports, but even if that is the SAO’s practice, it is beside the point. There is no evidence the SAO initiated its audits “subsequent to or in relation to any investigation of fraud.” See R. 418 (Art. III § D(4) of SAO Contract). The SAO Contract therefore restricts the SAO from auditing more than two cost report periods.

2. Countrywood is a Third-Party Beneficiary to the SAO Contract.

Although it is clear that the SAO Contract prohibits the SAO from auditing more than two cost reports absent allegations of fraud, DHHS argues that Countrywood is not a party to the contract and has no right to enforce it. A third party has the right to enforce a contract if the third party is the contract’s intended, rather than incidental, beneficiary. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 344, 340, 611 S.E.2d 485, 487 (2005). When a state agency enters into a

statutorily authorized contract it waives sovereign immunity and can be sued on its contractual obligations. *Kinsey Constr. Co. vs. S.C. Dep't of Mental Health*, 272 S.C. 168, 172, 249 S.E.2d 900, 903 (1978). Intended beneficiaries of state contracts may sue to enforce the contract. *Sloan Constr. Co. v. Southco Grassing, Inc.*, 377 S.C. 108, 120, 659 S.E.2d 158, 165 (2008).

Section 44-6-50 of the South Carolina Code authorizes DHHS to enter into contracts in order to carry out its statutory duties. One such duty is to ensure the equitable administration of DHHS programs. S.C. Code Ann. § 44-6-40(5). In the present case, Medicaid nursing homes such as Countrywood are the obvious intended beneficiaries of DHHS's duty to equitably administer Medicaid audits. This is especially true under the circumstances of this case, when, following negotiations with the South Carolina Health Care Association, DHHS acceded to the Association's demands and revised the SAO Contract in a way that specifically benefits Association members.

3. Countrywood Has Standing Under the Public Importance Exception.

Even if Countrywood were not a third-party beneficiary to the SAO Contract, it would have standing to allege a breach of that contract pursuant to the public importance doctrine. South Carolina courts have long recognized the public importance exception to standing requirements. *ATC South, Inc v. Charleston County*, 380 S.C. 191, 198, 669 S.E.2d 337, 341. "Standing is not inflexible and standing may be conferred upon a party when an issue is of such public importance as to require its resolution for future guidance." *Id.* (quoting *Davis v. Richland County Council*, 372 S.C. 497, 500, 642 S.E.2d 740, 741 (2007)). Whether an issue is of sufficient public importance requires an "appropriate balance" by the court of "competing policy concerns." *Sloan v. Sanford*, 357 S.C. 431, 434, 593 S.E.2d 470, 472 (2004).

While the nature of the public importance exception "resists a formulaic approach," the "key" to the analysis is "whether a resolution is needed for future guidance." *ATC South*, 380 S.C. at 199, 669 S.E.2d at 341. "It is this concept of 'future guidance' that gives meaning to an issue which transcends a purely private matter and rises to the level of public importance." *Id.*

Over the years, South Carolina courts have held that the public importance exception conferred standing on plaintiffs in a variety of cases. *See, e.g., Davis* (county commissioners have standing to challenge the constitutionality of legislation that authorized their removal from office); *Sloan v. Dep't of Transportation*, 365 S.C. 299, 618 S.E.2d 876 (2005) (taxpayer had standing to sue Department over alleged statutory bidding violations); *Baird*, 333 S.C. at 530, 511 S.E.2d at 75 (doctors have standing to sue county to enjoin issuance of bonds for purchase and renovation of hospital); *Thompson v. S.C. Comm'n on Alcohol and Drug Abuse*, 267 S.C. 463, 229 S.E.2d 718 (1976) (law enforcement officials have standing to challenge constitutionality of the Uniform Alcohol and Intoxication Treatment Act).

The present case is particularly appropriate for application of the public importance exception. Rather than promulgate regulations, two state agencies have entered into a contract which purportedly regulates how Medicaid audits are to be conducted. These two agencies have violated their own contract, however, by ignoring its restriction that, except for fraud investigations, only two cost report periods may be audited. This practice has a significant impact not only on Countrywood, but on other providers, patients, and the entire Medicaid program. DHHS and the SAO have performed this practice in the past and apparently intend to perform it in the future. For all these reasons, a resolution is needed for future guidance. *See ATC South*, 380 S.C. at 199, 669 S.E.2d at 341.

II. The SAO Failed to Issue Timely Audit Reports, in Violation of the SAO Contract and Facility Contract.

A. Statement of Facts

In addition to limiting the SAO to auditing two cost report periods, Article III, Section D(1) of the SAO Contract places time limits on the SAO to issue final audit reports:

For non-hospital based/related nursing facilities, the SAO will be required to issue the final reports of the two cost report period no later than three (3) years after the end of the closed rate period that is associated with the preceding cost report period.

R. 418. As demonstrated above, the "preceding cost report period" in this case was 11/29/07-9/30/08. R. 112:25-27.

At all times relevant to his action, Countrywood and DHHS have been parties to a contract dated October 1, 2006 (the "Facility Contract").² R. 439-461. Article V, Section 7 of the Facility Contract is entitled "Time Limit for Issuance of the Final Audit Report." It provides, consistent with the SAO Contract: "Any disallowance made pursuant to an on-site audit shall be made in the final audit report, which shall be issued within three (3) years of the close of the contract period. . . ." R. 449.

The Facility Contract defines "contract period" in three ways, but each definition applies only to a specific section of the contract. R.443. For Article V, Section F, "contract period" means "the rate period as defined by the South Carolina State Plan." R. 443. The South Carolina State Plan (the "Plan"), however, does not define "rate period."³ R. 463-503.

² The original parties to the Facility Contract were DHHS and Ridgeview of the Midlands, which was purchased by Countrywood. R. 116:9-13; 156:25-30.

³ The Plan describes a "rate cycle" as lasting "from October 1 through September 30 and will be recomputed every twelve (12) months." R. 474. However, a "rate cycle" and "rate period" have different meanings. R. 120:11-12.

In the present case, the earliest Countrywood cost report audited by the SAO was a six-month report from 11/29/07-5/31/08. R. 505. The Plan provides that a six-month cost report establishes a rate for the first six months of operations. R. 483. Effective on the first day of the seventh month of operation, an inflation factor is added and "a new prospective rate" is determined. R. 484, 486, 123:14-124:5. As Mr. Saxon testified, ordinarily the rate changes again every October 1, due to a variety of annual revisions to the Plan. R. 122:21-31.

Consistent with Plan requirements, Countrywood's Medicaid rate during its first six months of operation (11/29/07-5/31/08) remained unchanged at \$129.21. R. 505, 121:27-122:12. As the Plan dictates, on the first day of Countrywood's seventh month of operation (6/1/08), DHHS changed its rate to \$134.74. R. 505. The rate did not change again until October 1, 2008, when DHHS raised it to \$135.11. R. 505, 122:13-23.

Accordingly, in its desk audits the SAO identified 11/29/07-5/31/08, 6/1/08-9/30/08, and 10/1/08-9/30/09 as three separate "rate periods." R. 508, 511, 520, 533. The SAO's final audit reports also identified these three periods as separate "contract periods," R. 359-393, a term the Facility Contract equates with "rate periods." R. 443. On December 16, 2011, Debra Myers, DHHS's Director of the Division of Long Term Care Reimbursements and Mr. Saxon's "right hand person," R. 120:19-26, wrote DHHS's recoupment letter to Countrywood in which she, too, identified these same three periods as three separate "rate periods." R. 505-506.

B. Argument

DHHS argues that the rate period for Countrywood's First Cost Report Period – the six month period from 11/29/07-5/31/08 – is an "extended period" of 22 months, from 11/29/07-9/30/09. Nothing in the Plan, the SAO Contract, the Facility Contract, or any other document references "extended" rate periods or otherwise supports DHHS's position.

Consistent with the Plan and as evidenced by the desk audit reports, final audit reports, and the December 16, 2011 recoupment letter, both DHHS and the SAO considered 11/29/07-5/31/08, 6/1/08-9/30/08, and 10/1/08-9/30/09 as three separate rate periods, not one grand extended period. R. 359-409, 463-540, 505-506. The reason these are three separate rate periods is simple – in each period Countrywood had a different rate.

The Facility Contract requires the SAO to issue its final audit report within three years of the close of the rate period. R. 418. In this case, the close of the first rate period was May 31, 2008. R. 505. The close of the second rate period was September 30, 2008. R. 505. The SAO, however, did not issue its final audit reports until November 22, 2011, R. 359-409, clearly missing deadlines for the first two rate periods and violating both the Facility Contract and the SAO Contract.

The South Carolina Supreme Court issued a decision in a situation similar to this matter in *C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission*, 373 S.E.2d 584 (S.C. 1988). In *C.A.N. Enterprises* a nursing home and the South Carolina Health and Human Services Finance Commission (“State”) entered into a contract which provided for payment and reimbursement for Medicaid benefits. *See id.* at 585. The contract allowed for audits during the contract period and for a period of three years after the contract. *Id.* The State conducted a post-contract audit of the nursing home’s cost information but did not issue its final audit report, disallowing over \$24,000, until over three years after the contract period. *Id.*

The supreme court ruled that “[b]ecause the contract provides that audits, which we interpret to mean audit reports, must be completed within three years from the termination of the contract, and since the audit report was not submitted to Oakmont until after the three years

expired, we hold the State is not entitled to recoup the funds disallowed in its final audit report.”

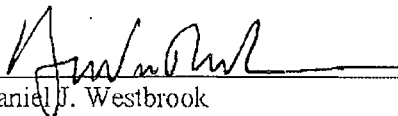
Id.

The facts in *C.A.N. Enterprises* are analogous to those in the present case. DHHS is not entitled to recoup funds based on untimely audit reports issued in violation of the SAO Contract and the Facility Contract.

CONCLUSION

DHHS violated the SAO Contract by basing its recoupment demand on the SAO’s audits of three cost report periods, rather than two. DHHS further violated the SAO Contract, as well as the Facility Contract, by basing its recoupment demand on a final audit report issued over three years after the close of two relevant rate periods. For these reasons, DHHS is not entitled to any recoupment from Countrywood and the agency decision should be reversed.

NELSON MULLINS RILEY & SCARBOROUGH LLP

By: 

Daniel J. Westbrook
dan.westbrook@nelsonmullins.com
Alice V. Harris
alice.harris@nelsonmullins.com
1320 Main Street, 17th Floor
Post Office Box 11070
Columbia, SC 29201
(803) 799-2000

Attorneys for Appellant Countrywood Nursing, LLC

Columbia, South Carolina

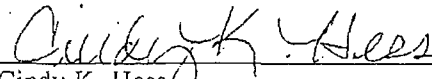
April 13, 2015

CERTIFICATE OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Countrywood Nursing, LLC, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by mailing a copy of the same to the following address(es):

Pleadings: **BRIEF OF APPELLANT**

Counsel Served: U.S. Mail
W. Allen Nickles, III, Esq.
Nickles Law Firm, LLC
1122 Lady Street, Ste. 610
Columbia, SC 29201


Cindy K. Hess
Sr. Administrative Assistant

April 13, 2015

FILED

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SC ADMIN. LAW COURT

STATE OF SOUTH CAROLINA	)	BEFORE THE DIVISION OF APPEALS
	)	AND HEARINGS OF THE
COUNTY OF RICHLAND	)	SOUTH CAROLINA DEPARTMENT
	)	OF HEALTH AND HUMAN SERVICES
Countrywood Nursing Center, LLC,	)	AC #3-RDM-J8; AC #12-AUD-010
	)	AC #3-RDM-J9; AC #12-AUD-011
Petitioner,	)	AC #3-RDM-E8; AC #12-AUD-012
	)	
v.	)	
	)	RESPONDENT'S REPLY TO
South Carolina Department of Health	)	PETITIONER'S MOTION TO ALTER
and Human Services,	)	OR AMEND
	)	
<u>Respondent.</u>	)	

Petitioner has filed a motion to alter or amend requesting that the Final Administrative Decision "address" twenty-one proposed "factual findings." For the following reasons, this motion is without merit and should be denied.

The Final Administrative Decision issued December 16, 2014 contains twenty-eight designated findings of fact, ten conclusions of law and discussion on each of the issues raised by Petitioner. In addition, the Decision states that the Hearing Officer has considered "all of the evidence and testimony presented for review." Although Petitioner objects to the Decision, there is no requirement in law that the Hearing Officer accept Petitioner's proposed findings. To the contrary, controlling law of this State provides that a decision is arbitrary only "if it is without rational basis, is based on one's will and not upon any course of reasoning and exercise of judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standards." Trimmier v. S.C. Dept. of Labor, Licensing and Regulation, 405 S.C. 239, 246, 746 S.E.2d 491, 495 (Ct. App. 2013) *quoting* Deese v. S.C. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985)

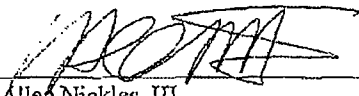
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SCDHHS APPEALS

There can be no question that the Final Administrative Decision addresses the issues brought before the Hearing Officer and that the facts articulated in the Decision are sufficiently detailed to enable a reviewing court to determine whether the findings are supported by the record. See generally, Converse Power Corp. v. South Carolina Dept. of Health and Environmental Control, 350 S.C. 39, 564 S.E.2d 341 (Ct. App. 2002) (Permit denial based upon the agency's reasonable interpretation of its own regulations) Having identified the issues on appeal and having addressed those issues supported by factual findings, legal conclusions and discussion, the Final Administrative Decision complies with all legal requirements. Accordingly, Petitioner's request to include additional factual findings is without merit and should be denied.

NICKLES LAW FIRM, LLC

By: 

W. Allen Nickles, III
1122 Lady Street, Suite 610
Columbia, South Carolina 29201
(803) 779-8080

Attorneys for Respondent

January 8, 2015
Columbia, South Carolina

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SCDHHS APPEALS

STATE OF SOUTH CAROLINA	)	BEFORE THE DIVISION OF APPEALS
	)	AND HEARINGS OF THE
COUNTY OF RICHLAND	)	SOUTH CAROLINA DEPARTMENT
	)	OF HEALTH AND HUMAN SERVICES
Countrywood Nursing, LLC	)	Appeal Case Nos.
	)	12-AUD-010,
Petitioner,	)	12-AUD-011, and
	)	12-AUD-012
v.	)	
South Carolina Department of Health	)	
and Human Services,	)	<u>PETITIONER'S MOTION</u>
	)	<u>TO ALTER OR AMEND</u>
Respondent.	)	

Pursuant to Rule 59(e) of the South Carolina Rules of Civil Procedure, Petitioner Countrywood Nursing, LLC ("Countrywood") hereby moves to alter or amend the Final Administrative Decision in this matter. Specifically, Countrywood moves that the Final Administrative Decision be altered or amended to include or address the following factual findings:

1. For purposes of the contract between the South Carolina Department of Health and Human Services ("DHHS") and the South Carolina State Auditor's Office ("SAO") "for the Purchase and Provision of Agreed-Upon Procedure Activities Related to Medicaid Institutional Providers" ("SAO Contract"), "agreed-upon procedure activities" includes audits and audit reports, such as the 11/22/11 final audit reports SAO issued on Countrywood.

2. A former version of the SAO Contract provided that the SAO could audit an unlimited number of cost report periods.

3. Several years ago DHHS entered into a series of discussions with the South Carolina Health Care Association (the "Association"), a nonprofit, professional association

whose members include Countrywood and the vast majority of the state's nursing homes, concerning the number of cost report periods the SAO could audit.

4. According to DHHS's Jeff Saxon, DHHS's Director and Deputy Director participated in these discussions, which lasted for weeks or months and involved both face-to-face meetings and telephone conferences.

5. As a result of these discussions Article II, Section D(1) of the SAO Contract was revised to its present form: "The SAO will perform agreed-upon procedures involving two cost report periods."

6. The SAO Contract specifies which two cost report periods the SAO may audit:

For non-hospital based/related nursing facilities, the periods will be defined as the cost report period which was used to set the provider's Medicaid rate in effect at the time the field work for the engagement is initiated, plus the preceding cost report period.

7. The cost report period used to set Countrywood's Medicaid rate in effect when field work was initiated was the period of 10/1/08-9/30/09. The preceding cost report period was 11/29/07-9/30/08.

8. The only limitation the SAO Contract imposes on the two-cost report restriction is set forth in Article III, Section D(4): "These restrictions do not apply in relation to any procedures initiated subsequent to or in relation to any investigation of fraud."

9. On the day before the final hearing, in an email from DHHS's counsel to Countrywood's counsel, DHHS raised for the first time an allegation that Countrywood had improperly omitted listing in a cost report certain related-party costs. Countrywood's expert witness, Terry Schmoyer, testified at the hearing that this omission was an unintentional mistake that had no impact on the amount of reimbursement Countrywood received. DHHS offered nothing to rebut Mr. Schmoyer's testimony, presented no evidence that the SAO audits were

based on or related to such omissions, and presented no evidence that any of the audits at issue were initiated subsequent to or in relation to any investigation of fraud.

10. At all times relevant to his action, Countrywood and DHHS have been parties to a contract dated October 1, 2006 (the "Facility Contract").

11. Article V, Section 7 of the Facility Contract is entitled "Time Limit for Issuance of the Final Audit Report." It provides, consistent with the SAO Contract: "Any disallowance made pursuant to an on-site audit shall be made in the final audit report, which shall be issued within three (3) years of the close of the contract period. . . ."

12. The South Carolina State Plan (the "Plan") does not define "rate period." The Plan describes a "rate cycle" as lasting "from October 1 through September 30 and will be recomputed every twelve (12) months." Mr. Saxon and Mr. Schmoyer both testified, however, that "rate cycle" and "rate period" have different meanings.

13. In the present case, the earliest Countrywood cost report audited by the SAO was a six-month report from 11/29/07-5/31/08. The Plan provides that a six-month cost report establishes a rate for the first six months of operations.

14. Effective on the first day of the seventh month of operation, an inflation factor is added and "a new prospective rate" is determined.

15. The rate changes again every October 1, due to a variety of annual revisions to the Plan.

16. Consistent with Plan requirements, Countrywood's Medicaid rate during its first six months of operation (11/29/07-5/31/08) remained unchanged at \$129.21.

17. As the Plan dictates, on the first day of Countrywood's seventh month of operation (6/1/08), DHHS changed its rate to \$134.74.

18. The rate did not change again until October 1, 2008, when DHHS raised it to \$135.11.

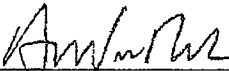
19. Accordingly, in its desk audits the SAO identified 11/29/07-5/31/08, 6/1/08-9/30/08, and 10/1/08-9/30/09 as three separate "rate periods." The SAO's final audit reports also identified these three periods as separate rate periods.

20. Nothing in the Plan, the SAO Contract, the Facility Contract, or any other document references "extended" rate periods.

21. The Facility Contract requires the SAO to issue its final audit report within three years of the close of the rate period. In this case, the close of the first rate period was May 31, 2008. The close of the second rate period was September 30, 2008.

Respectfully submitted,

NELSON MULLINS RILEY & SCARBOROUGH LLP

By: 

Daniel J. Westbrook
SC Bar No. 12939
Alice V. Harris
SC Bar No. 66223
1320 Main Street / 17th Floor
Post Office Box 11070 (29211-1070)
Columbia, SC 29201
(803) 799-2000

Attorneys for Petitioner

Columbia, South Carolina

December 29, 2014

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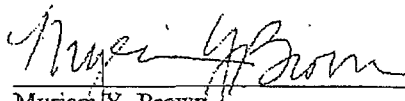
SCDHHS APPEALS

CERTIFICATE OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Countrywood Nursing, LLC, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by mailing a copy of the same to the following address(es):

Pleadings: PETITIONER'S MOTION TO ALTER OR AMEND

Counsel Served: VIA E-MAIL AND REGULAR MAIL
W. Allen Nickles, III, Esq.
Nickles Law Firm, LLC
1122 Lady Street, Suite 610
Columbia, SC 29201
wanickles@nickleslaw.com


Myriam Y. Brown
Administrative Assistant

December 29, 2014

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SCDHHS APPEALS

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP
Attorneys and Counselors at Law
1320 Main Street / 17th Floor / Columbia, SC 29201
Tel: 803.799.2000 Fax: 803.255.5164
www.nelsonmullins.com

Daniel J. Westbrook
Tel: 803.255.9456
Fax: 803.255.5164
dan.westbrook@nelsonmullins.com

October 17, 2014

Via Electronic Mail and Hand Delivery

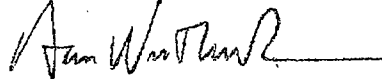
Betsy Schindler, Hearing Officer
South Carolina Department of Health
& Human Services
Division of Appeals and Hearings
1801 Main Street, 9th Floor
Post Office Box 8206
Columbia, SC 29202-8206

RE: Countrywood Nursing, LLC v. SC DHHS
Appeal Case Nos. 12-AUD-010, 12-AUD-011, and 12-AUD-012
Our File No. 39092/09001

Dear Ms. Schindler:

Pursuant to your request, I am enclosing herewith Petitioner's proposed Final Order for your review and use. By copy of this letter, I am serving opposing counsel with a copy of same.

Very truly yours,



Daniel J. Westbrook

DJW:myb

cc: W. Allen Nickles, Esq. (Via email)

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SCDHHS APPEALS

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R0091

STATE OF SOUTH CAROLINA	)	BEFORE THE DIVISION OF APPEALS
	)	AND HEARINGS OF THE
COUNTY OF RICHLAND	)	SOUTH CAROLINA DEPARTMENT
	)	OF HEALTH AND HUMAN SERVICES

Countrywood Nursing, LLC	)	Appeal Case Nos.
	)	12-AUD-010,
Petitioner,	)	12-AUD-011, and
	)	12-AUD-012

v.

South Carolina Department of Health
and Human Services,

Respondent.

FINAL ORDER

I. INTRODUCTION

This is an administrative appeal challenging a demand for Medicaid recoupment. The Petitioner, Countrywood Nursing Center, LLC ("Countrywood"), is a freestanding, 38-bed nursing home in Hopkins, South Carolina. The Respondent, South Carolina Department of Health and Human Services ("DHHS"), is the state agency charged with administering the South Carolina Medicaid program. On November 22, 2011 the South Carolina State Auditor's Office (the "SAO") issued three final Medicaid audit reports to Countrywood: AC#3-RDM-E8, based on cost report period 11/29/07-5/31/08; AC#3-RDM-J8, based on cost report period 11/29/07-9/30/08; and AC#3-RDM-J9, based on cost report period 10/1/08-9/30/09. Pet. Ex. 7, Tabs 1-3. Based on these audit reports, DHHS demands a recoupment of \$546,968. *Id.*, Tab 8. For the reasons set forth below, I reverse the DHHS decision.

II. THE SAO CONTRACT PROHIBITS AUDITS OF THREE COST REPORT PERIODS, ABSENT ALLEGATIONS OF FRAUD.

A. Findings of Fact

DHHS is party to a contract with the SAO "for the Purchase and Provision of Agreed-Upon Procedure Activities Related to Medicaid Institutional Providers" ("SAO Contract"). Pct. Ex. 7, Tab 4. "Agreed-upon procedure activities" includes audits and audit reports, such as the 11/22/11 final audit reports SAO issued on Countrywood. *See id.*, Tab 4, p. 2. DHHS's Jeff Saxon is a program manager who oversees Medicaid rates and activities for all Medicaid contracting in South Carolina. At the final hearing, Mr. Saxon testified that a former version of the SAO Contract provided that the SAO could audit an unlimited number of cost report periods. However, Mr. Saxon further testified that several years ago DHHS entered into a series of discussions with the South Carolina Health Care Association (the "Association") concerning the number of cost report periods the SAO could audit. The Association is a nonprofit, professional association whose members include the vast majority of the state's nursing homes, including Countrywood. According to Mr. Saxon, DHHS's Director and Deputy Director participated in these discussions, which lasted for weeks or months and involved both face-to-face meetings and telephone conferences. Both Mr. Saxon and Countrywood's expert witness, accountant Terry Schmoyer, testified that as a result of these discussions Article II, Section D(1) of the SAO Contract was revised to its present form: "The SAO will perform agreed-upon procedures involving *two* cost report periods." *Id.*, Tab 4, p. 4 (emphasis added).

The SAO Contract specifies which two cost report periods the SAO may audit:

For non-hospital based/related nursing facilities, the periods will be defined as the cost report period which was used to set the provider's Medicaid rate in effect at

the time the field work for the engagement is initiated, plus the preceding cost report period.

Id.

Mr. Saxon testified that the SAO initiated the field work for the Countrywood audits in July or August of 2011. *See* Pet. Ex. 7, Tabs 5, 13. Mr. Saxon acknowledged that the cost report period used to set Countrywood's Medicaid rate in effect when field work was initiated was the period of 10/1/08-9/30/09. The preceding cost report period was 11/29/07-9/30/08.

The only limitation the SAO Contract imposes on the two-cost report restriction is set forth in Article III, Section D(4): "These restrictions do not apply in relation to any procedures initiated subsequent to or in relation to any investigation of fraud." *Id.*, Tab 4, p 4. On the day before the final hearing, in an email from DHHS's counsel to Countrywood's counsel, DHHS raised for the first time an allegation that Countrywood had improperly omitted listing in a cost report certain related-party costs. Mr. Schmoyer testified at the hearing that this omission was an unintentional mistake that had no impact on the amount of reimbursement Countrywood received. DHHS offered nothing to rebut Mr. Schmoyer's testimony, presented no evidence that the SAO audits were based on or related to such omissions, and presented no evidence that any of the audits at issue were initiated subsequent to or in relation to any investigation of fraud.

B. Conclusions of Law

Article III, Section D(1) of the SAO Contract states in plain terms that the SAO "will perform agreed-upon procedures involving *two* cost report periods." *Id.*, Tab 4, p. 4 (emphasis added). DHHS argues that this language should somehow be construed as allowing the SAO to perform agreed-upon procedures involving "a minimum" of two cost report periods, but the word "minimum" is not to be found in Section D(1). Rather than a "minimum," Article III, Section D(4) of the SAO Contract characterizes the two cost report provision as a "restriction," which

applies in all cases except those involving allegations of fraud. Pet. Ex. 7, Tab 4, p. 4. Section D(1) even specifies which two cost report periods the SAO may audit: (1) the one used to set the rate in effect at the time the field work is initiated; and (2) the preceding cost report period. Pet. Ex. 4, p. 4. To drive home the point, a few lines later in the same section the contract states "the SAO will be required to issue the final reports for *the two cost report periods* no later than three (3) years after the end of the closed rate period that is associated with the preceding cost report period." *Id.*

As set forth in the Findings of Facts, the SAO audited three cost report periods:

1. 11/29/07-5/31/08 (the "1st Cost Report Period")
2. 11/29/07-9/30/08 (the "2nd Cost Report Period"); and
3. 10/1/08-9/30/09 (the "3rd Cost Report Period").

The SAO did not initiate field work until July or August, 2011. The cost report period used to set the rate in effect in July and August, 2011 was the 3rd Cost Report Period (10/1/08-9/30/09). The preceding period was the 2nd Cost Report Period (11/29/07-9/30/08). Under the plain terms of the SAO Contract, the SAO had no right to audit the 1st Cost Report Period (11/29/07-5/31/08).

Mr. Saxon testified that the SAO routinely audits six-month cost reports, but even if that is the SAO's practice, it is beside the point. Absent allegations of fraud, the SAO Contract restricts the SAO from auditing more than two cost report periods. If the SAO had initiated its field work sooner, it could have audited the 1st and 2nd Cost Report Periods. Because it waited until August 16, 2011 to initiate field work, it had the right only to audit the 2nd and 3rd Cost Report Periods, but not the 1st.

Although it is clear that the SAO Contract prohibits the SAO from auditing more than two cost reports absent allegations of fraud, DHHS argues that Countrywood is not a party to the contract and has no right to enforce it. A third party has the right to enforce a contract if the third party is the contract's intended, rather than incidental, beneficiary. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 344, 340, 611 S.E.2d 485, 487 (2005). When a state agency enters into a statutorily authorized contract it waives sovereign immunity and can be sued on its contractual obligations. *Kinsey Constr. Co. vs. S.C. Dep't of Mental Health*, 272 S.C. 168, 172, 249 S.E.2d 900, 903 (1978). Intended beneficiaries of state contracts may sue to enforce the contract. *Sloan Constr. Co. v. Southco Grassing, Inc.*, 377 S.C. 108, 120, 659 S.E.2d 158, 165 (2008).

Section 44-6-50 of the South Carolina Code authorizes HHS to enter into contracts in order to carry out its statutory duties. One such duty is to ensure the equitable administration of HHS programs. S.C. Code Ann. § 44-6-40(5). In the present case, Medicaid nursing homes such as Countrywood are the obvious intended beneficiaries of HHS's duty to equitably administer the "agreed-upon procedure activities related to Medicaid institutional providers." This is especially true under the circumstances of this case, when, following negotiations with the South Carolina Health Care Association, HHS acceded to the Association's demands and revised the SAO Contract in a way that specifically benefits Association members.

Even if Countrywood were not a third party beneficiary to the SAO Contract, it would have standing to allege a breach of that contract pursuant to the public importance doctrine. South Carolina courts have long recognized the public importance exception to standing requirements. *ATC South, Inc v. Charleston County*, 380 S.C. 191, 198, 669 S.E.2d 337, 341. "Standing is not inflexible and standing may be conferred upon a party when an issue is of such public importance as to require its resolution for future guidance." *Id.* (quoting *Davis v.*

Richland County Council, 372 S.C. 497, 500, 642 S.E.2d 740, 741 (2007). Whether an issue is of sufficient public importance requires an "appropriate balance" by the court of "competing policy concerns." *Sloan v. Sanford*, 357 S.C. 431, 434, 593 S.E.2d 470, 472 (2004).

While the nature of the public importance exception "resists a formulaic approach," the "key" to the analysis is "whether a resolution is needed for future guidance." *ATC South*, 380 S.C. at 199, 669 S.E.2d at 341. "It is this concept of 'future guidance' that gives meaning to an issue which transcends a purely private matter and rises to the level of public importance." *Id.*

Over the years, South Carolina courts have held that the public importance exception conferred standing on plaintiffs in a variety of cases. See, e.g., *Davis* (county commissioners have standing to challenge the constitutionality of legislation that authorized their removal from office); *Sloan v. Dep't of Transportation*, 365 S.C. 299, 618 S.E.2d 876 (2005) (taxpayer had standing to sue Department over alleged statutory bidding violations); *Baird*, 333 S.C. at 530, 511 S.E.2d at 75 (doctors have standing to sue county to enjoin issuance of bonds for purchase and renovation of hospital); *Thompson v. S.C. Comm'n on Alcohol and Drug Abuse*, 267 S.C. 463, 229 S.E.2d 718 (1976) (law enforcement officials have standing to challenge constitutionality of the Uniform Alcohol and Intoxication Treatment Act).

The present case is appropriate for application of the public importance exception. Rather than promulgate regulations, two state agencies have entered into a contract which purportedly regulates how Medicaid audits are to be conducted. These two agencies have violated their own contract, however, by ignoring its restriction that, absent fraud, only two cost report periods may be audited. This practice has a significant impact not only on Countrywood, but on other providers, patients, and the entire Medicaid program. DHHS and the SAO have performed this practice in the past and apparently intend to perform it in the future. For all these

reasons, a resolution is needed for future guidance. See *ATC South*, 380 S.C. at 199, 669 S.E.2d at 341.

III. THE SAO FAILED TO ISSUE TIMELY AUDIT REPORTS IN VIOLATION OF THE SAO CONTRACT AND FACILITY CONTRACT.

A. Findings of Fact

In addition to limiting the SAO to auditing two cost report periods, Article III, Section D(1) of the SAO Contract places time limits on the SAO to issue final audit reports:

For non-hospital based/related nursing facilities, the SAO will be required to issue the final reports of the two cost report period no later than three (3) years after the end of the closed rate period that is associated with the preceding cost report period.

Pet. Ex. 7, Tab 4, p. 4. As demonstrated above, the "preceding cost report period" in this case was 11/29/07-9/30/08.

At all times relevant to his action, Countrywood and DHHS have been parties to a contract dated October 1, 2006 (the "Facility Contract"). Pet. Ex. 7, Tab 6. Article V, Section 7 of the Facility Contract is entitled "Time Limit for Issuance of the Final Audit Report." It provides, consistent with the SAO Contract: "Any disallowance made pursuant to an on-site audit shall be made in the final audit report, which shall be issued within three (3) years of the close of the contract period. . . ." *Id.*, Tab 6, p. 8.

The Facility Contract defines "contract period" in three ways, but each definition applies only to a specific section of the contract. *Id.*, Tab 6, p. 2. For Article V, Section F, "contract period" means "the rate period as defined by the South Carolina State Plan." *Id.* The South Carolina State Plan (the "Plan"), however, does not define "rate period."¹ See Pet. Ex. 7, Tab 7.

¹ The Plan describes a "rate cycle" as lasting "from October 1 through September 30 and will be recomputed every twelve (12) months." Pet. Ex. 7, Tab 7, p. 12. Mr. Saxon and Mr. Schmoyer both testified, however, that "rate cycle" and "rate period" have different meanings.

In the present case, the earliest Countrywood cost report audited by the SAO was a six-month report from 11/29/07-5/31/08. The Plan provides that a six-month cost report establishes a rate for the first six months of operations. Pet. Ex. 7, p. 21. Effective on the first day of the seventh month of operation, an inflation factor is added and "a new prospective rate" is determined. *Id.*, p. 22. As Mr. Saxon testified, the rate changes again every October 1, due to a variety of annual revisions to the Plan.

Consistent with Plan requirements, Countrywood's Medicaid rate during its first six months of operation (11/29/07-5/31/08) remained unchanged at \$129.21. *Id.*, Tab 8. As the Plan dictates, on the first day of Countrywood's seventh month of operation (6/1/08), DHHS changed its rate to \$134.74. *Id.* The rate did not change again until October 1, 2008, when DHHS raised it to \$135.11. *Id.*

Accordingly, in its desk audits the SAO identified 11/29/07-5/31/08, 6/1/08-9/30/08, and 10/1/08-9/30/09 as three separate "rate periods." Pet. Ex. 7, Tabs 9-12. The SAO's final audit reports also identified these three periods as separate rate periods. *Id.*, Tabs 1-3. On December 16, 2011, Debra Myers, DHHS's Director of the Division of Long Term Care Reimbursements and Mr. Saxon's "right hand person", wrote a letter to Countrywood in which she, too, identified these same periods as three separate "rate periods." *Id.*, Tab 8.

B. Conclusions of Law

DHHS argues that the rate period for Countrywood's 1st Cost Report Period -- the six month period from 11/29/07-5/31/08 -- is an "extended period" of 22 months, from 11/29/07-9/30/09. As conceded by Mr. Saxon, nothing in the Plan, the SAO Contract, the Facility Contract, or any other document references "extended" rate periods or otherwise supports DHHS's position.

Consistent with the Plan and as evidenced by the desk audit reports, final audit reports, and the 12/16/11 Myers letter, both DHHS and the SAO considered 11/29/07-5/31/08, 6/1/08-9/30/08, and 10/1/08-9/30/09 as three separate rate periods, not one grand extended period. *See id.* Tabs 1-3, 7-12. The reason these are three separate rate periods is simple – in each period Countrywood had a different rate.

The Facility Contract requires the SAO to issue its final audit report within three years of the close of the rate period. In this case, the close of the first rate period was May 31, 2008. The close of the second rate period was September 30, 2008. The SAO, however, did not issue its final audit report until November 22, 2011, clearly missing both deadlines and violating both the Facility Contract and the SAO Contract.

The South Carolina Supreme Court issued a decision in a situation similar to this matter in *C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission*, 373 S.E.2d 584 (S.C. 1988). In *C.A.N. Enterprises* a nursing home and the South Carolina Health and Human Services Finance Commission (“State”) entered into a contract which provided for payment and reimbursement for Medicaid benefits. *See id.* at 585. The contract allowed for audits during the contract period and for a period of three years after the contract. *Id.* The State conducted a post-contract audit of the nursing home’s cost information but did not issue its final audit report, disallowing \$24,080, until over three years after the contract period. *Id.*

The South Carolina Supreme Court concluded in *C.A.N. Enterprises* that “[b]ecause the contract provides that audits, which we interpret to mean audit reports, must be completed within three years from the termination of the contract, and since the audit report was not submitted to Oakmont until after the three years expired, we hold the State is not entitled to recoup the funds disallowed in its final audit report.” *Id.*

The facts in *C.A.N. Enterprises* are analogous to those in the present case. DHHS is not entitled to recoup funds based on final audit reports issued in violation of the SAO Contract and the Facility Contract.

IV. CONCLUSION

DHHS violated the SAO Contract by basing its recoupment demand on the SAO's audits of three cost report periods, rather than two. Furthermore, DHHS violated the SAO Contract and the Facility Contract by basing its recoupment demand on a final audit report issued over three years after the close of two relevant rate periods. For these reasons, DHHS is not entitled to any recoupment from Countrywood. DHHS's decision is reversed.

AND IT IS SO ORDERED.

Betsy Schindler
DHHS Hearing Officer

_____, 2014.
Columbia, South Carolina

NICKLES LAW FIRM, LLC
- ATTORNEYS AT LAW -
1122 Lady Street, Suite 610
Columbia, South Carolina 29201

W. Allen Nickles, III

Telephone: (803) 779-8080
Facsimile: (803) 256-1816
Email: wanickles@nickleslaw.com

October 17, 2014

Via Email & Hand Delivery

Betsy Schindler, Hearing Officer
SC Department of Health & Human Services
Division of Appeals and Hearings
1801 Main Street
Columbia, South Carolina 29201

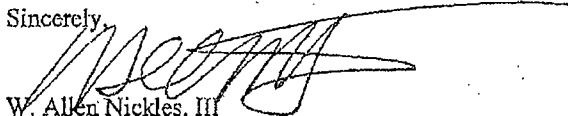
RE: Countrywood v. SCDHHS

Dear Ms. Schindler:

As requested, I am providing Respondent's proposed order in the above appeal. The order provided by email is in Word format. A hard copy is being provided by hand delivery.

Please contact me if I may provide any additional information or assistance.

Sincerely,


W. Allen Nickles, III

WAN/pfb
Enclosure

cc: Dan Westbrook, Esquire (via email only)
Alice V. Harris, Esquire (via email only)
Byron Roberts, Esquire (via email only)
Rick Hepfer, Esquire (via email only)

File #12-089

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OCT 17 2014

SCDHHS APPEALS

R0102

STATE OF SOUTH CAROLINA	)	BEFORE THE DIVISION OF APPEALS
	)	AND HEARINGS OF THE
COUNTY OF RICHLAND	)	SOUTH CAROLINA DEPARTMENT
	)	OF HEALTH AND HUMAN SERVICES
Countrywood Nursing Center, LLC,	)	AC #3-RDM-J8; AC #12-AUD-010
	)	AC #3-RDM-J9; AC #12-AUD-011
Petitioner,	)	AC #3-RDM-E8; AC #12-AUD-012
	)	
v.	)	
	)	FINAL ADMINISTRATIVE ORDER
South Carolina Department of Health	)	
and Human Services,	)	
	)	
<u>Respondent.</u>	)	

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (SCDHHS) to administer various programs and grants (See e.g., S.C. Code Ann. § 44-6-5, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of SCDHHS (S.C. Code Ann. R. 126-150 et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. § 1-23-310 et seq.)

STATEMENT OF THE CASE

Petitioner, Countrywood Nursing Center, LLC, is a provider of services under the South Carolina Medicaid program administered by SCDHHS. Petitioner filed a timely appeal from the audit reports identified above. Thereafter, Petitioner and Respondent participated in a prehearing conference, exchanged documents, conducted depositions and filed prehearing briefs. A motion for summary judgment filed by Petitioner was denied by order dated December 19, 2012 with permission to raise the issues presented in the hearing. The parties appeared before the Hearing Officer on September 17, 2014.

ISSUES

In this appeal, Petitioner has elected to proceed on two issues. The first issue claims that the contract between SCDHHS and the State Auditor's Office ("SAO") limits audit reviews to two cost report periods. Petitioner asserts that it is a third-party beneficiary of the contract between SCDHHS and the SAO. Petitioner further asserts that "public interest" confers standing to enforce the contract between SCDHHS and the SAO. The second issue claims that the contract between SCDHHS and the Petitioner bars recovery of disallowances in audit report AC #3-RDM-E8 (addressing the cost report for the period November 29, 2007 through May 31, 2008 and the rate period through September 30, 2009). Petitioner contends that certain disallowances identified in this report were issued more than three years following the close of the contract period under review and that SCDHHS is barred from recovering identified overpayments for the period November 29, 2007 through September 30, 2008. Based upon these claims, Petitioner seeks to retain \$546,968 in identified overpayments for Medicaid services.¹

As to Petitioner's first issue, Respondent asserts that Petitioner is not a beneficiary and has no standing to raise claims relating to the contract between SCDHHS and the SAO. Respondent further asserts that the contract between SCDHHS and the SAO does not limit the SAO to review of two cost reports. As to Petitioner's second issue, Respondent asserts that reviews were conducted and final audit reports were issued in a timely fashion.

INFORMATION BEFORE THE HEARING OFFICER

The information presented for review in this appeal includes testimony by Terry Schmoyer, CPA, offered as an expert on behalf of the Petitioner and testimony by Jeff Saxon, a Program Manager for SCDHHS, offered as an expert on behalf of Respondent. In addition to

¹ The cost report for the period November 29, 2007 through May 31, 2008 alone resulted in an overpayment of \$292,592.00.

testimony provided at the hearing, the depositions of Mr. Schmoyer and Mr. Saxon are part of the record. Both parties presented documents that were marked as exhibits.

Respondent raised an objection to Mr. Schmoyer's participation as an expert on grounds that he is employed as an advocate of the Petitioner. In making this objection, Respondent offered deposition testimony that Mr. Schmoyer was aware of undisclosed related party transactions that were reported for reimbursement and was responsible for preparing cost reports improperly claiming these undocumented costs. Respondent argued that Mr. Schmoyer's opinion concerning the proposed limit on audit reviews and untimeliness of audit reports seeks to prevent the State from recouping unearned Medicaid payments based on reports that he submitted on behalf of Petitioner. Respondent also argued that Mr. Schmoyer served as an advocate in recommending that Petitioner retain a former SCDHHS director as its legal representative based upon the former director's "many connections" and ability to obtain "the best (lowest) repayment terms." I have considered Respondent's objections and have determined that issues raised challenging Mr. Schmoyer's impartiality go to the weight of his testimony rather than admissibility.

Respondent has also raised an objection to hearsay testimony offered by Mr. Schmoyer concerning communications between representatives of SCDHHS and Nursing Home Association representatives during the 1990's regarding the number of cost reports to be reviewed by the SAO. I agree that hearsay testimony is not admissible in this proceeding. Nevertheless, in view of testimony provided by Mr. Saxon concerning his recollection of the reported communications, and the determination that Petitioner has no standing to interfere in contractual relations between SCDHHS and SAO, I find admission of Mr. Schmoyer's testimony to be harmless.

Having considered all of the evidence and testimony presented for review, and having weighed the credibility and relevance of the evidence presented, for the following reasons, I find that Petitioner has not met its burden on appeal. Accordingly, Respondent is entitled to recoup overpayments identified in the challenged audit reports.

FINDINGS OF FACT

Based upon the documents and testimony presented at the hearing, I make the following findings of fact:

1. Providers of Medicaid services are reimbursed for their allowable costs in accordance with Medicare principles as found in the Provider Reimbursement Manual (HIM-15), unless modified by the State Plan.
2. Costs that are reasonable, necessary and related to patient-care are allowable, reimbursable costs under State Plan and HIM-15.
3. As a condition of participation in seeking Medicaid reimbursement, providers must follow the rules set forth in the HIM-15 and State Plan.
4. HIM-15-1, Section 2304 (Adequacy of Cost Information) states in part: "Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning cost, etc.), which pertain to the determination of reasonable cost, capable of being audited. . ."
5. The State Plan is a legislative document that cannot be modified, revoked or amended judicially.

6. The State Plan provides that: "All nursing facilities are required to detail their cost for the entire reporting period..." Attachment 4.19-D, I. (B)

7. The State Plan provides that cost reports submitted by nursing facilities: "shall be certified by the operator..." Attachment 4.19-D, I. (D)

8. The State Plan provides that all nursing facilities must maintain accurate and detailed financial records for "at least six (6) years following the end of the contract period for which the cost report was used to set this rate..." and that such records "must be made available upon demand to representatives of the Medicaid Agency [SCDHHS], or the State Auditor..." Attachment 4.19-D, I. (E)

9. The State Plan provides that: "All cost reports are subject to on-site audit." If there is a dispute about audit findings, "[t]he provider has the right to appeal..." through the present process. Attachment 4.19-D, II. (H)

10. Petitioner entered the South Carolina Medicaid program on November 29, 2007, having obtained an existing nursing facility (Ridgeview Manor). Petitioner accepted assignment of the contract for Medicaid services entered between Ridgeview Manor and SCDHHS.

11. As a "new facility" Petitioner filed an initial cost report for the period November, 29, 2007 through May 31, 2008, rather than the usual annual cost report filed by facilities operating in South Carolina for a year or more. Attachment 4.19-D, III. (E) This initial cost report set the Petitioner's reimbursement rates through September 30, 2009.

12. The contract assumed by Petitioner provides that: "For purposes of Article V, Section F only [Time Limit on Issuance of the Final Audit Report], the contract period will be the rate period as defined by the South Carolina State Plan." Petitioner Contract Article II

13. The contract assumed by Petitioner "expressly incorporates" a number of governing laws, regulations and guidelines, including the State Plan. Petitioner Contract Article III

14. The contract assumed by Petitioner provides for audits and appeal from audit disallowances. Petitioner Contract Article V (A) and (B)

15. The contract assumed by Petitioner provides that final audit reports "shall be issued within three (3) years of the close of the contract period..." Petitioner Contract Article V (F)

16. The contract assumed by Petitioner provides that all cost reports "shall be certified as true, accurate, and complete..." and shall not include claims for payment that the provider "knows, or has reason to know, are not properly prepared or payable..." Petitioner Contract Article V (G)

17. The contract assumed by Petitioner provides that financial records shall be maintained for the same six year period designated in the State Plan and that such records are subject to inspection "at any time" by SCDHHS, the SAO and other identified agencies. Petitioner Contract Article V (G)(1) and (2)

18. The contract assumed by Petitioner provides that it "shall be construed to be the complete integration of all understandings between the parties hereto." Petitioner Contract Article IX (L)

19. SCDHHS and the SAO have entered a contract for "Agreed -Upon Procedure Activities Related To Medicaid Institutional Providers." This contract provides that the parties "have a common and concurrent interest in ascertaining that expenditures of Medicaid funds is in accordance with the Provider contracts and the State Plan." SCDHHS/SAO Contract, p.1.

20. The SAO contract provides that: "The SAO will perform agreed-upon procedures involving two cost report periods." The contract further provides that for non-hospital based/related nursing facilities [such as Petitioner], the SAO will be required to issue the final reports of the two cost report periods no later than three (3) years after the end of the closed rate period that is associated with the preceding cost report period." SCDHHS/SAO Contract Article IV (D)(1).

21. The cost reports submitted by Petitioner contain the following certification: "Under penalties of perjury, I declare that I have examined this cost report, including any accompanying schedule and/or statement, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of the preparer (other than facility owner/personnel) is based on all information of which the preparer has knowledge)"

22. Petitioner's initial cost report, for the period November 29, 2007 through May 31, 2008, was signed by its representative on February 11, 2009. This cost report did not disclose related party transactions involving the purchase of more than \$60,000.00 in "minor equipment."

23. Petitioner's second cost report, for the period November 29, 2007 through September 30, 2008 was signed by its representative on May 12, 2009. Like Petitioner's initial report, this second cost report did not disclose related party transactions involving the purchase of more than \$60,000.00 in "minor equipment."

24. Because Petitioner's initial cost report was used to set the reimbursement rates through September 30, 2009, non-recurring expenses, including disallowed "minor equipment" purchases, had a reimbursement impact of \$131,665.00.

25. Petitioner's witness, Terry Schmöyer, prepared the cost reports for Petitioner. Mr. Schmöyer admitted that the "minor equipment" reported by Petitioner was obtained through a

related party that was not disclosed as required and certified. Mr. Schmoyer further admitted that Petitioner did not retain records of this transaction. Such records are required as a condition of reimbursement by contract, State Plan and controlling guidelines.

26. The SAO initiated field work on the challenged cost reports on August 10, 2011.

27. The SAO issued final audit reports on the challenged cost reports on November, 22, 2011.

28. Following issuance of the final audit reports, the SAO continued to receive and consider additional information from Petitioner through at least August 6, 2012. (Warrington email to Schmoyer, dated August 1, 2012)

29. "A Hearing Officer has the authority, among other things, to: direct all procedures, issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or conclusions of law; call witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with the requirements of this subarticle." South Carolina Department of Health and Human Services, Chapter 126, "Administration" R. 126-154, § 44-6-90, S.C. Code 1976, as amended.

CONCLUSIONS OF LAW

1. In a contest involving review of a statute, regulation or other public document, the plain language of the document in question controls and there is no need for explanation by way of testimony. See, Paschal v. State Election Comm'n, 317 S.C. 434, 436, 454 S.E.2d 890, 892 (1995)

2. If there is any question about the meaning or intent of a public document, it is the responsibility of the reviewing body to ascertain the public interest at stake and to rule in a

manner that serves that interest. Kiriakides v. United Artists Communications, Inc., 312 S.C. 271, 440 S.E.2d 364 (1994) (an interpretation that leads to an unintended result must be rejected)

3. In determining intent, the reviewing body may consider the interpretation and application of the agency responsible for execution of the legislation. See, Nucor Steel v. South Carolina Public Serv. Comm'n., 310 S.C. 539, 426 S.E. 2d. 319 (1992)

4. Where an administrative agency has consistently applied a statute or regulation in a particular manner, its construction may not be overturned absent cogent reasons. S.C. Cable Television Ass'n. v. Southern Bell Tel. & Tel. Co., 308 S.C. 216, 417 S.E.2d 586 (1992); Emerson Electric Co. v. Wasson, 278 S.C. 394, 339 S.E.2d 118 (1986)

5. The words used in a statute or regulation should be given their ordinary and common meaning, consistent with their manifest purpose. See, Floyd v. Nationwide Mut. Ins. Co., 367 S.C. 253, 260, 626 S.E.2d 6, 10 (2005) A construction or interpretation that leads to an absurd or unintended result must be rejected. Peake v. S.C. Dept. of Motor Vehicles, 375 S.C. 589, 599, 654 S.E.2d 284, 289 (Ct. App. 2007); Jones v. State Farm Mut. Auto Ins. Co., 364 S.C. 222, 232, 612 S.E.2d 719, 724 (Ct. App. 2005)

6. There is no need to interpret the contract between DHHS and the SAO. See, Lee v. University of South Carolina, 407 S.C. 512, 517, 757 S.E.2d 394, 397 (2014) (Contractual language is to be construed according to its plain terms and courts are not at liberty to consider unexpressed or secret intentions)

7. Petitioner is not an intended beneficiary of the contract between DHHS and SAO. Instead, this contract is for the purpose of formalizing the relationship between two agencies of the State. Additionally, Petitioner has identified no legal basis to support a private cause of action or remedy arising out of this document. See, Wogan v. Kunze, 366 S.C. 583, 604, 623

S.E.2d 107, 118 (Ct. App. 2007) (a third party has no right to enforce a contract absent a showing that the contract is intended to create a direct rather than incidental or consequential benefit to the third person)

8. Petitioner contends that C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission, 296 S.C. 373, 373 S.E.2d 584 (S.C. 1988), requires a finding that audit report AC #3-RDM-E8 (addressing the cost report for the period November 29, 2007 through May 31, 2008 used to set the reimbursement rate through September 30, 2009) was issued in an untimely fashion as it relates to the period November 29, 2007 through September 30, 2008. The C.A.N. opinion addressed **former** contract language that required audits to be conducted "during the contract period and . . . after termination of **this contract** and for a period of three years thereafter." The Supreme Court held that the former contract language required audit reports to be issued within three years of the contract ending date. The audit periods applicable to current contracts are governed by the "rate period as defined by the South Carolina State Plan." (Petitioner Contract Art. II, Definitions "Contract Period") The deadline for issuance of the challenged audit reports differs from deadline addressed in the C.A.N. opinion. As addressed below the language of the controlling State Plan establishes that the audit reports on appeal were timely. Accordingly, disallowances identified in the challenged reports are subject to recoupment.

9. Petitioner contends that "public interest" supports its intervention in the contract between SCDHHS and the SAO. No authority offered by Petitioner supports this argument. For example, in Sloan Construction Co., Inc. v. Southco Grassing, Inc., 377 S.C. 108, 659 S.E.2d 158 (2008), the South Carolina Supreme Court determined that a third party breach of contract claim applies against a public entity only if supported by an expression of legislative intent. In

Sloan, the Court found the required intent in a statute requiring contractors to maintain bonds protecting the interest of subcontractors on public projects. No such expression of intent is contained in the contract between SCDHHS and the SAO. To the contrary, the public interest in confining Medicaid payments to costs documented as reasonable and necessary to achieve program purposes would be undermined by allowing providers to limit audit reviews in a manner inconsistent with the State Plan and controlling law. The limit proposed by Petitioner would also subvert legislation incorporated in the SCDHHS/SAO contract authorizing the SAO to review Medicaid costs to the full extent available under state and federal law. (SCDHHS/SAO Contract, "Recitals") (p. 1))

10. Petitioner has no standing to intervene in the contractual relationship between SCDHHS and the SAO under the "public importance" exception addressed in ATC South, Inc. v. Charleston County, 380 S.C. 191, 669 S.E.2d 337 (2008). As stated above, Petitioner's private interest in maintaining unearned public funds does not satisfy the "level of public importance" necessary to establish standing.

DECISION

I. Petitioner's initial cost report was subject to review by the SAO.

Petitioner's argument that the SAO is contractually barred from examining more than two cost reports for purposes of issuing final audit reports is not supported by the record or controlling law. For example, the SCDHHS/SAO contract provides that the SAO shall conduct "all engagements to determine if the reimbursement rate or amount is in accordance with the provision of the provider contracts, State Plan, and all state and federal laws and regulations." (SCDHHS/SAO Contract Art. III, ¶ B.3 (p. 3)) Limiting audit reviews in a manner inconsistent with governing law would be improper and exceed the authority of this office.

The SCDHHS/SAO contract states that it is the complete integration of all understandings between the parties. (SCDHHS/SAO Contract Art. IX, ¶ H (p. 10)) The contract's express purpose is to serve a "common and concurrent interest in ascertaining that the expenditure of Medicaid funds is in accordance with the Provider contracts and the State Plan." Even without this language, the controlling State Plan makes all records required to be maintained by Medicaid providers available on demand to the SAO. (State Plan Attachment 4.19-D, ¶ I (E) (p. 3))

If the two reporting periods referenced in the contract were intended to limit audit reviews, a construction denied by SCDHHS, the review language would contain limiting terms such as "only." This limitation is not stated in the contract and may not be added to alter the agreement between the parties. See, (SCDHHS/SAO Contract Art. III, ¶ D.1 (p. 4)) Petitioner was not a party to the SCDHHS/SAO contract, and its agreement acknowledges that: "All decisions and determinations regarding the administration of the Medicaid program shall be made by SCDHHS." (Petitioner Contract Art. IX, ¶ GG "Single State Agency Responsible for Medicaid") Petitioner's agreement also makes clear that the SAO shall have access to Petitioner's records for a period of six years following any contract, including amendments or extensions. See, Petitioner Contract Art. V, ¶ G.2 (p. 9) This is consistent with the State Plan section on "Auditing" authorizing on site audit of "all cost reports." (State Plan Attachment 4.19-D ¶ II (H) "Auditing" (p. 12))

Petitioner's reading of the contract between SCDHHS and the SAO would lead to the absurd result of restricting the SAO from examining available records and prohibiting recovery of unnecessary and undocumented costs even when the provider reports and certifies costs without required documentation. Neither the plain language of the contract nor the State Plan

supports such an outcome. Moreover, there is no evidence that Petitioner relied on the alleged limitation or has suffered any prejudice (apart from repaying unearned funds). As in any contractual relationship, it is for the parties to determine the nature of their agreement. Absent a dispute between SCDHHS and the SAO or a statutory mandate, there is no basis to impose a limit on auditors' access to information or issuance of reports.² Accordingly, Petitioner's attempt to intervene in the contractual relationship between SCDHHS and the SAO is not supportable.

Petitioner is responsible for documenting costs sufficient to demonstrate that purchases were made, used for patient care and meet all requirements for reimbursement. All transactions between related parties (entities that share common ownership or control) must be documented and limited to actual costs. Reporting undocumented related party costs is an irregularity warranting further review, even if the report related to a period outside the review process.

Terry Schmoyer testified as Petitioner's expert and was responsible for preparing Petitioner's cost reports. Mr. Schmoyer admitted that undocumented, undisclosed related party transactions were reported for reimbursement. Mr. Schmoyer further admitted that the related party and undocumented nature of these costs were known before the audit review. Submitting costs that a provider knows or has reason to know are not "true, correct and accurate" violates the cost report certification required as a condition of obtaining reimbursement for Medicaid services. The reporting of undocumented costs authorized review of Petitioner's initial report, regardless of the number or the timing of the report. (SCDHHS/SAO Contract Art. VI. 6, ¶

² Jeff Saxon is the person responsible for drafting both the SCDHHS/SAO contract and the contract assumed by Petitioner. In addition, Mr. Saxon is responsible for State Plan provisions. Any question concerning the construction of contractual or Plan language must take into account Mr. Saxon's testimony that, read together, these provisions are intended to allow the SAO full access to Medicaid provider records.

A(2); Provider Contract Art. V, ¶ G; State Plan 4.19-D (pp. 1-3)) Based upon this record, Petitioner has no enforceable claim to maintain unearned public funds.

II. SCDHHS is not barred from recovering overpayments to Petitioner.

Petitioner further argues that SCDHHS is barred from recovering identified overpayments in report AC #3-RDM-E8 (addressing the cost report for the period November 29, 2007 through May 31, 2008 used to set the reimbursement rate through September 30, 2009) as it relates to the period November 29, 2007 through September 30, 2008. Petitioner contends that the language of its contract with SCDHHS supports this position.

The contract assumed by Petitioner specifies that "the contract period will be the rate period as defined by the South Carolina State Plan." The State Plan identifies both initial cost reports (commonly called "six month reports" although the periods of less than a year may vary) and annual cost reports. Six month reports follow a change of ownership and allow the new owner an opportunity to obtain a new prospective reimbursement rate. The initial report set the rates for extended periods of time, here November 29, 2007 through September 30, 2009. Differences in reimbursements during this extended period are based on inflation and amendments to the State Plan, not changes in Petitioner's costs. Because the "rate period" determined by Petitioner's initial report extended far beyond the period reported and reviewed, Petitioner enjoyed significantly enhanced reimbursements.

Petitioner argues that because the State Plan offers no express definition, the term "rate period" means any time a rate changes, regardless of the reason. Petitioner offers correspondence from SCHDDS using the term "rate period" in this fashion as evidence that the SAO exceeded its authority and that SCDHHS is barred from recouping overpayments. (Letter from Debra Myers to Joseph Hunt dated December 16, 2011) It is well established, however, that the

representations of public employees, even acting in the scope of employment, cannot alter controlling provisions of law or regulation. Ahrens v. State, 392 S.C. 340, 351, 709 S.E.2d 54, 59 (2011) (Retirement Systems' agents cannot alter benefits) Moreover, the correspondence offered by Petitioner is countered by Mr. Saxon, author and recognized expert on the State Plan. Mr. Saxon testified that a "rate period" is the time frame determined by information contained in a cost report and is not limited to the report period itself. Petitioner's witness, Mr. Schmoyer, acknowledged that the State Plan must be read in its entirety if questions arise as to its application. Mr. Schmoyer also agreed that Petitioner's initial cost report set the base for reimbursement through September 30, 2009. The challenged audit report was issued on November 22, 2011, well within the three year period following September 30, 2009.

A reading of the State Plan, without reference to testimony from Mr. Saxon or Mr. Schmoyer, confirms that a "rate period" is the period used to establish the foundation for a provider's reimbursement. The differing treatment afforded initial cost reports in setting extended rates and annual reports setting rates for one year only would make no sense under Petitioner's interpretation. For example, applying Petitioner's interpretation of "rate period" would lead to the absurd result of setting different limitations periods for the **same costs**. Indeed, Petitioner admits that the costs addressed in AC #3-RDM-E8 and AC #3-RDM-J8 overlap, each starting on November 29, 2007. Petitioner does not contest the timeliness of AC #3-RDM-J8, so that overpayments identified in that report are subject to recovery by SCDHHS. Petitioner argues, however, that AC #3-RDM-E8 has three reporting deadlines that would render some of the same overpayments shielded from recovery by SCDHHS.

Petitioner's construction of the term "rate period" renders the distinction between initial and annual cost reports contained in the State Plan meaningless, ignores the advantages accepted

by Petitioner due to the extended application of its initial report, and undermines the public interest in maintaining the fiscal integrity of the Medicaid program. In the absence of a definition section in the State Plan addressing the term "rate period," the meaning of this term must be ascertained by the purpose of the South Carolina Medicaid program and must take into account the whole of the State Plan. This exercise confirms that the meaning of "rate period" offered by Petitioner is not consistent with the purpose of the Medicaid program or the State Plan as a whole and must be rejected. See, Gaffney v. Mallory, 186 S.C. 337, 195 S.E. 840, 845 (1938) (The meaning of statutory language is not governed by words found in one clause, sentence or part, but by consideration of the whole and the public purpose sought to be accomplished) For all of these reasons, Petitioner's objections to recoupment of funds disallowed in the final audit reports on appeal are denied.³

AND IT IS SO ORDERED.

Betsy Schindler, Hearing Officer
Division of Appeals and Hearings

Columbia, South Carolina
_____, 2014

³ Any equitable claim asserted by Petitioner would fail because the alleged "delay" in issuing audit reports was neither unreasonable nor prejudicial to Petitioner. See generally, Emery v. Smith, 361 S.C. 207, 603 S.E.2d 598 (2004) (delay alone does not establish a right to relief from payment of monies due)

1 SCHINDLER: We are on the record. You've got that one on, Thomas?
2 SMITH: Yes, it's on.
3 SCHINDLER: Thank you. This is an Administrative Appeal brought by the Countrywood
4 Nursing Center, LLC. The present date is September 17, 2014 and my name
5 is Betsy Schindler. I will be the presiding officer in this matter. I will
6 conduct this hearing in accordance with the South Carolina Administrative
7 Procedures Act and the Department of Health and Human Services
8 Regulations 126-150 through 126-158 which are regulations on appeals and
9 hearings. I will not make a decision today. When I make my decision, both
10 parties will be notified in writing. During the hearing each party has the
11 following rights. The right to ask questions, the right to call witnesses and
12 present documents, the right to cross-examine witnesses and examine
13 documents of the other party and the right to rebuke testimony of the other
14 party. The Petitioner today is Countrywood Nursing Center, LLC, who is
15 represented by Mr. Daniel Westbrook, and the Respondent is the South
16 Carolina Department of Health and Human Services who is represented by
17 Mr. Allen Nickles, III. I understand that someone from Health and Human
18 Services, Office of General Counsel may come to the hearing.
19 NICKLES: That's correct. Rick Hcpfer indicated he may come in and observe only.
20 SCHINDLER: Well, we'll give him a sign-in sheet if he does come. So I believe the parties
21 have been in discussion and may have settled some things, so if there are
22 any stipulations the sides can agree, let's go ahead and get that on the record.
23 NICKLES: Yeah, the parties engaged in settlement discussions over an extended period
24 of time relating to the reimbursement of oxygen therapy by the Petitioner.
25 The parties have reached an agreement as to the process that will be utilized
26 to identify those costs that are appropriately reimbursable. That process
27 will involve both the Office of State Auditor and representatives of
28 Countrywood Nursing Center. A report will then be provided to DHHS
29 through Mr. Saxon's office and it will be a calculation as to any costs that
30 are reimbursable for that service. Is that an accurate representation of what
31 we've agreed to?

1 VOICES: Yes, yes.
2 SCHINDLER: All right. And do you have any other stipulations?
3 NICKLES: Not that I'm aware of. I think that, you know, there are some stipulations
4 represented in the briefs of the other parties but beyond those things that
5 were previously presented to you, I'm not aware of any others.
6 SCHINDLER: All right. I guess I'll finish my spiel and then I'll get into trying to clarify a
7 few things. Okay. In attendance today other than Mr. Westbrook and Mr.
8 Nickles, we also have Ms. Alice Harris, who is an attorney for the Petitioner,
9 Terry Schmoeyer, who is a Certified Public Accountant, is that correct?
10 SCHMOYER: Correct.
11 SCHINDLER: Who has worked for the Petitioner or with the Petitioner in this case?
12 SCHMOYER: Correct.
13 SCHINDLER: And Tammie Pope who is a paralegal who is with Mr. Westbrook and Ms.
14 Harris. For the Respondent we have Mr. Jeff Saxon who is with Health and
15 Human Services. Could you tell us what your title is?
16 SAXON: Program Manager.
17 SCHINDLER: All right. Thank you. And Mr. Jay Von Kannel who I believe is with the
18 State Auditor's Office.
19 VON KANNEL: That's correct.
20 SCHINDLER: All right. Thank you. And observing the hearing, we have Mr. Thomas
21 Smith and Ms. Janet Bell. These are both Hearing Officers with the
22 Division of Appeals and Hearings. I'm assuming, I put it in email just
23 asking if anybody had any objections to the Hearing Officers observing this
24 hearing and I believe both sides said that they were fine with that.
25 NICKLES: That's correct.
26 SCHINDLER: Everybody in agreement?
27 WESTBROOK: That's fine.
28 SCHINDLER: Okay. Obviously this hearing is being recorded. This is to keep a clear
29 record so that if either party decides they want to appeal to the
30 Administrative Law Court, we will be able to get a transcript. At any point
31 during the hearing, if someone needs to take a break or needs to go off the

1 record and you just motion to me and we can take a break and we can take
2 the record down for a minute or shut off the recorders. So the issue involved
3 in the case today is whether the South Carolina Department of Health and
4 Human Services and its agent, the State Auditor's Office, correctly
5 identified and requested reimbursement for overpayment in the amount of
6 \$546,968.00 as specified in audit reports, 3RDME8, 3RMDJA and
7 3RDMJ9. I wonder if I got some of those letters wrong. I'm going to have
8 clarify that. Anyway, Mr. Westbrook, is that the issue as you understand it?
9 WESTBROOK: Yes.
10 SCHINDLER: And Mr. Nickles?
11 NICKLES: I don't think that the total amounts of the identified costs for reimbursement
12 are in issue. I do think that, for example, the oxygen therapy I believe was
13 among that amount but yes, those are the cost reports that are an issue in
14 this appeal.
15 SCHINDLER: Okay. I'm going to allow you to or allow Mr. Westbrook to argue the
16 objection that came in at the end of the day yesterday but before I do that, I
17 really want to clarify the case numbers and the numbers on the appeals and
18 the timeframe and make sure I have everything correct, because I've gotten
19 some documents that have incorrect numbers on them.
20 NICKLES: What I have and I stand to be corrected are 3RDM, J8, J9 and E8 and they
21 would be audit numbers or I guess appeal numbers 12-AUD-010, 011, and
22 012.
23 SCHINDLER: Okay, so this is what I have that 3RDM J8 is for the time period, J8 is for 9
24 through 9/30/08. Is that what...
25 WESTBROOK: Yes, that's what I have.
26 SCHINDLER: Mr. Nickles, is that what you have?
27 NICKLES: I believe so.
28 SCHINDLER: And I have that as Appeal Number 12-AUD-011.
29 NICKLES: All right.
30 WESTBROOK: AUD-011?
31 SCHINDLER: Yes.

1 WESTBROOK: I'm going to have...

2 NICKLES: I have that as J9. Is that what you're saying?

3 SCHINDLER: Yeah, apparently my original appeal letters I received, I had two appeal
4 letters that used 3RDMJ8 and no J9 so from what I can make of what's in
5 the file, I believe J9 is Case number 010 and that ended September 30th of
6 '09.

7 NICKLES: Okay.

8 WESTBROOK: And I'm sorry, Ms. Schindler, you said and that would be 12-AUD-010?

9 SCHINDLER: Dash J9, oh, I'm sorry, 12-AUD-010, yes.

10 WESTBROOK: 12-AUD-010 and J9.

11 SCHINDLER: It's actually 010.

12 WESTBROOK: 010. That's J9, okay.

13 SCHINDLER: That's J9 and then E8 which ends May 31st '08 is 12-AUD-012.

14 WESTBROOK: 012, okay. Yeah.

15 SCHINDLER: I just want to make sure we're all taking about the same time periods.

16 WESTBROOK: Right, right. I think the, you know, the time, I'm sure that's right but I don't
17 have the appeal numbers at my fingertips. We can certainly verify that now
18 if you want to or at a break or whenever you'd like.

19 SCHINDLER: You can do it at a break. I just wanted to try and get on the record which,
20 which timeframes I'm considering which appeal numbers so.

21 NICKLES: Okay.

22 WESTBROOK: Those jive with my timeframes.

23 SCHINDLER: Okay.

24 WESTBROOK: And the audit numbers but I just don't have the appeal numbers.

25 SCHINDLER: Okay. Okay, so Mr. Westbrook, do you want to respond to the—Mr.
26 Nickles objection of the admission of the parole evidence that came in at
27 the end of the day yesterday?

28 WESTBROOK: Sure. I do. I also, let me just mention that before we get started I have a
29 couple of other questions about procedure...

30 SCHINDLER: Sure.

1 WESTBROOK: ...but I can hold if you like until after we talk about the parole evidence.
2 However you'd like to do it.
3 SCHINDLER: Go ahead and do the objection and then we'll get on to that.
4 WESTBROOK: All right. Well, yes, I got Mr. Nickles' memo yesterday about parole
5 evidence and what his memo says is he's objecting to the admission of
6 parole evidence in the deposition of Jeff Saxon and in his pre-hearing brief,
7 Petitioner attempts to address the intent of parties to his contract. I don't
8 think that's true. I, I agree that parole evidence is, we all know the parole
9 evidence rule but I think what he's characterizing as parole evidence is not
10 parole evidence. Parole evidence is evidence as he says in his brief, that its
11 extrinsic evidence whether written or verbal of agreements or
12 understandings used to contradict, vary or explain the written instrument,
13 and in this case it's a contract and in this case it's the contract between SAO
14 and DHHS, what I am referring to as the SAO contract. That's not our
15 position at all. We believe the contract stands by itself, doesn't need any
16 extrinsic evidence to explain it or to vary it or contradict it. We stand by the
17 language of that contract. That's our case or our argument. We have two
18 arguments, based on two different contracts and both of our arguments rest
19 on the language of those contracts. We don't want anything. We don't
20 believe there's any written or verbal testimony that needs, that's needed to
21 explain or vary or contradict any one of those contracts. What Mr. Nickles,
22 I believe, is referring to is the testimony that Mr. Saxon gave in his
23 deposition and which we noted in our brief related to negotiations years ago
24 between the Healthcare Association which is a nursing home association,
25 and DHHS that resulted in contractual change. Now, that evidence, whether
26 it comes through the testimony of Mr. Saxon or regardless of the source, is
27 not offered, has not been offered in our brief and has not been intended to
28 be offered today to contradict, vary or explain the contract. It's simply
29 offered that nursing homes are the intended beneficiaries of the SAO
30 contract. That's a huge difference. Where that comes in is, the SAO
31 contract is a contract, as I say, that no nursing home is a party to. It's a

1 contract between HHS and SAO. So Mr. Nickles' argument is you, that
2 Countrywood, don't have any right to enforce that contract, to discuss that
3 contract, even if the con—even if the contract is being violated, you don't
4 have a right, Countrywood, to complain about it. Our response to that is oh
5 yes we do, because we are an intended beneficiary. We are third party
6 beneficiary of that contract. The evidence we have or some of the evidence
7 that we have that we are third party beneficiary, beneficiaries of the contract
8 is the testimony that Mr. Saxon is going to give and gave in his deposition
9 about the negotiations that resulted in the change in the contract. So those
10 negotiations and the evidence of the negotiations are not offered to vary or
11 explain. They're completely consistent with the terms of the contract. All
12 their offer has is a defense to his allegation that we're not third party
13 beneficiaries. It's, it's offered in support of our position that we are third
14 party beneficiaries. So that's—so the evidence is not parole evidence. It's
15 evidence that goes—it doesn't go to the meaning of the contract. It goes to
16 who's the beneficiary of the contract and I might add something related to
17 that. When it comes time, when and if the Department presents, tries to
18 present evidence today, verbal evidence of, of practices by HHS that vary
19 or explain or modify the contractual terms, I intend to object on the grounds
20 that that is parole evidence. I'll give you some specifics of that. In his
21 deposition Mr. Saxon also said that we always or we routinely, it's our
22 practice to audit six month cost reports and that's why you can ignore this
23 language about, in the contract, that only two con—only two cost reports
24 can be audited. He also testified that many times over the years we've been
25 audited more than two cost reports at a time. Even though the contract says
26 you're only audited two at a time. Now that is quintessential parole
27 evidence. That is evidence that's used that's being offered, if it's offered
28 today, by the Department to explain and vary and modify the terms of the
29 contract. So I'm going to be objecting to that parole evidence. What Mr.
30 Nickles is objecting to is not parole evidence. It's not evidence that goes to

1 the meaning of the contract. It's evidence that goes to whether we are
2 beneficiary of the contract.

3 NICKLES: If I might respond?

4 SCHINDLER: Yes.

5 NICKLES: Okay. I find the Petitioner's argument interesting in that they are asserting
6 that verbal testimony can be introduced by, for their purposes, to explain
7 what they contend is a disputed issue in the contract. I know that Mr.
8 Westbrook didn't mean to misspeak. There is no term "only" in the contract
9 related to the number of reports that will be examined. We'll look at the
10 plain language in the contract as to that particular matter. What he's
11 attempting to do is bootstrap his argument that somehow his client, this
12 Petitioner, is a third party beneficiary of a public contract between two State
13 agencies. We've addressed that issue in our pre-hearing brief and what the
14 law of this State is that in order to establish status as a third party
15 beneficiary, in order to establish status or standing to even comment on or
16 examine a public contract, one has to show that there is some legislative
17 intent to provide a benefit to a particular entity or a particular industry and
18 the way that is done is through statute. And the case is presented by the
19 Petitioner in support of its argument actually will encounter to their
20 argument in this case because those cases clearly establish that in order to
21 be a party to or a participant in or a contestant to a public contract, it has to
22 be demonstrated that there is a direct intent to benefit that industry or
23 individual. There is no such thing in this and what he's attempting to do or
24 the Petitioner's attempting to do is to go back in time to say that well, yes,
25 there were dis—there were discussions among parties and individuals and
26 others about what contractual language should be. The parole evidence
27 says, rules says you cannot introduce any language about negotiations or
28 intent or what was proposed beyond the four corners of the document.
29 That's the essence of the parole evidence rule. It says contracts speak for
30 themselves, particularly as in this case where there are integration clauses,
31 those clauses that say specifically we ain't kidding, we mean what we say

1 and we say what we mean and you can't look beyond the four corners of
2 this document. Those clauses are in not only the agreement between DHHS
3 and the Auditor's Office but between DHHS and this Petitioner. So the
4 proposal that we ignore controlling law of this State, that we ignore the
5 expressed intent and representation of the parties to these documents, and
6 we allow testimony to come in to somehow explain what the Petitioner
7 contends is a contested term which we have never contended to be the case,
8 it's a clear term. It does not say only in any respect and there are other
9 provisions inside the contract that verify that to be the case. So our position
10 here is that this is an attempt to go beyond the four corners of a document
11 that was entered between two State agencies. The Petitioner was not a party
12 to that. The Petitioner was not a participant in that. The Petitioner was not
13 a negotiator in that and even if had been, it's excluded from commenting on
14 it by the parole evidence rule that governs the construction, the application,
15 and the enforcement of contracts in this State, so our position is a very
16 simple one. There are documents that require certain actions and allow for
17 certain actions. The Petitioner stipulated that there are no facts in dispute
18 in this proceeding, therefore, there is no need for any testimony on, on any
19 of these issues. The—the issue before you is what does the contract say?
20 Not does what—what was the motivating process that resulted in the
21 contract because that's excluded. It was excluded by law and it's excluded
22 by the agreement between the parties. So we're here to say with the contract,
23 with the State Plan, those things authorize the actions that were taken, they
24 contend that those documents do not and let's get to the issue that's properly
25 presented for appeal.

26 SCHINDLER: All right. Thank you both for that. Before I rule on this objection, I'm going
27 to ask both Counsel to please keep a list of the objections made during this
28 hearing and at the end of the hearing we'll compare notes and make sure we
29 have all of them and I've ruled on them or whether I've ruled on them in
30 the decision but I just want to make sure that I'm addressing everything so
31 I'm going to task y'all with that to begin with. As far as this objection goes,

1 I think I'm going to allow the testimony that we're discussing about the
2 terms of the contract and I'll make a decision when I'm writing my decision
3 whether I'll use that for probative value or I'll discard it at that time. But
4 I'll allow it on the record at this time.

5 NICKLES: And for purposes of the record, would Counsel agree that I need not iterate
6 the verbal objection on each occasion which this is presented and my
7 objections will be continue to be preserved in the record?

8 WESTBROOK: Yes sir.

9 NICKLES: All right. There is one other evidentiary issue that we've raised in our pre-
10 hearing brief that we'd like to discuss in regard...

11 SCHINDLER: Okay.

12 NICKLES: ...to his testimony. And that goes to the testimony to be offered by Mr.
13 Schmoyer.

14 SCHINDLER: What's the grounds of that objection?

15 NICKLES: Mr. Schmoyer has been identified by Petitioner as an expert who can offer
16 opinions as to the propriety of the actions taken by the Respondent in this
17 case. Mr. Schmoyer in his deposition admitted that he is a, an agent of this
18 Petitioner, that he is employed by the Petitioner to maximize their
19 reimbursement, Mr. Schmoyer has shown that he has attempted to tilt the
20 even playing field here by an email that I have made available to you
21 suggesting that the retention of Nelson, Mullins in the negotiation process
22 and the employment of Bill Prince, a former Executive Director of this
23 Agency would put them in a favorable position to obtain a preferential result
24 in this case. He has also admitted in his deposition that he was aware of
25 undisclosed and unreported related party transactions which are contrary to
26 the obligation of the Petitioner. The Petitioner has actually signed under
27 penalty of perjury, a—two cost reports in which these undisclosed and
28 unreported related party transactions are sought to be reimbursed. We think
29 that Mr. Schmoyer's involvement in this process shows him to be an
30 advocate, not to be someone without an interest in the outcome of this

1 proceeding and that his testimony as to opinions in this matter are—should
2 not be admitted and should not be provided any weight.

3 SCHINDLER: All right. So are you asking him to be struck as a witness or just struck as
4 an expert?

5 NICKLES: I'm ask—struck as an expert. If he has factual information that he wants to
6 present, I mean I think that he can present that and his credibility would be
7 up for you to decide but as to the offering of opinions in this thing, I don't
8 think that he meets the standards.

9 SCHINDLER: All right. Mr. Westbrook, would you like to respond?

10 WESTBROOK: Sure. I would, thank you. Mr. Nickles' objections go to Mr. Schmoyer's
11 credibility, not to his qualifications as an expert. He's got eminent
12 qualifications as an accounting and cost reporting expert. He's been a CPA
13 for twenty-something years. He's plowed over a thousand Medicaid cost
14 reports. He's clearly qualified as an expert. They go towards his credibility.
15 I'm going to talk about that for a minute. Obviously credibility is an
16 important thing. He, first of all, he's not employed by Countrywood. He's
17 retained by Countrywood as a third party contractor. There is—I've been
18 practicing law for almost as Mr. Nickles has been practicing, but he's older
19 than I am, I'm sure. But he looks young. But most of the cases that I do
20 has an expert and I've never had an expert, I don't believe, in any case and
21 I don't recall any expert opposing me. I've never done a DHHS hearing
22 before where the expert wasn't paid by the other side, I mean by his, by, by,
23 not the other side, paid by his, the person who's retaining him, either
24 employees or like Mr. Schmoyer's an independent contractor. That doesn't
25 mean that the expert is tainted in any way. That doesn't mean that he's not,
26 he's not a credible expert. What Mr. Schmoyer will be prepared to testify
27 here today is sure, it's part of every accountant's job to do the best they can
28 for their client who as Mr. Nickles put it, maximized their revenue within
29 the bounds of the law and ethical guidelines. As long as they do that, I'm
30 sure all of us here want our accountants to do the very best they can when
31 we file our tax returns to maximize whatever returns we get from the IRS

1 within the bounds of the law. And that's what Mr. Schmoyer's going to
2 testify he did here. Now with respect to my law firm and, and my former
3 partner, Bill Prince. Bill Prince was a Medicaid Director, then he came to
4 our law firm for a few years and now he's with somebody else, and at the
5 time there was an email that Mr. Nickles referenced and is relying on where
6 Mr. Schmoyer wrote to Countrywood and said, do you need a lawyer, I
7 recommend you use—hire Bill Prince at Nelson, Mullins because he's a
8 former Medicaid Director and he has good connections there. Well, sure,
9 and what Mr. Schmoyer will testify is that Bill Prince has good connections
10 at DHHS because he has a good reputation, because he has a reputation for
11 honesty, integrity, and knowledge and competence and that he knows who
12 to go and ask. Mr. Schmoyer's going to say I didn't know who to go to and
13 talk to about a payment plan. Mr. Prince would know that individual. It's
14 not that there's anything shady or anything implied as a backroom deal
15 about this. It's just that if you want to hire somebody to try to negotiate
16 with an Agency about working out a payment plan or a settlement, it would
17 be helpful to have somebody who A., has a good reputation who they know,
18 and secondly, who knows who to call and talk to about that. That's
19 absolutely nothing wrong, unethical or illegal about any of that. With
20 respect to the undisclosed, unreported related party transactions, that's a
21 mistake. It's an oversight and what Mr. Schmoyer's going to testify is that
22 it's, it is a mistake but it certainly was not done intentionally. Cost reports
23 are complicated things and there's a lot of information that occurs on them
24 and sometimes oversights happen. But that doesn't mean that it was
25 anything intentionally negligent or intentionally, it doesn't mean it was an
26 intentional oversight. And it's certainly no reason to exclude him as an
27 expert. He is a qualified expert in cost reporting and accounting,
28 particularly for nursing homes. So he ought to be able to offer opinions in
29 those fields.

30 NICKLES: And if I might just reply. I'm gratefully...

31 SCHINDLER: Certainly.

1 NICKLES: Mr. Westbrook is correct and the two of us have been practicing law a long
2 time. I have never been in a case where the expert hand-picked the lawyers.
3 I've never been in a case where the expert assisted in concealing improper
4 requests for reimbursement by a party. You know, these are very serious
5 matters and the purpose of expert testimony is to assist a decision maker in
6 providing information beyond the kin of the decision maker's knowledge
7 base or ability. I think in this instance there is no need for that and
8 secondarily, I think that the record shows that Mr. Schmoyer is first and
9 foremost an advocate, is first and foremost someone who is attempting to,
10 even at the expense of truthfulness, to obtain a desired result for his client,
11 and for those reasons I think he should not be allowed to testify on matters
12 that call for the expression of opinion.

13 SCHINDLER: Thank you.

14 WESTBROOK: Can I respond just very briefly to that, please? If it's not necessary, I won't.
15 This is something new.

16 SCHINDLER: I don't think it's necessary.

17 WESTBROOK: Okay.

18 SCHINDLER: I'm going to rule that I will allow Mr. Schmoyer to be an expert witness in
19 his accounting role. That's my interest, and I will make decisions about his
20 credibility as I look at the record in this case. Are there any other objections
21 at this time?

22 NICKLES: No, I think that as you said earlier that this is governed by the
23 Administrative Procedures Act and therefore the Rules of Evidence would
24 apply in this proceeding. Is that correct?

25 SCHINDLER: Yes, you are correct.

26 NICKLES: Okay.

27 SCHINDLER: All right. So now I'm getting back to...

28 NICKLES: And similarly, if my objection can continue through the process, I would
29 appreciate that, just to Mr. Schmoyer's testimony without having to object
30 at every occasion which he offers an opinion.

31 SCHINDLER: And I'll certainly note that.

1 WESTBROOK: All right. I want to note my objection then. If Mr.—to the extent that Mr.
2 Nickles' objection to Mr. Schmoyer is based on lack of neutrality from an
3 expert, something I have never heard argued before in court, then I'm
4 making the same objection about Mr. Saxon's lack of neutrality.

5 NICKLES: Well, we'll stipulate Mr. Saxon wants to make certain that, you know, that
6 the Agency collects what is due.

7 WESTBROOK: That's not my (unclear).

8 SCHINDLER: And I will also recognize Mr. Saxon as an expert witness. I'm just going to
9 quickly correct. I misquoted. One of these audit reports, I believe they're
10 all supposed to be 3RDM-JA. I called it RMD so excuse my dyslexia there
11 for a moment. All right, so I'm going to take official notice of the file for
12 the record at this time. For the appeals I have before me audits 12-AUD-
13 010, 011, and 012. I have Petitioner's Exhibit 1 is the actual appeal for Case
14 010; Petitioner's 2 is the appeal for 011; and Petitioner's 3 is the appeal for
15 012. Petitioner's 4 is the Motion for Partial Summary Judgment.
16 Petitioner's 5 is Petitioner's reply to DHHS's memorandum in opposition
17 of Plaintiff's Motion of Partial Summary Judgment; Petitioner's 6 is Pre-
18 hearing Conference Summary; and Petitioner's 7 is a Pre-hearing Brief.
19 The Respondent's Exhibits I have at this time are Respondent's 1 is
20 Respondent's Memorandum of Opposition to Petitioner's Motion of Partial
21 Summary Judgment; Respondent's 2 is the Pre-hearing Brief; and
22 Respondent's 3 is Objection to Admission of Parole Evidence.

23 NICKLES: And there are attachments that are a part of each of those by both parties, I
24 believe.

25 SCHINDLER: There are.

26 NICKLES: That are a part of the record as well.

27 SCHINDLER: And I intend to use the numbers, how you numbered your exhibits,
28 especially on the briefs, but I'm going to call them all under the umbrella,
29 Respondent's Exhibit 3 or Petitioner's 4, or whatever. For Hearing
30 Officer's Exhibits, I—the Hearing Officer Exhibit 1 is the pre-hearing
31 orders which include Pre-hearing Conference Order, Scheduling Orders and

1 then there's Scheduling Order Notice of Hearing, the various emails about
2 continuances and scheduling issues. The Hearing Officer's Exhibit 2 is the
3 Order denying Petitioner's Motion for Partial Summary Judgment. Are
4 there other exhibits that either party wishes to present at this time? I see I
5 have a notebook of Petitioner's Exhibits. Is this...
6 WESTBROOK: I just left that for you, Ms. Schindler. I don't know if you need that or want
7 that but...
8 SCHINDLER: And is this all the exhibits I've already got or is this all...
9 WESTBROOK: No, actually, it's the 1 through 13, I think you already have. 1 through 13
10 are the ones, the exhibits to our pre-hearing brief.
11 SCHINDLER: Okay.
12 WESTBROOK: Let me make sure I've got those numbers right. I think 14, yeah.
13 SCHINDLER: Did you give Mr. Nickles a copy of all these?
14 WESTBROOK: I don't—I can, I think he's got all that. I've got to get him, if he doesn't
15 have it but I'm sure he's got it all.
16 NICKLES: I'm sure I have it in one place or another.
17 WESTBROOK: Yeah, let me tell you about...
18 SCHINDLER: Well, let's go through it and see exactly what it is and make sure both sides
19 have everything.
20 WESTBROOK: Sure. First of all 1 through 13 are Exhibits 1 through 13 of our pre-hearing
21 brief so both of you already have that. 14, 15 and 16 are the 1997, 1998 and
22 1999 SAO Contracts which are also exhibits to Mr. Nickles pre-hearing
23 briefs so...
24 SCHINDLER: Yes, so I already have those...
25 WESTBROOK: ...you already got them.
26 SCHINDLER: ...in Respondent's Exhibits.
27 WESTBROOK: Yeah, I'm not sure I even included them (unclear).
28 SCHINDLER: Okay. 15, 16 and 17.
29 WESTBROOK: That's 14, 15, and 16.
30 SCHINDLER: 14, 15, and 16. I'm sorry. All right.
31 WESTBROOK: Now the last one, I believe it's the last one, 17, is that right?

1 SCHINDLER: No, I've got an 18 and 19—I've got 17, 18 and 19.
2 VOICE: The depositions.
3 WESTBROOK: Huh?
4 VOICE: The depositions.
5 WESTBROOK: Ah, okay. 17, let me tell you about—17 is a letter that is related to the
6 oxygen issue that we settled so it's, I'm sorry.
7 SCHINDLER: That's all right. It looks like 17 in my notebook is Mr. Saxon's deposition.
8 WESTBROOK: Hah, okay. A couple of notes here on exhibits—17 is the Saxon deposition,
9 18 is the Schmoyer deposition.
10 SCHINDLER: All right. And these are the complete depositions, not just excerpts?
11 WESTBROOK: Correct.
12 SCHINDLER: All right. So these are new exhibits to me. Mr. Nickles, are these new
13 exhibits to you? Do you already have them?
14 NICKLES: Well, what we've, what we've done is that there were some excerpts that
15 were introduced during the, I guess pre-hearing briefing process and Mr.
16 Westbrook asked that the entire deposition be made available. I have no
17 objection to the, to the deposition itself being made available, you know,
18 preserving any hearsay objections or whatever we may want to identify at
19 some point in time because these were taken subject to the exercise of those
20 objections at the appropriate time, and I quite frankly haven't looked at them
21 to that extent. If it is necessary I think both parties could go through at some
22 point after this hearing during the deliberate process and identify any areas
23 that we believe should not be considered by the Hearing Officer. Is that a
24 fair way of doing it?
25 WESTBROOK: That's fine. And, yeah, I don't have an objection.
26 NICKLES: So they're, they're admitted subject to objections that may be raised as to
27 hearsay or other evidentiary issues.
28 WESTBROOK: Let me just add something here about the depositions. I'm, you know the
29 only reason I'm offering these as exhibits is because Mr. Nickles offered
30 excerpts and I'd rather have them, you know, full depositions than just

1 excerpts. You know, if we're—I don't know to what extent the Civil Rules,
2 the Rules of Civil Procedure apply at a hearing like this. I mean I...
3 NICKLES: They apply completely.
4 WESTBROOK: If they do apply completely, I don't think the depositions are appropriate as
5 evidence in this case under Rule 32 because the witnesses are here. We can
6 use them to impeach the witnesses but the only reason, you know, that I'm
7 offering those is because I'd rather have the full than the excerpts. I really
8 don't think under the rule they're appropriate at all. I don't object to them.
9 If nobody objects to them I guess it's okay but I think it's still up to the
10 Hearing Officer to decide whether, you know, whether she wants to put in
11 her record the stuff that really shouldn't be there. That's my thoughts. But
12 so I'm just going to leave it with you. I'll just add any objection to them.
13 NICKLES: Well, the parties can always, the parties can always stipulate regardless of
14 the rules that they'll be, you know, subject to review with the caveat that
15 the parties would like to reserve opportunity let's say not later than you
16 know five days following the close of the hearing to identify any...
17 WESTBROOK: Let's make it fifteen days.
18 NICKLES: Fifteen days following the close of the hearing to identify any areas that we
19 object to.
20 SCHINDLER: That's acceptable.
21 WESTBROOK: That's fine.
22 SCHINDLER: What I'm going to do, it looks like 19 in the notebook is a letter and you're
23 saying this letter...
24 WESTBROOK: Yes.
25 SCHINDLER: ...deals with the O2 settlement, the oxygen settlement. Is it—it looks to me
26 and I've taken time to read this...
27 NICKLES: It really doesn't relate to any issue currently.
28 WESTBROOK: If we resolve the oxygen issue, Exhibit 19 is not—does not relate to the
29 remaining issues.

2

1 SCHINDLER: Okay, so this letter is dated January 17, 2013 and it looks like it's something
2 about diabetic supplies and other things. I'm not seeing oxygen mentioned
3 in here at all.

4 WESTBROOK: Well, it's, it's—oxygen is covered by it, but again because I think we've
5 resolved the oxygen issue, I'm happy to withdraw that.

6 SCHINDLER: Okay. I'm going to just take this out of the notebook then because it is not
7 a current issue. Okay, so I'm going to call what's in the notebook as 17 and
8 18 which are Mr. Saxon's and Mr. Schmoeyer's complete depositions are
9 going to be Petitioner's 8.

10 NICKLES: Okay. And just for the record, there will be exhibits referenced in those
11 depositions. I think most of the exhibits are introduced otherwise and not
12 attached to the deposition that's provided in those exhibits.

13 SCHINDLER: And those are part of the Respondent's pre-hearing brief, is that or do you
14 have some of them?

15 NICKLES: I think some of them are in mine, some of them are in his, I mean...

16 SCHINDLER: All right.

17 WESTBROOK: Between the two of them. I also have a question that relates to exhibits as
18 well. I notice that Mr. Nickles I believe has both his pre-hearing brief and
19 his summary judgment brief as exhibits. You know, obviously I don't want
20 to have anything in the record on his side that's not on my side. They're
21 not—they're already part of the record though.

22 NICKLES: Right, they're part of the record.

23 WESTBROOK: So my, my—we have a Summary Judgment Brief and Summary Judgment
24 Reply Brief and a Pre-hearing Brief.

25 SCHINDLER: Yes.

26 WESTBROOK: And since those are all part of the record I guess I don't see any need to
27 make them exhibits to the trial unless you...

28 SCHINDLER: They are all part of the record already.

29 WESTBROOK: And they would be on the record on appeal, if there is an appeal?

30 SCHINDLER: Yes. The Motion of Partial Summary Judgment and your Reply to Motion
31 of...

1 WESTBROOK: And the memorandum.
2 SCHINDLER: Yes.
3 WESTBROOK: Okay.
4 SCHINDLER: And are those the things, was there something else I'm missing?
5 WESTBROOK: The pre-hearing briefs.
6 SCHINDLER: And I've got the pre-hearing briefs, yeah, so all of those are already exhibits
7 that exist in the record so no need to...
8 WESTBROOK: Good.
9 SCHINDLER: ...submit those multiple times. All right, so and at that all the exhibits at this
10 time that either party wants to give me.
11 WESTBROOK: It's all the (unclear).
12 NICKLES: I just want to make sure that our written objection to the parole is part of the
13 record as well.
14 SCHINDLER: I've got that as Respondent's Exhibit Number 3.
15 NICKLES: Okay, thank you. That works.
16 SCHINDLER: Okay. And I'm assuming, I'm not going to assume, I'm going to confirm
17 on the record that Mr. Westbrook, you have no objection to any of the
18 exhibits I've listed being part of the record?
19 WESTBROOK: No objection.
20 SCHINDLER: All right. And Mr. Nickles?
21 NICKLES: No objection.
22 SCHINDLER: All right. Thank you. Okay, as the Petitioner has the burden of proof in this
23 case, I'm going to have the order of presentation be the Petitioner first and
24 then the Respondent as we stated in our emails going back and forth. So...
25 NICKLES: Do you entertain brief opening statements?
26 SCHINDLER: Yes. I will and please keep them brief. I would appreciate it. I'll have Mr.
27 Westbrook to go ahead with his opening statement now.
28 WESTBROOK: Before I do that, could I ask—I have two or three procedural questions that
29 have been...
30 SCHINDLER: Certainly.

1 WESTBROOK: If that's okay. Given the argument that we had a few minutes ago and your
2 ruling on the parole evidence argument, do I—it sounds like that Mr.—you
3 have already decided that both Mr. Saxon and Mr. Schmoyer are qualified
4 as experts. Do I need to take the time during my examination to move to
5 have him qualified?

6 SCHINDLER: No. I think we can go ahead and say that I recognize both as experts.

7 WESTBROOK: Is it customary, just as a matter of procedure here in your practice and in
8 DHHS practice for these kind of hearings to have direct, cross, re-direct and
9 re-cross? Is that...

10 SCHINDLER: Yes, that's the normal.

11 WESTBROOK: ...the normal procedure?

12 SCHINDLER: Yes.

13 WESTBROOK: That's—okay, I just want to make sure. And finally, last but not least, since
14 I didn't get Mr. Nickles' memo on parole evidence until last night, can I be
15 allowed to submit to the record a very brief written response to that?

16 NICKLES: I have no objection to that.

17 SCHINDLER: Certainly.

18 WESTBROOK: And it'll be a minimal.

19 SCHINDLER: Okay, and I will actually when you submit that, that will become
20 Petitioner's Exhibit 9.

21 WESTBROOK: Okay.

22 SCHINDLER: And you will have that to me within three business days, is that reasonable?

23 WESTBROOK: Yes ma'am.

24 SCHINDLER: Okay. And just a quick housekeeping note before you give your opening.
25 The restrooms are on this floor if anyone needs them. You found the water.
26 If anyone needs to take a break, let me know. We will take a lunch break if
27 we need to and we'll try and do it and, you know, find a good time but if
28 anybody has any parking restrictions that they need to go put money in a
29 meter or anything, please let me know so. All right? Please proceed Mr.
30 Westbrook.

1 WESTBROOK: All right. Thank you, Ms. Schindler. Yes. This is a case about two
2 contracts. One is what I'm going to call the SAO Contract which stands for
3 State Auditor's Office and the other is what I'm going to refer to as the
4 Facility Contract which is a contract between Countrywood, which is the
5 facility in question, and DHHS. The issue with the SAO Contract is this.
6 It's simple. The contract says that the SAO can audit two cost reports absent
7 allegations of fraud. There is—its simple language, its plain language, we
8 don't have any attempt, we're not going to try to show that there's any sort
9 of hidden meaning for that or that there's any outside evidence to that
10 qualifies that in any way. We think the language means what it says, two
11 audits and in this case they audited three. The second contract is the Facility
12 Contract. And the Facility Contract, and of course I'm paraphrasing here
13 but we don't put up the exact language, show you the exhibit what the exact
14 language is. The Facility Contract, key section there says that the final audit
15 report, when you're auditing and the SAO is conducting its audits, final
16 audit report must be issued three years from the close of the contract period.
17 Then it goes on to say that the contract period is the rate period, so contract
18 period and rate periods, the terms of the Facility Contract are the same thing.
19 So the question for the second issue, there are two questions really, A.,
20 what's a rate period and B., when did the rate relevant rate period close?
21 Because the final audit report has to be issued within three years of the close
22 of that rate period. Now these are alternative grounds that Countrywood
23 has, meaning we don't have to—I hope we win on both of them but only
24 one of them will be fine with us, on either ground, either under the SAO
25 Contract provision or the Facility Contract provision, these audits were
26 done improperly in violation of one or both of these contracts. These are
27 separate grounds from reversal of DHHS decision in this case.
28 SCHINDLER: Thank you. Mr. Nickles?
29 NICKLES: Yes, thank you very much. One thing I wanted to do inviting some context
30 to this appeal is to give just a brief outline in general terms of the process
31 that brought us here today. The Petitioner in this case, Countrywood, is a

1 Medicaid provider, in Mr. Westbrook's terms, a facility, and in order to
2 participate in the South Carolina Medicaid Program, it must submit cost
3 reports for reimbursement and in those cost reports, and we will go through
4 two of the reports provided by this facility in some detail, there are two
5 fundamental requirements. Those reports must be complete and they must
6 be accurate. There is a desk review at DHHS following the issuance of a
7 cost report in which preliminary reimbursement rates are established. This
8 desk review does not examine the records of the provider. It relies upon the
9 accuracy and the honesty of information submitted in the cost report. Those
10 reports are subject to further audit review and facilities' providers know that
11 their rates are not final until this review is performed or the period of time
12 in which it is allowed for the review is exhausted. These facilities have to
13 maintain their records for a minimum of six years in order to provide the
14 Office of State Auditor and DHHS the opportunity to examine and
15 determine whether or not monies that have been paid to these facilities are
16 in fact appropriately paid and if they're designated as inappropriate for
17 whatever reason, provider's given notice through a report, they're given an
18 opportunity for a hearing such as we have today. Now the audit review
19 process is different from the desk review in a number of respects. Primarily
20 in the opportunity to visit the facility, to examine the services being
21 provided, to examine the costs, to examine the backup, to determine
22 compliance with program requirements, to make certain that the amounts
23 that are being charged to the State are appropriate, reasonable and necessary
24 for the Medicaid Program. Now there are certain guiding principles that
25 apply here, State Plan, Federal Guidelines that govern the receipt and the
26 maintenance of this money that's being paid by the State. If a provider
27 doesn't satisfy all program requirements, then they're pay is subject to
28 disallowance or adjustment and they are provided that notice. Now in this
29 appeal process it is the burden of the facility to provide—to identify why it
30 should be allowed to retain funds that have been designated as
31 overpayments for services provided and that's the reason that they go first

1 because the burden of proof is there's. And it only makes sense because
2 what they're doing is they're getting paid essentially in advance for
3 providing Medicaid services subject to examination after the fact. So
4 they've had this money for a while, been using it, now they've got to justify
5 continuing to maintain that. One of the key and critical provisions of the
6 Medicaid Program is that all transactions between related parties and those
7 parties would share ownership and control must be disclosed. There's a
8 specific provision with cost report requiring that disclosure and that any
9 request for reimbursement must be at no more than the actual cost of that
10 good or service provided. You can't self-bill. You can't bill then profit
11 when you are a related party. And that's well known within the industry.
12 Now in this instance what we have is a dispute about whether or not the
13 initial report issued to this provider was timely and whether or not they even
14 had the authority to examine the costs in that report. Now that's a novel
15 issue and one that requires some degree of examination of the State Plan
16 and the contracts, but what is clear in this instance is that the costs being
17 claimed as not subject to examination, the report being claimed as untimely
18 covers the very same costs, the very same costs as in a report that is not
19 contested in this case. Because the first report for a shorter period of time
20 when this facility came—changed ownership and was allowed to get a new
21 and increased reimbursement rate, is a short of period of time that sets a rate
22 for a long period of time. The second report under review which there is no
23 challenge to covers the exact same period of time plus a few months. And
24 what this provider wants to say is the State has to ignore these first six
25 months of costs, that they are immunized from any dereliction in that report,
26 that they cannot be held accountable for the services provided and the
27 monies received during that period of time and it's sort of a gotcha type of
28 position that's being taken. That's troubling in this instance for a number of
29 respects. One is because the testimony will show that not only are the same
30 costs being requested in both these reports, but the same misrepresentation
31 was made in both reports as to not disclosing related party transaction and

1 seeking to retain funds based on that failure to disclose. That's troubling.
2 We'll address that during the course of the proceedings. So what we have
3 here today is an effort by this Petitioner to construe an authorization within
4 the contract as a limitation and to impose upon a reading of the contract and
5 State Plan something that's entirely inconsistent with its guiding principles
6 and purposes. We'll address those throughout the course of the proceeding.
7 I think at the conclusion of the testimony, the conclusion and examination
8 of the records, the only result that can be obtained is that there is no two
9 cost report limit as advocated by this Petitioner and that the reports issued
10 in this instance were well within the three years provided by law and with
11 those findings then all of these costs that have been identified as
12 overpayments, this half million dollars or so that is in issue which this
13 Petitioner's not contesting that they should have gotten it originally, they're
14 saying we can't collect it for procedural reasons, okay. That their procedural
15 arguments are without merit, the State is entitled to recover these funds they
16 were overpaid, and that the legal arguments asserted by the Petitioner are
17 not consistent with controlling law, with controlling contractual language,
18 with controlling provisions of the State Plan.

19 SCHINDLER: Thank you. I just have one question for clarification. When you were
20 talking about the auditing process and you said that the initial desk audit is
21 to establish a preliminary rate before any on-site review is done, and you
22 said the rate is not final until the review is performed, is that the desk review
23 is performed or...

24 NICKLES: During the audit.

25 SCHINDLER: ...that's the on-site review. Okay, so the initial desk audit sets the rate but
26 then the rate becomes final when the live on-site....

27 NICKLES: Or when this process is complete.

28 SCHINDLER: Okay, when the appeal proc—okay, so that's the final, all right, thank you.
29 That's all I needed. So do I understand correctly the only witnesses that are
30 going to testify today are Mr. Saxon and Mr. Schmoyer?

31 NICKLES: That's correct.

1 SCHINDLER: All right. I think...

2 NICKLES: As far as I know. Is that...

3 SCHINDLER: I'm going to swear them both in right now and that way we'll have that out
4 of the way. So Mr. Saxon and Mr. Schmoyer, if you don't mind raising
5 your right hand and I'm going to read the oath and if then if you'll affirm it
6 and state your name for the record. Do you swear or affirm that the
7 testimony you are about to give is the truth, the whole truth, and nothing but
8 the truth?

9 SCHMOYER: I do.

10 SAXON: I do.

11 SCHINDLER: And can you state your name for the record?

12 SCHMOYER: Terry Schmoyer.

13 SAXON: Jeff Saxon.

14 SCHINDLER: You have both failed the first test.

15 SCHINDLER: I apologize.

16 (Laughing)

17 SCHINDLER: That's fine. We're ready to go ahead with the case now. Mr. Westbrook,
18 would you like to proceed with your case?

19 WESTBROOK: Thank you, thank you, Ms. Schindler. I would, and I'll call Mr. Saxon as
20 my first witness. Mr. Saxon, good morning.

21 SAXON: Good morning.

22 WESTBROOK: You are employed by the Department of Health and Human Services as
23 Program Manager II, I believe, is that right?

24 SAXON: Yes, that's correct.

25 WESTBROOK: And as Program Manager II, you oversee Medicaid rates and activities of
26 all Medicaid contracts, is that correct?

27 SAXON: Yes.

28 WESTBROOK: You also, a part of your job duties is to write and revise the language in the
29 State Plan, is that correct?

30 SAXON: Yes, it is.

1 WESTBROOK: Now I want to hand you this, Mr. Saxon. This is just a notebook of
2 Petitioner's Exhibits, the same one that you have, Ms. Schindler, except I'll
3 take out 19 as well so we won't get confused. And Mr. Saxon, I may need
4 this same notebook when you get through with it for Mr. Schmoyer, if that's
5 okay?

6 SAXON: Certainly. I'm not going to keep it.

7 WESTBROOK: You might want a copy. I will make a gift of it after the hearing. And how
8 about turning, if you don't mind, to Exhibit 8. And I think...

9 NICKLES: For those of us who don't have a notebook...

10 WESTBROOK: Oh, I'm so sorry, I'm so sorry. Exhibit 8 is the December 16, 2011—I'm
11 going to get Mr. Saxon if you can confirm this for me for the record, please.
12 I believe Exhibit 8 is the December 16, 2011 letter from Deborah Myers of
13 HHS to Joseph Hunt of Countrywood, is that correct?

14 SAXON: That's correct.

15 WESTBROOK: All right. And I just want—the only reason I'm asking about this letter at
16 the moment is if you'll look at the first paragraph about the fourth line down
17 it establishes the three cost report periods in this, in this audit. In fact, what
18 I'm going to do just to facilitate things is I'm going to read aloud that first
19 sentence and you tell me if I read it correctly, okay?

20 SAXON: Yes.

21 WESTBROOK: All right. Based on the recommendation of the Office of the State Auditor
22 and their audit reports, AC Number 3RDME8, 3RDMJ8 and 3RDMJ9, the
23 Department of Health and Human Services is establishing an accounts
24 receivable of \$546,968.00. In order to finalize your facility's November 29,
25 2007 through May 31, 2008, November 29, 2007 through September 30,
26 2008, and October 1, 2008 through September 30, 2009 cost reports. Now
27 did I read that correctly?

28 SAXON: Yes.

29 WESTBROOK: I'm going to ask my friend, Tammie, to put up a demonstrative exhibit,
30 please. And I just want you to verify that those date ranges, and this is just
31 because for my own sake, it's hard for me to remember these dates, that

1 those three cost report date ranges there, Mr. Saxon, are those the same three
2 that are mentioned in Ms. Myers' letter?
3 SAXON: Yes, they are.
4 WESTBROOK: Okay. And let's see if we can get that—how about that?
5 SCHINDLER: Perfect.
6 WESTBROOK: Is that better?
7 SCHINDLER: Yeah.
8 WESTBROOK: Tammie, you're going to have to walk a little further. All right. Now, with
9 that in mind, let me ask you now to turn to the Exhibit 4 which is the, what
10 I call the SAO Contract. And Mr. Saxon, this is the SAO Contract dated as
11 of July 1, 2011, is that correct?
12 SAXON: That's correct.
13 WESTBROOK: All right, how about turning over to page 4, please sir? And on page 4, what
14 I'd like you to look at, this is where within Article III of that contract, I'd
15 like you to look at Section D.I. All right.
16 SAXON: I'm there.
17 WESTBROOK: All right. And Tammie, why don't you leave that what you have up there
18 and if you can slide in front of it the next demonstrative. This might be a
19 little easier to read. But I want to ask you, Mr. Saxon, Section D. there says
20 nursing facility agreed upon procedure requirements and just read the first
21 sentence for me, please, aloud into the record.
22 SAXON: The SAO will perform agreed upon procedures involving two cost report
23 periods.
24 WESTBROOK: All right. Now the term agreed upon procedures that we see right there, that
25 includes audits and audit reports, does it not?
26 SAXON: Yes, it does.
27 WESTBROOK: All right. And Mr. Saxon, several years ago the South Carolina Healthcare
28 Association had discussions with the Department, when I say Department
29 I'm referring to HHS of course, with the Department about the number of
30 cost reports that could be reviewed and you're aware of those discussions,
31 are you not?

1 SAXON: Yes, I am.

2 WESTBROOK: And those discussions, and let me just back up for a second, South Carolina

3 Healthcare Association, that's the association, professional association

4 made up of most of the nursing homes in the State, is that correct?

5 SAXON: Yes sir.

6 WESTBROOK: And those discussions involved the Director of the Department, the Deputy

7 Director and Mr. Lee, who is the Director of the Association, is that correct?

8 SAXON: Yes.

9 WESTBROOK: And those discussions lasted from somewhere between several weeks and

10 maybe even a few months, I believe you said.

11 SAXON: That's what I recall.

12 WESTBROOK: All right. They involved both face to face meetings and phone calls, didn't

13 they?

14 SAXON: Yes.

15 WESTBROOK: And as a result of those discussions, this contract, the SAO Contract was

16 revised to include that current sentence that you just said that you just read

17 into the record, isn't that correct?

18 SAXON: Yes, that's correct.

19 WESTBROOK: All right. And before then it didn't say two cost report periods, did it?

20 SAXON: I cannot exactly remember but there's one in here to look at.

21 WESTBROOK: All right. Well, let's look at the 1997 contract which I believe is Exhibit 14

22 in our notebook there. And just verify for us, this is 1997 contract between

23 SAO and the Department.

24 SAXON: That is correct.

25 WESTBROOK: Why don't you look through here and take a, take a few minutes if you need

26 to unless you just know off the top of your head, that sentence is not in there,

27 is it, that the SAO will perform agreed upon procedures involving two cost

28 report periods?

29 SAXON: I don't see it under (unclear) the SAO responsibilities.

30 WESTBROOK: Well, you know, for the sake—you can look for it as long as you'd like. For

31 the sake of time...

1 SAXON: Right.
2 WESTBROOK: ...and the fact that we—I don't think anybody wants you to spend fifteen
3 minutes reading it page by page, the contract obviously will speak for itself,
4 but let's assume for a moment that it doesn't have that language, okay?
5 SAXON: Okay.
6 WESTBROOK: Now, let's look at the next exhibit in there which is Exhibit 15, I believe,
7 which is the 1998 contract, SAO Contract.
8 SAXON: Okay.
9 WESTBROOK: If you'll turn over to page 4 of that contract and look at the very top of the
10 page, please sir. See at the top of the page it says Section E., Nursing
11 Facility Audit Requirements?
12 SAXON: Yes.
13 WESTBROOK: Would you read the first sentence under E.1., please, into the record?
14 SAXON: The SAO will audit two cost report periods.
15 WESTBROOK: All right. Thank you very much. Now, let's go back to the 2011 contract.
16 That's Exhibit 4.
17 SAXON: Okay, same page?
18 WESTBROOK: Yes sir. Exhibit 4, page 4. This is the 2011 SAO Contract.
19 SAXON: Okay.
20 WESTBROOK: Now let's take a look at the second sentence. How about reading the second
21 sentence and you can look at it on there...
22 SAXON: That first section, right, D.1.?
23 WESTBROOK: I'm sorry, yeah, and I apologize I wasn't clear but let's try not to talk over
24 each other since this is being recorded and I'll try to watch that because I'm
25 bad about that myself. But what I'd like you to do is read into the record
26 the second sentence at D.1. Just read it aloud, please sir. Thank you.
27 SAXON: All right. For non-hospital based related nursing facilities, a provid—
28 periods will be defined as the cost report period which was used to set the
29 provider's Medicaid rate in effect at the time of the field work for the
30 engagement is initiated plus the preceding cost report period.

1 WESTBROOK: Okay. So the first sentence says SAO will perform agreed upon procedures,
2 including—which include audits, you testified, involving two cost report
3 periods and the second sentence tells you what two cost report periods are
4 to be audited, is that correct?

5 SAXON: Yes.

6 WESTBROOK: And it uses the term engagement in that second sentence, doesn't it?

7 SAXON: Yes, it does.

8 WESTBROOK: Now an engagement is when the audit starts, is that correct?

9 SAXON: Yes sir.

10 WESTBROOK: An engagement is when the agreed upon procedures activity starts or
11 begins, is that right?

12 SAXON: That's right.

13 WESTBROOK: All right. So what it says is the periods will be the cost report period used
14 to set provider's Medicaid rate in effect at the time the field work for the
15 engagement is initiated. Is that what it says?

16 SAXON: I'm sorry, where were you?

17 WESTBROOK: In that second sentence, the...

18 SAXON: (Unclear). It does.

19 WESTBROOK: ...the first period it talks about is the period used to set the provider's
20 Medicaid rate in effect at the time the field work for the engagement is
21 initiated.

22 SAXON: That's correct.

23 WESTBROOK: All right. So what I'd like now for you to do is turn over to Exhibit 5, the
24 next tab, and Exhibit 5 appears to be a letter dated August 4, 2011 from
25 SAO, in fact it's Mr. Von Kannel, I believe, signature there on page 2.

26 SAXON: Yeah.

27 WESTBROOK: To Countrywood, is that correct?

28 SAXON: Yes, it is.

29 WESTBROOK: And take a look at the second paragraph, the one that begins Larry
30 Warrington, okay? And how about reading that sentence, that first sentence
31 of the second paragraph into the record for us.

1 SAXON: Larry Warrington along with two members of our staff will start the field
2 work portion of our review on August 10, 2011 at 10 o'clock a.m.
3 WESTBROOK: All right. So according—do you know who Larry Warrington is?
4 SAXON: He's an employee of the State Office.
5 WESTBROOK: All right. So according to Mr. Von Kannel, Mr. Warrington is going to start
6 the field work portion on August 10, 2011 at 10 a.m., right?
7 SAXON: Yes sir.
8 WESTBROOK: And let me also ask you now to turn over to Tab 13 for just a moment,
9 please. And Tab 13 appears to be an email from Mr. Larry Warrington to
10 Terry Schmoeyer and if you'll, where it says, Terry, I was wondering if you
11 could provide us some information, would you read the second sentence,
12 the next sentence into the record, please?
13 SAXON: We are in the process of starting up a review of cost reports submitted by
14 Countrywood Nursing Center, formerly Ridgeview Manor.
15 WESTBROOK: All right. And the date of that email is July 15, 2011, correct?
16 SAXON: Yes sir.
17 WESTBROOK: All right. Now, I'm going to ask Tammie to go back to our demonstrative
18 number 1 and let's look at those three cost report periods. Remember those
19 were the ones that were identified earlier. Now my question to you, Mr.
20 Saxon, is this. In July and August of 2011, the cost report period which was
21 in effect at that time was C, is that correct?
22 SAXON: Yes, it would have been.
23 WESTBROOK: All right. And C, says October 1, 2008 through 9/30/09, is that right?
24 SAXON: That's right.
25 WESTBROOK: And the preceding period would have been 11/29/07 through 9/30/08, is that
26 correct?
27 SAXON: Yes, it would.
28 WESTBROOK: All right. Now take a look back at Exhibit 4, if you don't mind. And again,
29 let's go back to page 4, that same section, Section D. Now I believe it's
30 your opinion, you correct me if I'm wrong, that that first sentence, the one
31 that says SAO will perform agreed upon procedures involving two cost

1 report periods sets a minimum of cost reports that can be audited at one
2 time, is that correct?

3 SAXON: Yes.

4 WESTBROOK: Now take a look in Section D. or maybe you already know this. There's no
5 language in that Section D. that uses the word minimum or anything to that
6 affect, is there?

7 SAXON: Well, it doesn't say—no, well, there's nothing that says a maximum either.

8 WESTBROOK: All right. Let's see what it says, look down at D.4., what does D.4. say?
9 How about reading that into the record.

10 SAXON: These restrictions do not apply in relation to any procedures initiated
11 subsequent to or in relation to any investigation of fraud.

12 WESTBROOK: So in D.4. refers to the D.1. through D.3. as restrictions, does it not? Isn't
13 that the term used?

14 SAXON: Yes, it does.

15 WESTBROOK: All right. And the only exception it says that's identified in this Section D.
16 to these restrictions is investigation of fraud, is that correct?

17 SAXON: That's what it says but if you look at that chart that all appeared at the
18 beginning, that six months is incorporated in that so-called preceding cost
19 report period.

20 WESTBROOK: Now, this is my first objection to—I move to strike his last sentence on the
21 grounds that it's parole evidence. I'm asking what the contract says and
22 what we talked about was the contract says what it says. He just quoted his
23 interpretation of...

24 NICKLES: I'm not—just saying his observation is he was reading off of your exhibit
25 showing that the same periods included in A. and B., I mean that's your
26 exhibit. I don't know how you can object to him noting it for the record.

27 WESTBROOK: No, it's not that I note—I don't object to his noting the exhibit. I object to
28 the conclusion that he drew. My question was where in Section D. does it
29 identify any exception to those restrictions other than the investigation of
30 fraud? That was my question. Why don't we start over...

31 SCHINDLER: I'll sustain that.

1 WESTBROOK: Mr. Saxon, is there anything, once again, in Section D. that says, notes an
2 exception to those restrictions other than an investigation of fraud?
3 SAXON: As I answered before, I don't see anything else.
4 WESTBROOK: All right. Is there anything, is there any language in the State Plan or in any
5 statute or regulation or guideline or written policy or standard that you know
6 of that makes an exception for these restrictions in Section D. other than
7 D.4.'s investigation of fraud? Do you know of anything written down?
8 SAXON: There is a section I think in the contract that refers to DHA—DHHS, SAO
9 or other designees or other Federal agencies can actually come in and audit
10 a facility's cost reports slash Medicaid rate. Again, like I said in my
11 deposition, the OIT has come in on several occasions, not just on nursing
12 home providers but a lot of other providers and just go in at any point in
13 time and they can...
14 WESTBROOK: Can you point me to language that says that the SAO will perform agreed
15 upon procedures involving two cost report periods except in the following
16 instances where they don't say investigation of fraud?
17 SAXON: It does not say that specific, in that specific language.
18 WESTBROOK: Let's look at page 3 of Exhibit 4, please.
19 SAXON: Okay.
20 WESTBROOK: Same exhibit. Just turn over one page. Page 3, you see that heading there
21 that says Article III, SAO Responsibilities?
22 SAXON: Yes sir.
23 WESTBROOK: This is a listing which follows SAO Responsibilities, correct?
24 SAXON: Yes sir.
25 WESTBROOK: And B. says, excuse me, Section B. there says SAO shall be responsible for
26 and then there's a list of things, right?
27 SAXON: Yes sir.
28 WESTBROOK: How about reading Number 3 into the record, please?
29 SAXON: Conducting all engagements to determine if the reimbursement rate or
30 amount is in accordance with the provision of the provider contract, State
31 Plan and State and Federal laws and regulations.

1 WESTBROOK: All right. And I believe you already said that engagements, an engagement
2 is when an audit or when an agreed upon procedure's activity begins, is that
3 right?

4 SAXON: Yes.

5 WESTBROOK: And so Number 3 there on B.3., does it say anything about the number of
6 audits that may be conducted at one time by the Agency?

7 SAXON: No.

8 WESTBROOK: All right. Okay. Is there anything in the SAO Contract, any language that
9 you're aware of that requires an audit of six month cost report period?

10 SAXON: Not specifically stated.

11 WESTBROOK: Is there anything in the Facility Contracts or the State Plan or any statute,
12 regulation, written policy or guideline that requires an audit of a six month
13 cost report?

14 SAXON: The State Plan says all cost reports are subject to audit.

15 WESTBROOK: Does it say that they're all subject to—it says they're all subject to audit and
16 that's on page 12 of the State Plan?

17 SAXON: Something like that. I'd...

18 WESTBROOK: Let's take a look at the State Health Plan. I think it's in Tab 7. Let's look
19 towards the bottom of the page there, Roman Numeral II, it says Auditing,
20 you see that?

21 SAXON: Yes sir.

22 WESTBROOK: And there's a Section G. and a Section H. And that's on page 12 of the Plan
23 which is Exhibit 7.

24 SAXON: That's correct.

25 WESTBROOK: If you'll just bear with me just a moment, Mr. Saxon. And we're looking
26 at Roman Numeral II, Section H., okay?

27 SAXON: Yes.

28 WESTBROOK: How about reading that first sentence for me into the record, please?

29 SAXON: Okay. All cost reports are subject to on-site audit.

30 WESTBROOK: All right. That's what you were referring to a moment ago?

31 SAXON: Yes.

1 WESTBROOK: Now does it say anywhere in that section that more than two audits can be
2 conducted at one time?

3 SAXON: It doesn't say it doesn't, it can't.

4 WESTBROOK: Either way, it doesn't address it?

5 SAXON: It doesn't address it.

6 WESTBROOK: Okay, thank you. I appreciate that. All right. Now let's go move away from
7 the SAO Contract for a few minutes and go over to Exhibit 6. And again
8 this is, I guess I should have said this for the record but when I say exhibit
9 I'm talking about the Petitioner's Exhibits here. So Petitioner's Exhibit 6
10 and Petitioner's Exhibit 6 is the October 2006 contract between DHHS and
11 Ridgeview of the Midlands, which is the predecessor company to
12 Countrywood, is that your understanding?

13 SAXON: Yes sir.

14 WESTBROOK: All right. And that's—I'm going to refer to this for short as the Facility
15 Contract or the provider contract, if that's okay with you.

16 SAXON: Yes sir.

17 WESTBROOK: All right. Let's look at Exhibit 6 for a minute. Let's turn over to page 8, if
18 you don't mind.

19 SAXON: Okay.

20 WESTBROOK: And I'll ask Tammie to put up the demonstrative 3, please. And again, this
21 is just a blow-up of the section. Let's look at...

22 SAXON: Lots of highlights.

23 WESTBROOK: Yeah, it's—I didn't realize the contract was highlighted but I guess that's
24 the official highlight. No, I take responsibility for the highlights because
25 those are the questions I want to focus—sentences I want to focus you on.
26 Well, we can certainly talk about the unhighlighted part too. So the heading
27 there, F. heading says Time Limit for Issuance of the Final Audit Report,
28 right?

29 SAXON: Yes sir.

30 WESTBROOK: And how about reading the first sentence down to the semi-colon, the part
31 that's highlighted on the demonstrative.

1 SAXON: Okay.

2 WESTBROOK: If you'd just read that into the record, please sir.

3 SAXON: All right. Any disallowance made pursuant to an on-site audit shall be made

4 in the final audit report which shall be issued within three years of the close

5 of the contract period.

6 WESTBROOK: Okay. Now in fact, you know, let's go ahead—I'm glad you brought up

7 about the highlight. Now let's deal with the unhighlighted, non-highlighted

8 portion first. It goes on to say provided, however, if there is, and I'm just

9 going to skip over some of these words, if it's fault or interference by the

10 provider then the, then more time can be allowed. In this particular case,

11 the Countrywood case, you're not aware of any interference or fault by

12 Countrywood affecting the time of these audits, are you?

13 SAXON: I'm not personally aware of any.

14 WESTBROOK: All right. Now going back to the highlighted language there in the first

15 sentence, it says any disallowance made pursuant to an on-site audit. I think

16 it's not disputed here, that this appeal involves a disallowance made

17 pursuant to an on-site audit, right?

18 SAXON: Yes.

19 WESTBROOK: Okay. And it says within three years of the close of the contract period,

20 correct?

21 SAXON: Yes.

22 WESTBROOK: And if you'll see that parenthetical sentence at the very end of the

23 paragraph, how about reading that into the record, please?

24 SAXON: See Article I for the definition of the contract period per facility.

25 WESTBROOK: Is it Article I or Article II?

26 SAXON: It is II, you're right.

27 WESTBROOK: All right, so I guess we've got to see Article II for the definition of contract

28 period. Article II, I think, is over on, maybe on page 2 actually, I believe.

29 Take a look at page 2 of Exhibit 6. That's the definitions page, right?

30 SAXON: Yes sir.

1 WESTBROOK: And you'll see there, the second definition is contract period, how about
2 reading into the record the last sentence of that contract period definition.
3 SAXON: For other purposes of Article V, Section F. only the contract period will be
4 the rate period as defined by the South Carolina State Plan.
5 WESTBROOK: Okay, and just to clarify what we were talking about earlier there about the
6 time limit for issuance, the one that's on the demonstrative there, that is
7 Article V, Section F., isn't it?
8 SAXON: Yes sir.
9 WESTBROOK: Okay, so if Article V, Section F. according to the contract, the contract
10 period will be the rate period as defined by the South Carolina State Plan,
11 correct?
12 SAXON: Yes.
13 WESTBROOK: All right. Now the problem is the rate period is not really defined by the
14 State Plan is it?
15 NICKLES: I'm going to object to the question.
16 SAXON: Well...
17 WESTBROOK: There was objection?
18 NICKLES: Just object to the form.
19 WESTBROOK: Oh, okay.
20 NICKLES: He can answer the question.
21 WESTBROOK: Okay, so, let me repeat that question. Just make sure. The term rate period
22 is actually not defined by the State Plan, is it?
23 SAXON: There is no definition section in the State Plan, however, rate periods are
24 reflected and are referred to as an October through September period, I
25 believe.
26 WESTBROOK: Let me ask you to look at your deposition. Do we have Mr. Saxon's
27 deposition here?
28 SAXON: I was trying to decide if it said rate period or contract period is what I'm
29 trying to remember.
30 WESTBROOK: All right. Thank you. And I'm going to hand this to you. It's your
31 deposition. You can go ahead and break open the seal if you don't mind.

1 We make it tough for you, we want to give you a challenge. If you would
2 verify that is your deposition.
3 SAXON: It looks like it.
4 WESTBROOK: Good. And this is the deposition that you gave on August 8, 2014, right?
5 SAXON: Yes sir.
6 WESTBROOK: How about turning over to page 91 if you don't mind.
7 SAXON: Okay.
8 SCHINDLER: Where is that in the—I think that was down here, 17, 18, one of those?
9 WESTBROOK: One of those, I'm sorry, Ms. Schindler.
10 SCHINDLER: Okay, I found it. It's actually 17.
11 WESTBROOK: Okay, so good, 17.
12 SCHINDLER: And I'm calling it Petitioner's Exhibit 8.
13 WESTBROOK: Okay, great. And if I can ask everyone just to turn over to page 91 for a
14 moment. And what I'm going to do is starting at line 14, I'm going to read
15 the question and I'm going to ask you to read your answer, okay?
16 SAXON: Uh-huh.
17 WESTBROOK: My question in that deposition starting at line 14 is, a rate period, that
18 precise term, is not defined anywhere in the Plan with a precise definition,
19 is that correct? There's no place you can turn to where like it's a page, and
20 your answer is?
21 SAXON: That's not a definition—oh, there's not a definition. It says what rate period
22 is, yeah, I think that's what I answered.
23 WESTBROOK: Okay.
24 SAXON: There was no defined definition but what I was trying to remember is all
25 references to reimbursement rate periods, whatever you want to call them
26 from October to September, that's what I was trying to remember.
27 WESTBROOK: Okay, well, let's look at Exhibit 7 which is the Plan.
28 SAXON: Okay.
29 WESTBROOK: And let's go to page 12. I think we already visited page 12 one time.
30 SAXON: I think so.
31 WESTBROOK: Yeah, sounds familiar, doesn't it?

1 SAXON: Uh-huh.

2 WESTBROOK: Let's go back to page 12 on Exhibit 7 and if you'll see at the bottom of the

3 page, Roman Numeral III, it says Payment Determination, right?

4 SAXON: Right.

5 WESTBROOK: And what is, read that sentence under there that starts rate cycle.

6 SAXON: The rate cycle will be October 1 through September 30th and will be

7 repeated every twelve months utilizing cost reports submitted in accordance

8 with Section I, Cost Finding and cost reports of the Plan.

9 WESTBROOK: All right. So that tells you what a rate cycle is, doesn't it?

10 SAXON: Right, and that's what I was...

11 WESTBROOK: But a rate cycle's not the same thing as a rate period, is it?

12 SAXON: A rate cycle's not the same thing as a rate period. Um, no.

13 WESTBROOK: Okay. All right. Let me ask you to go to Exhibit 8 again. We looked at that

14 earlier. Exhibit 8 is that December 16, 2011 letter from Ms. Myers of HHS

15 to Countrywood, right?

16 SAXON: Yes.

17 WESTBROOK: Are you there now?

18 SAXON: Yeah.

19 WESTBROOK: Okay. Now the lady who wrote this letter, Deborah Myers, you know her

20 don't you?

21 SAXON: Yes I do.

22 WESTBROOK: In fact I think you've described her as your right-hand person, right?

23 SAXON: That's right.

24 WESTBROOK: She, at this time she wrote the letter, she was Director of the Division of

25 Long-Term Care Reimbursements.

26 SAXON: That's correct.

27 WESTBROOK: She has a different position now, right?

28 SAXON: Yes sir.

29 WESTBROOK: And what's her, what's her current position?

30 SAXON: She's actually a Program Manager. She, instead of being over the Long-

31 Term Care area, she assists me in drafting all plan amendments, funding

1 request, all these different projects and Mr. Keck has us working on for the
2 provider part.

3 WESTBROOK: Right. And she reports directly to you, doesn't she?

4 SAXON: She does.

5 WESTBROOK: And back when she was a Long-Term Care Director, she reported to you,
6 didn't she?

7 SAXON: Yes.

8 WESTBROOK: And this is, I assume this is obvious but Long-Term Care would include
9 nursing homes, right?

10 SAXON: Yes.

11 WESTBROOK: All right. Now in Exhibit 8 in this letter that Ms. Myers wrote Countrywood,
12 you go to the first page, you see two columns, the first column says rate
13 period and the second column says audited rate, correct?

14 SAXON: Yes sir.

15 WESTBROOK: And the first rate period that she identifies is 11/29/07 to 5/31/08, is that
16 correct?

17 SAXON: Yes sir.

18 WESTBROOK: And the second rate period she identifies is 6/1/08 to 9/30/08, correct?

19 SAXON: Yes sir.

20 WESTBROOK: And the third rate period she identifies is 10/1/08 to 9/30/09, correct?

21 SAXON: Yes sir.

22 WESTBROOK: And I'm going to ask Tammie to put up our next demonstrative and just the
23 other one that says rate period and I think that's demonstrative 4, and just
24 ask you to verify that those are the same dates that we just read out, the first
25 three rate periods that Ms. Myers identifies.

26 SAXON: Yes.

27 WESTBROOK: All right. Now, if you'll look back at Ms. Myers' letter, that first rate period
28 she identifies, 11/29/07 to 5/31/08, the rate for Countrywood did not change
29 during that period, did it? During the first six months.

30 SAXON: It did, well, it must, let's see, it must have changed because they owed us
31 money and that...

1 WESTBROOK: What's the audited rate amount that's listed on this letter?

2 SAXON: 129.21.

3 WESTBROOK: \$129.21, right?

4 SAXON: Yes.

5 WESTBROOK: All right. And that 129.21 from 11/29/07 to 5/31/08 remained the same,

6 didn't it?

7 SAXON: The audited rate.

8 WESTBROOK: The audited rate?

9 SAXON: Yes sir.

10 WESTBROOK: Okay, stayed the same. So the audited rate stayed the same through that

11 period, that six month period, right?

12 SAXON: Yes sir.

13 WESTBROOK: Okay. Now the next rate period identified by Ms. Myers begins on June 1st

14 of 2008, right?

15 SAXON: Yes sir.

16 WESTBROOK: And on June 1, 2008, an inflation factor was added and a new rate came into

17 being, is that correct?

18 SAXON: Yes sir.

19 WESTBROOK: And that new rate was \$134.74, correct?

20 SAXON: Yes sir.

21 WESTBROOK: All right. And that new rate did not change until October 1st, is that correct,

22 of 2008?

23 SAXON: That's correct.

24 WESTBROOK: And it changed on October 1st because every October 1st there are a lot of

25 changes to the State Health Plan that you and folks working with you

26 implement, is that correct?

27 SAXON: That's correct, as long as funding is provided to do such things.

28 WESTBROOK: Right, as long as funding is provided, always a big "if". But ordinarily...

29 SAXON: Ordinarily.

30 WESTBROOK: Ordinarily on October 1st that rate is going to change again, is that right?

31 SAXON: Yes sir.

1 WESTBROOK: And it did in this case and so their audited rate for Countrywood on August
2 1st of '08 went up to \$135.11, correct?

3 SAXON: That's correct.

4 WESTBROOK: All right. Bear with me just a moment, Mr. Saxon.

5 SAXON: And those rates were based all on that one cost report period.

6 WESTBROOK: Let me ask you to look at and what you just said I believe was those three
7 rate periods identified by Ms. Myers were all based on that one cost report
8 period...

9 SAXON: That six months period.

10 WESTBROOK: That six month period?

11 SAXON: Uh-huh.

12 WESTBROOK: Right.

13 SAXON: Yes sir.

14 WESTBROOK: All right. Now, let's go back to the Plan for a moment which is Exhibit 7.
15 And let's go over to page 24 for just a moment.

16 SAXON: Okay.

17 WESTBROOK: I think we've already—you just testified a moment ago on June 1st which
18 for Countrywood was the first day of the, of the 7th month that its operation
19 had got a new rate, is that right?

20 SAXON: Yes sir.

21 WESTBROOK: And that's consistent with this language in the State Health Plan, I believe,
22 and I'm going to ask you to read. In the first paragraph, maybe two-thirds
23 of a way down that paragraph, there's a sentence that begins with the word
24 effective, see if you can find that.

25 SAXON: I see it.

26 WESTBROOK: All right. How about reading that sentence into the...

27 SAXON: Effective on the first day of the seventh month of operation, a new
28 prospective rate based upon the uniform financial and statistical report will
29 be determined using the methodology as previously stated in Section 3.C.
30 of this plan.

Jeff Saxon - Cross

1 WESTBROOK: All right. So effective, according to the Plan, effective on the first day of
2 the seventh month of operation, a new prospective rate will be determined.
3 And that is in fact what happened with Countrywood, isn't it?
4 SAXON: Or any provider in that same situation.
5 WESTBROOK: Or any other provider in the same situation, okay. Thank you. I don't have
6 any other questions for you. Thank you, Mr. Saxon.
7 SCHINDLER: Mr. Nickles, before you do your cross, we're going to take a five minute
8 break.
9 NICKLES: That'd be fine.
10 SCHINDLER: I'm going to pause the record. We are back on the record. Mr. Nickles you
11 can proceed with your examination of Mr. Saxon.
12 NICKLES: Mr. Saxon, in response to questions posed by counsel for the Petitioner, you
13 indicated that your current position is a Program Manager II, is that correct?
14 SAXON: Yes.
15 NICKLES: Do you recall preparing an affidavit in this proceeding that you signed back
16 in November of 2012?
17 SAXON: Yes.
18 NICKLES: And in that affidavit, did you provide a little more detail as to the nature of
19 your position and your experience in the area of Medicaid services and
20 reimbursement?
21 SAXON: Yeah.
22 NICKLES: Did you attempt to provide information accurately in that affidavit?
23 SAXON: Yes.
24 NICKLES: Has anything changed apart from the fact that you obtained more experience
25 in this area since November 7, 2012?
26 SAXON: Well, actually I am getting promoted to a higher Program Manager position.
27 NICKLES: Got your promotion since then?
28 SAXON: Yeah.
29 NICKLES: You don't sound too enthusiastic about that.
30 SAXON: Well, it's working out. It's just too (unclear). It's subdued happiness, I
31 guess.

1 NICKLES: Mr. Saxon, when you prepared your affidavit back in November of 2012,
2 did you have an opportunity of not only those specific parts of the State Plan
3 that Mr. Westbrook brought to your attention, but the entire State Plan?
4 SAXON: Yes sir, I did.
5 NICKLES: Did you review it and attempt to provide accurate information in that
6 affidavit?
7 SAXON: Yes.
8 NICKLES: And anything, any opinion you express in that affidavit, back in November
9 change from that day to today.
10 SAXON: No.
11 NICKLES: Let me ask you some questions about this contract between the Office of
12 the State Auditor and DHHS. I believe that that is provided as Exhibit
13 Number 4 to Mr. Westbrook's materials. Do you have that before you?
14 SAXON: Yes I do.
15 NICKLES: All right, sir. Let me ask you about some provisions on page 4 of that
16 contract in Section D. Did you follow-up and ask questions about it?
17 SAXON: Yes, I did.
18 NICKLES: And there are four enumerated elements to that paragraph, correct? One,
19 two, three and four?
20 SAXON: Yes.
21 NICKLES: One of those says the SAO will perform agreed upon procedures involving
22 two cost report periods, is that correct?
23 SAXON: Yes.
24 NICKLES: Did you participate in the drafting of that document?
25 SAXON: Yes.
26 NICKLES: And let's say, all right, look at Number 2, agreed upon procedures must be
27 performed for each nursing home at least once out of every four consecutive
28 cost reporting years. Do you see that?
29 SAXON: Yes.
30 NICKLES: So that indicates that there was a timeframe that was required of the Auditor
31 to perform certain reviews, correct?

1 WESTBROOK: Objection, leading.
2 NICKLES: Isn't that what it says to you?
3 SAXON: Yes.
4 WESTBROOK: I'd like my objection to be ruled upon.
5 NICKLES: What does it say?
6 WESTBROOK: I'm going to object under the Rules of Evidence. And let me just add to
7 that if I may, Ms. Schindler. I realize that the Rules of Evidence may be a
8 little relaxed in a situation like that and I'm fine with that and if, if, I simply
9 say that I, since I'm new to this, I'm not sure how strict things like leading
10 questions are going to be. Judge, and I'm...
11 NICKLES: I'll try to restrain myself.
12 WESTBROOK: I'm happy as long as the same rules apply to both of us.
13 SCHINDLER: Yes, and I realize. Can you restate that question?
14 NICKLES: And, and, believe me...
15 SCHINDLER: Leading questions on.
16 NICKLES: What's, what's Number 2 say?
17 WESTBROOK: Unrelivant.
18 SAXON: Can I talk?
19 NICKLES: Yes sir.
20 WESTBROOK: Yes sir.
21 SAXON: Agreed upon procedure activities must be performed for each nursing
22 facility at least once out of every four consecutive cost reporting periods.
23 NICKLES: Okay, and that, in your view, is that a directive to the Office of State
24 Auditor?
25 SAXON: Yes.
26 NICKLES: And read Number 4 if you would.
27 SAXON: These restrictions do not apply in relation to any procedures initiated
28 subsequent to or in relation to any investigation of fraud.
29 NICKLES: Okay. So there are direct—are there directives other than two cost report
30 periods in Paragraph D?
31 SAXON: Could you ask that again?

1 NICKLES: Are there directives in Paragraph 1. and Paragraph 2., subparagraph 1. and
2 2. of Paragraph D.?
3 SAXON: Yes.
4 NICKLES: All right. Now Mr. Saxon, you were asked the question is there a definition
5 of, what was it, reporting periods or cost reports or rate periods in the State
6 Plan. Do you remember being asked a question about...
7 SAXON: Yes.
8 NICKLES: ...definition? Is there a description of rate periods in the State Plan?
9 SAXON: There's a description of rate cycle, which you know, is...
10 NICKLES: Tell me what that means to you.
11 SAXON: All right. Again, rate cycles is basically our normal payment period of
12 which we make changes to provider rates beginning, you know, effective
13 October 1 of each year.
14 NICKLES: Okay. And how is that meaningful in terms of reimbursements being
15 provided to the facilities involved in the Medicaid Program.
16 SAXON: Well, I mean it basically, for the most part nursing homes over the course
17 of time have always received on an industry-wide basis an increase in
18 funding every October 1st so it's, you know, it's something they've relied
19 upon for the most part and received it until, you know, when the economy
20 tanked back nine to ten for those few years it got a little tight, but actually
21 now we've actually kind of restored them back to their full methodology.
22 NICKLES: You've indicated, I believe, you tried to testify about an Exhibit that was
23 shown by the Petitioner showing three cost reports. Do you remember
24 seeing that listed on the board up there?
25 SAXON: Yes.
26 NICKLES: Two of those cost reports were for the same period of time, were they not?
27 SAXON: Yes.
28 NICKLES: Okay. Is that unusual when there is a new facility?
29 SAXON: No.
30 NICKLES: Why?

1 SAXON: No, you know, again, what happens is normally providers who have
2 enrolled as providers, they file them October through September year end
3 or we do allow maybe some county owned facilities file June 30th, but most
4 people file it October through September. That sets the rate for the
5 following October 1 payment period. Now new providers, if there's change
6 of ownership and new providers can be a few different, I mean you can, you
7 can become a new provider under certain criteria and under that criteria, we
8 will allow a new provider, let's just say the change of ownership resulted in
9 a new provider in this case, so what happened is we allow them to update
10 their rate effective the date of the change of ownership to the place which
11 is, you know, a benefit too then because you have providers, all other
12 providers have rates placed on older cost reports compared to the guys that
13 files a more, a more recent cost report.

14 NICKLES: In this instance, if this provider files an initial cost report, it resulted in a
15 preliminary rate?

16 SAXON: Yes.

17 NICKLES: Okay. And that was far shorter than the normal twelve month cost report,
18 correct?

19 SAXON: Yes, it was.

20 NICKLES: Okay, and there's acknowledgement of that and treatment of that in the State
21 Plan, is there not?

22 SAXON: Yes, there is.

23 NICKLES: And is it your experience, Mr. Saxon, that providers are generally familiar
24 with that process?

25 WESTBROOK: Objection, leading.

26 NICKLES: He can answer yes or no. Is it your experience?

27 WESTBROOK: If it's yes, he can answer it.

28 NICKLES: Okay.

29 SAXON: Yes, they are familiar with it.

30 SCHINDLER: And I'm going to allow you to proceed with that questioning.

1 NICKLES: Okay, thank you. In this instance, did this particular provider submit an
2 initial report?
3 SAXON: Yes.
4 NICKLES: Okay.
5 SAXON: And they're really no different than any other one in the same
6 circumstances.
7 NICKLES: Right. Mr. Saxon, I believe that there is a contract that is entered between
8 providers and Medicaid Services and DHHS, is that correct?
9 SAXON: Yes.
10 NICKLES: And Mr. Westbrook I believe provides that as Number 6 in his notebook.
11 Do you see that?
12 SAXON: I do.
13 NICKLES: And Mr. Westbrook, can we stipulate that our letters was—has another
14 name on it that says contract that was inherited by your client,
15 Countrywood?
16 WESTBROOK: Yes.
17 NICKLES: Okay. If you would look at page 4 under Article IV of that agreement, Mr.
18 Saxon, and look at the last sentence on that page, could you read that for
19 me?
20 SAXON: The last sentence of that...
21 NICKLES: Yes sir.
22 SAXON: ...Article IV.
23 NICKLES: On the page 4, page 4, Article IV. It goes the provider...
24 SAXON: That's the next to the last.
25 NICKLES: All right. Start there then, I'm sorry.
26 SCHINDLER: Wait a minute. I haven't found where we are yet.
27 NICKLES: We're on page—their Exhibit Number 6.
28 SCHINDLER: Yeah.
29 NICKLES: Page 4.
30 SCHINDLER: Okay.
31 NICKLES: At the bottom of the page.

1 SCHINDLER: Conditions for reimbursement, is that where we are?

2 SAXON: Yes.

3 NICKLES: That's correct.

4 SCHINDLER: All right.

5 NICKLES: And if you'd go the next to the last sentence and the last sentence.

6 SAXON: I'll read mine. The provider expressly understands that the total per diem

7 rate is subject to audit and may be adjusted to a lower or higher amount.

8 Claim for payment must be made in accordance with SCDHHS procedures

9 and on such forms and in the manner prescribed by SCDHHS.

10 NICKLES: And is there a cost reporting form that these providers must include?

11 SAXON: Yes.

12 NICKLES: Okay. If you look on the next page of your conformity with the policies and

13 procedures, Paragraph D., do you see that?

14 SAXON: Yes I do.

15 NICKLES: And what does the first sentence of that provision state?

16 SAXON: No payment by SCDHHS shall be made for services to a recipient unless a

17 provider has strictly conformed to the policies and procedures of SCDHHS,

18 including but not limited to recipient admissions, authorization for service

19 and certification of service.

20 SCHINDLER: Can I interrupt with a quick question?

21 NICKLES: Yes ma'am.

22 SCHINDLER: When they're saying recipient, are they talking about the facility, is that the

23 recipient or are they talking about Medicaid beneficiaries?

24 SAXON: (Unclear).

25 NICKLES: For the services to a recipient.

26 SCHINDLER: To a, okay, that's to a beneficiary, okay.

27 NICKLES: But if a payment is made to the provider to...

28 SCHINDLER: Okay.

29 NICKLES: But the services are to the recipients.

30 SCHINDLER: Okay, thank you.

1 NICKLES: If you will look over on page 8 of this contract, Paragraph G., do you see
2 that?
3 SAXON: Yes, I do.
4 NICKLES: Would you read the first...
5 SAXON: The provider...
6 NICKLES: Yes, go ahead.
7 SAXON: The provider agrees that the Uniform Financial Statistical Report, all
8 statements, reports and claims, initial and otherwise shall be certified as
9 true, accurate and complete and the provider shall not submit for payment
10 purposes those claims, statements or reports which it knows or has reason
11 to know are not properly prepared or payable pursuant to Federal/State law,
12 applicable regulations, this contract and SCDHHS policy.
13 NICKLES: Thank you. And on the next page, mine, it has Section 1, Maintenance of
14 Records. Could you read the first sentence there, please?
15 SAXON: The provider must maintain an accounting system with supporting fiscal
16 records adequate to assure the claims for funds are in accordance with this
17 contract and all applicable laws, regulations and policies.
18 NICKLES: And in Paragraph 2, the first sentence there.
19 SAXON: At any time during normal business hours and as often as SCDHHS, the
20 State Auditor's Office, the Office of the Attorney General, the Controller
21 General, GAO and USDHHS and/or any, and/or any of this—or their
22 designees of the above may deem necessary during the contract period.
23 Wait a minute, let me start this over again. I got lost. At any time during
24 normal business hours and as often as SCDHHS, the State Auditor's Office,
25 the Office of the Attorney General, the Controller General, GAO and
26 USDHHS and/or any of its—any of the designees of the above may deem
27 necessary during the contract period, including any amendments and/or
28 extensions to the contract and for six years thereafter, a provider shall make
29 all program and financial records in service delivery sites open to a
30 representatives of USDHHS...
31 NICKLES: That's good.

1 SAXON: I was going to say. That's a mouthful.
2 NICKLES: Now Mr. Saxon, is this an obligation on the part of the providers to maintain
3 those records?
4 SAXON: Yes.
5 NICKLES: And to have them available for inspection?
6 SAXON: Yes.
7 NICKLES: As often as deemed necessary...
8 WESTBROOK: Further objection, leading. Objection, leading.
9 NICKLES: I'll withdraw the question. Mr. Saxon, you had invited to your attention
10 some provisions of the State Plan. What...
11 SAXON: Section...
12 NICKLES: Seven?
13 SAXON: Seven.
14 NICKLES: Okay. All right. Mr. Saxon, did this Petitioner ever indicate to you any
15 confusion or concern or question about its obligations under the State Plan?
16 SAXON: No.
17 NICKLES: If there is a question, confusion, request for change or whatever, does that
18 ordinarily come to your office?
19 SAXON: Yes.
20 NICKLES: Okay. And if we look at the second page here and I believe it's designated
21 top of the page is 12 of the Exhibit, under Roman Numeral II Auditing, F.
22 Would you read the first sentence there?
23 SAXON: You mean is it G.? 2. G.?
24 NICKLES: It's 2. I've got Auditing, Roman Numeral II.
25 SAXON: G.
26 NICKLES: F. The one right under it, I believe. Well, you got H.
27 SAXON: The same, you want that one?
28 NICKLES: Okay. I'm sorry.
29 SAXON: Yeah, it depends upon which plan you get.
30 NICKLES: Well, yours says H. so what does that...
31 SAXON: Okay.

1 NICKLES: ...indicate to you?
2 SAXON: All cost reports are subject to on-site audit.
3 NICKLES: Does it say—does it place any limit on those being subject to on-site audit?
4 SAXON: No.
5 NICKLES: If you turn, I believe it's in your exhibit, if I might...
6 SAXON: Go right ahead.
7 NICKLES: ...on page, at the top again it says page 21, again this Petitioner's Exhibit
8 Number 7, has a section for Paragraph E. on that page.
9 SAXON: Yes.
10 NICKLES: And what, if anything, does this section provide for, Mr. Saxon?
11 SAXON: This section, this is the section provided for a new Medicaid rate due to the
12 change of ownerships and does meet our definition that allowed them to
13 receive a new provider rate which means they filed instead of using a cost
14 report that's a year or so old, they can, they can, you know, use actually
15 current costs in setting their respective payment rate.
16 NICKLES: And in your experience, has this ordinarily beneficial to the new provider?
17 SAXON: Yeah.
18 NICKLES: To the best of your knowledge, Mr. Saxon, was this provision in place at
19 the time that Countrywood entered the Medicaid Services Program?
20 SAXON: Yes.
21 NICKLES: And would this have been available to Countrywood to observe and rely
22 upon?
23 SAXON: Yes.
24 NICKLES: And to the best of your recollection did they do so?
25 SAXON: Yes.
26 NICKLES: All right. If you go over to page 23 at the top, I believe it should say
27 "payment determination for replacement facility or a change of
28 ownership"?
29 SAXON: Yeah. Yeah.
30 NICKLES: What, if anything, does that section of Plan provide for?

1 SAXON: You know, again, that would allow the, the new owner to receive a new cost
2 report based upon updated costs immediately.

3 NICKLES: All right, sir. Now, in your job with the Department of Health and Human
4 Services, do you from time to time, have to examine provisions of the State
5 Plan?

6 SAXON: Yes.

7 NICKLES: Okay. And I believe you said earlier that questions about the State Plan, are
8 those occasionally presented to you?

9 SAXON: Yes.

10 NICKLES: Now Mr. Westbrook asked you if there was a definition of a rate cycle in
11 the State Plan. Do you recall that?

12 WESTBROOK: Objection to the mischaracter use, mischaracterization.

13 SAXON: Yes, I recall that.

14 NICKLES: Okay.

15 WESTBROOK: Excuse me. I haven't got a ruling on my objection.

16 NICKLES: I'm sorry. I'll—and if I mischaracterized (unclear), I apologize.

17 WESTBROOK: (Unclear) Petitioner.

18 SCHINDLER: Would you like to clarify what...

19 WESTBROOK: Yeah, yeah. I believe I asked him for a definition of rate period...

20 SCHINDLER: Okay.

21 WESTBROOK: ...not rate cycle, yeah.

22 NICKLES: Okay, let me rephrase the question then. I want to be fair.

23 SCHINDLER: Okay.

24 WESTBROOK: (Unclear).

25 SCHINDLER: Withdraw the initial...

26 NICKLES: Do you recall Mr. Westbrook asking you if there was a definition of the
27 term rate period...

28 SAXON: Yes.

29 NICKLES: ...in the State Plan? Okay. Now is there a definition section for every term
30 that's utilized in the State Plan?

31 SAXON: No.

1 NICKLES: Okay. In your experience, what—has there been any confusion as to what
2 the term rate period means in reference to rate cycle?
3 SAXON: No.
4 NICKLES: What does it mean, in your experience?
5 SAXON: I mean again, the rate cycle is determined—I mean it does reflect in the
6 SPAS...
7 NICKLES: In the what, sir?
8 SAXON: I mean, I'm sorry, State Plan. I'm sorry. Sometimes I say State Plan and
9 SPAS and it's a little bit shorter. But State Plan does address what a rate
10 cycle is. Normally it's October through September.
11 NICKLES: All right. And, go ahead.
12 SAXON: And then basically those rate cycles are driven off the annual cost reports.
13 NICKLES: All right, sir. But in the event that there is a new participant, what, if any,
14 effect does that have?
15 SAXON: Well, the new participant, they go, depending upon the type of change it
16 was, in this event there was a purchase, because there was a purchase, fixed
17 assets and this provider was able to file a six month budget initially, then
18 followed up by a six month actual.
19 NICKLES: Okay.
20 SAXON: That's stated in writing on the effective date of change of ownership.
21 NICKLES: All right. In the Respondent's Brief, there is an Exhibit Number 2. There's
22 two costs reports and I'm going to ask the witness some questions about
23 that (unclear).
24 SCHINDLER: Okay, if you'd just hang on a second while I get it.
25 NICKLES: Give you the opportunity to...
26 SAXON: Are they in here?
27 NICKLES: No, I'll hand them to you.
28 SCHINDLER: All right. This is the correct document?
29 NICKLES: That's correct.
30 SCHINDLER: Okay, thank you.

1 NICKLES: Now, Mr. Saxon, I'm going to hand you something that is Countrywood
2 Nursing Center, LLC, November 29, 2007, May 31, 2008 and ask if you
3 recognize that document?
4 SAXON: Yes, I do.
5 NICKLES: Okay, and what does that document represent?
6 SAXON: This, this document represents the financial operations of the facility for the
7 period November 29, 2007 through May 31, 2008, as well as its census data.
8 NICKLES: Now would that be what you were making reference to as that initial or six
9 month cost report?
10 SAXON: Yes.
11 NICKLES: I also think you used the term budget. What do you mean by that?
12 SAXON: Well, you know, again when the provider changes ownership, he gets a new
13 rate immediately so he'll do a six month budget cost report which will set
14 up his interim rate and the date of change of ownership which will be
15 followed up with a six month cost report for six full calendar months of
16 operation.
17 NICKLES: And does it—does this appear to have been signed by some representative
18 of Countrywood Nursing Center, LLC?
19 SAXON: There's the owner's (unclear) signature there. I think it's, looks like
20 Hayden signed it, whoever.
21 NICKLES: And it has a date on it and what is that?
22 SAXON: On February 11, 2009.
23 NICKLES: Okay. February 11, 2009. And I'll ask you to look at this second document
24 I'm handing to you and ask if you recognize that?
25 SAXON: Yes, I do. It's the Medicaid Cost Report with the Financial and Statistical
26 Data covering the period of 11/29/2007 through September 30, 2008.
27 NICKLES: Okay, and it's assigned by a representative of Countrywood?
28 SAXON: Yes, it is.
29 NICKLES: What is the date of that?
30 SAXON: May 12, 2009.

1 NICKLES: Okay. Now, Mr. Saxon, let's look at these two exhibits side by side. The
2 first that you've identified as the initial cost report has a start date of
3 November 29, 2007, is that correct?
4 SAXON: That's correct.
5 NICKLES: The second that you've identified has the same start date, is that correct?
6 SAXON: That's correct.
7 NICKLES: The first has an end date of May 31, 2008, correct?
8 SAXON: Correct.
9 NICKLES: And the second has an end date of what?
10 SAXON: September 30, 2008.
11 NICKLES: Now based upon your experience, Mr. Saxon, would the costs reflected in
12 the initial report be reflected also in the annual report?
13 SAXON: Yes.
14 NICKLES: Okay. Would the provider have been under the same obligations to
15 accurately and truthfully report information in both reports?
16 SAXON: Yes.
17 NICKLES: If it were discovered at any time that a provider made a false report or did
18 not disclose required information in a cost report, what avenues, if any, are
19 available to the State?
20 SAXON: You know, depending upon what the, I guess the information was relating
21 to, we would have the Auditors look at it or you know, those claims related
22 stuff, it would be Program Integrity, things like that.
23 NICKLES: All right. Let me ask you this. If we look at this report, and this is the annual
24 report of November 29, 2007 through September 30, 2008 and we turn to
25 page 3, is this facility required to report whether it participates in
26 transactions with related organizations?
27 SAXON: Yes.
28 NICKLES: And did it report some related organization transactions?
29 SAXON: Yes, it did.
30 NICKLES: And what did that relate to?
31 SAXON: Management fees.

1 NICKLES: Okay.

2 SAXON: Or the pay to Putnam Counsel.

3 WESTBROOK: I'm sorry, what page are you on?

4 NICKLES: Page 3. And it's entry number 10, is that correct?

5 SAXON: Yes.

6 NICKLES: Now, after the issuance of this report, did it come to your attention that there

7 were other related party transactions that were not disclosed in the report?

8 SAXON: Not that I'm aware of.

9 NICKLES: Well, were you present at Mr. Schmoyer's deposition?

10 SAXON: Yes.

11 NICKLES: Did he indicate that there were related party transactions?

12 SAXON: Yes.

13 NICKLES: Okay. And let me ask you to turn to page 30 of this and it's account titled

14 3. to expense minor equipment purposes less than \$5,000. Do you see that?

15 SAXON: Yes, I see it.

16 NICKLES: Emergency minor equipment, \$58,833. Do you see that number there?

17 SAXON: Yes.

18 NICKLES: Okay. It's come to your attention since this report was issued that that was

19 a related party transaction?

20 WESTBROOK: Objection- leading. Judge, we would...

21 NICKLES: Yes.

22 WESTBROOK: I just want some clarification on whether to allow corrections, again I...

23 SCHINDLER: Yeah.

24 WESTBROOK: It's okay but I mean and I...

25 NICKLES: I'll talk...

26 WESTBROOK: Let me, let me, let me finish and let me get this on the record. We don't

27 want to talk over each other. You know, I, I, I'm happy to keep objecting

28 or I'm happy to not object, but there are a lot of leading questions and I just

29 want the same leeway with my witnesses if, if Mr. Nickles is continuing...

1 SCHINDLER: Yes, and I do not want leading questions, so please restate your question.
2 Before you restate your question, can you tell me where we are, what
3 section?
4 NICKLES: We're on page 30.
5 SCHINDLER: We're on 30, but what section?
6 NICKLES: It is...
7 SAXON: Adjustment Number 3.
8 SCHINDLER: Number 3, thank you.
9 NICKLES: Did you attend Mr. Schmoyer's deposition?
10 SAXON: Yes.
11 NICKLES: What do you recall, if anything, relating to or referencing the purchase of
12 minor equipment that was stated by Mr. Schmoyer in that deposition?
13 SAXON: That the purchase, purchases were from a related party.
14 NICKLES: If that is, testimony were true, Mr. Saxon, would that have been required to
15 be disclosed on this cost report?
16 SAXON: Yes.
17 NICKLES: Okay. Was it disclosed on the cost report?
18 SAXON: The management fees were but not the equipment.
19 NICKLES: Not this?
20 SAXON: Right.
21 NICKLES: Let me ask you, please, to look at the same pages on, and first on the cost
22 reports, is there, is there anything that the provider has to sign?
23 SAXON: Yeah, there's a certification.
24 NICKLES: What does it require?
25 SAXON: You want me to read it?
26 NICKLES: Yes sir.
27 SAXON: Under penalties of perjury, I declare that I have examined this cost report
28 including any (unclear) schedule in our statement and to the best of my
29 knowledge and belief, it is true, correct and complete. Declaration of the
30 preparer other than facility owner/personnel is based on all information
31 which preparer has knowledge.

1 NICKLES: Is this the type of document or let me put it—in a desk review, what type of
2 information do you review?
3 SAXON: The cost report against files and any supplemental schedules and trial
4 balances that come with it.
5 NICKLES: Okay. Now turning to page 30 of the initial cost report, is there anything
6 listed with regard to minor equipment?
7 SAXON: Yes sir, it is. It's Adjustment Number 3 again.
8 NICKLES: What does it show?
9 SAXON: It shows there was nursing minor equipment, an expense of \$58,833 and
10 some other minor equipment.
11 NICKLES: Okay, would you compare that entry to the entry on the annual cost report?
12 SAXON: Yeah, it's the same.
13 NICKLES: It's the same. Okay. Thank you. If it is discovered after the delivery of a
14 cost report that there are undisclosed related party transactions; what
15 measures, if any are available to the State to address that situation?
16 SAXON: You know, again, we would if it's financially related, we'll have the
17 auditors go out and look at it.
18 NICKLES: If the auditors discover an undisclosed related party transaction during their
19 on-site reviews of a cost report, what actions, if any, would be available to
20 them with regard to tracing that to other cost reports?
21 SAXON: We would expect them to go back in prior reports to see how far the expense
22 may or may not have been reported.
23 NICKLES: Now, Mr. Saxon, with regard to the initial cost reports, what periods of time
24 do those reports provide the basis for calculating reimbursement rates?
25 SAXON: All right. Say it one more time.
26 NICKLES: Yes. Initial cost reports—or what periods of time may the information in
27 those initial cost reports establish the basis for reimbursement rates?
28 SAXON: Both these six months reports, okay, they again, they can—this will set the
29 rate. The first—the initial report, being the six month cost reports set the
30 rate from November of 2007 through September of 2009.
31 NICKLES: Okay, an extended period of time.

1 SAXON: An extended period of time.
2 NICKLES: And I believe in your affidavit, you offered an illustration of how that may
3 impact the reimbursement of one-time costs?
4 SAXON: Yes.
5 NICKLES: Okay. I am going to hand you a document was attachment 5 to your
6 affidavit which is on the record and ask if you're familiar with that
7 document?
8 SAXON: Yes I am.
9 NICKLES: What does that document represent?
10 SAXON: Basically it shows the impact of, of incurring a non-recurring expense in the
11 base period and what kind of reimbursement effect it has on the payment
12 period in which this cost what was used to set that provider's rate.
13 NICKLES: Okay. And is this...
14 SCHINDLER: Excuse me a second. Can you be patient while I find that?
15 NICKLES: Sure.
16 SCHINDLER: I've got, if I can read that, I've got the...
17 NICKLES: No, it's not his deposition, it's his affidavit.
18 SCHINDLER: Okay, okay. And, do you know...
19 NICKLES: Which goes to the—our memorandum in opposition to summary judgment.
20 SCHINDLER: Okay, let me find that. I'm sorry. It's in a different file.
21 NICKLES: You're fine. And his attachment is after the affidavit.
22 SCHINDLER: Is this the correct...
23 NICKLES: You need the one proceeding that.
24 SCHINDLER: Thank you.
25 NICKLES: This document here.
26 SCHINDLER: Sorry for the interruption.
27 NICKLES: No, it's not a problem. Mr. Saxon, looking at that Exhibit Number 5 to your
28 affidavit, what does it reflect with regard to that particular cost and the
29 reimbursement consequences?

1 SAXON: It shows that the cost was \$67,996.00 as reported on the cost report but
2 overall the Medicaid paid days up for incurred over those payment periods
3 that \$67,996 turned into \$185,767.
4 NICKLES: All right, sir. Look at the next exhibit to your affidavit. It's Exhibit Number
5 6, I believe, and you were commenting earlier about the periods that the
6 initial cost report impact, does that—what, if anything does that Exhibit
7 reflect?
8 SAXON: What this exhibit does, it shows the different rate periods that were, that
9 were reimbursed based upon that initial six month cost report period.
10 NICKLES: And what does that show?
11 SAXON: It shows from the contract period, it's identified here, it set the rates during
12 November 29, 2007 and actually ended September 30, 2009.
13 NICKLES: Okay. And is that a consequence of the State Plan application to these initial
14 cost reports?
15 SAXON: Yes.
16 NICKLES: Okay. All right, Mr. Saxon, with regard to the cost reports that you've
17 identified, what, at the desk review is there a procedure for you to, y'all
18 strike that. Mr. Saxon, if it comes to a provider's knowledge that there has
19 been an inaccurate or false report of costs in their false report, is—what
20 actions, if any, are available to them?
21 SAXON: Well, providers can amend an open cost report.
22 NICKLES: Okay. And if it is discovered that there's an undisclosed related party
23 transaction, what action, if any, should be taken by the provider?
24 SAXON: Again, they should notify us and then we would adjust their rate
25 accordingly.
26 NICKLES: Okay. In this instance, do you have any record of that information of any
27 amendment to either of these cost reports?
28 SAXON: Not to my knowledge.
29 NICKLES: Give me just a minute. Let's go off the record for a minute.
30 SCHINDLER: All right. Certainly. We are off the record. We are back on the record. All
31 right, go ahead, Mr. Nickles.

Jeff Saxon - Redirect

1 NICKLES: No more questions, Mr. Saxon, at this time.
2 SCHINDLER: All right, Mr. Westbrook, do you have any redirect?
3 WESTBROOK: I do have just a few. Your Honor, bear with me a second here...
4 SCHINDLER: Take your time.
5 WESTBROOK: Mr. Saxon, Mr. Nickles asked you a number of questions about minor
6 equipment and the related party transactions involving minor equipment, do
7 you recall that?
8 SAXON: Yes.
9 WESTBROOK: Now, in this matter that's before us today, minor equipment was disallowed,
10 was it not?
11 SAXON: In the audit.
12 WESTBROOK: Isn't minor equipment not even an issue in this appeal because it was
13 disallowed?
14 SAXON: If it was disallowed, it's, it's...
15 WESTBROOK: It's not an issue, is it?
16 SAXON: Well...
17 WESTBROOK: Are we disputing? Is it your understanding that Countrywood is disputing
18 about reimbursement for minor equipment at this point in time?
19 SAXON: They're not disputing that but the can require them to report related party
20 transactions.
21 WESTBROOK: All right. The—let me go back and talk about this term rate period a minute.
22 Let me start, and, and, just ask you, and I apologize for this. I don't—but
23 Mr. Nickles asked you some questions about rate period and rate cycle and
24 contract period and I just want to clarify if I can. Let's go back to
25 Petitioner's Exhibit 4 for just a minute.
26 SAXON: Four?
27 WESTBROOK: That's right. And if you can do this from memory that's fine but if necessary
28 we can certainly go to Exhibit 4. In Exhibit 4, excuse me, which is the SAO
29 Contract, it says that a contract period will be the rate period. Do you recall
30 that? It says contract period, why don't we look just...
31 SAXON: Yeah, let's just look to be clear.

1 WESTBROOK: ...look, look on page 4 on this and...

2 SAXON: This is talking about...

3 WESTBROOK: Article III, D. 1. Tammie, why don't you see if you can find that one? This
 4 would be demonstrative 2, I believe. And I'll tell you where I think it is.
 5 Oh, I'm sorry, not any of those. I'm completely wrong. It's Exhibit 6, is
 6 what I'm talking about. Exhibit 6 is the Facility Contract.

7 SAXON: I was going to say I didn't think that was in there. That's why I was...

8 WESTBROOK: Feel free to correct me any time you want to, Mr. Saxon. I, I will probably
 9 make some other errors but what I'm talking about is Exhibit 6.

10 SAXON: Okay.

11 WESTBROOK: This is the Facility Contract. You know, this is the section that says time
 12 limit for issuance of the final audit report.

13 SCHINDLER: What the page is that?

14 WESTBROOK: That's on page 8, I'm sorry, of Exhibit 6. Tammie, if you could find, that
 15 would be demonstrative either 3 or 4, 3 I think. Now we looked at this
 16 earlier, Article V, Section F. of the Facility Contract. And remember that
 17 first sentence that you read into the record, into the record, talks about this
 18 three year period measured from the close of the contract period, right?

19 SAXON: Yes.

20 WESTBROOK: And then the parenthetical at the end of that paragraph says see Article II
 21 for the definition of the contract period, right?

22 SAXON: Right.

23 WESTBROOK: And when we looked over at page 2 earlier, it said for the definition of
 24 contract period it said as you recall, for purposes of Article V, Section F.,
 25 the contract period will be the rate period as defined by the South Carolina
 26 State Plan.

27 NICKLES: I'm going to object to—object to form of the statement being given, the
 28 language.

29 WESTBROOK: Okay, I wanted...

30 SCHINDLER: Wait a minute. What was your objection again? I didn't catch that.

31 NICKLES: In the misreading of the contract.

1 WESTBROOK: I'll be glad to read it over again and withdraw the question.

2 SCHINDLER: All right.

3 WESTBROOK: And read it (unclear). Over on page 2 of Exhibit 6, the Facility Contract
4 where it defines contract period, that last sentence that you read into the
5 record earlier, Mr. Saxon, says for purposes of Article V, Section F. only,
6 the contract period will be the rate period as defined by the South Carolina
7 State Plan. Is that correct?

8 SAXON: Yes.

9 WESTBROOK: Okay. All right. Now, you recall that on your direct exam, we looked at
10 Ms. Myers' letter where she identified certain rate periods. Do you recall
11 that?

12 SAXON: Yes.

13 WESTBROOK: And do you recall our demonstrative, which I'm going to ask Tammie to
14 put up there now, was consistent with those rate periods defined by Ms.
15 Myers in her letter or defined may be the wrong term, represented or
16 presented by Ms. Myers in her letter. And recall those were the three rate
17 periods she identified. Is that right?

18 SAXON: That's correct.

19 WESTBROOK: All right. Now I believe you testify on questions from Mr. Nickles that there
20 may have been some confusion about the term rate period. Do you recall
21 saying that?

22 SAXON: Yes.

23 WESTBROOK: All right. I want to ask you to look now, keeping in mind that those three
24 periods there are the three periods identified by Ms. Myers in her letter of
25 12/16/11 to Countrywood. Let's look at Petitioner's Exhibit 10, please.

26 SAXON: Okay.

27 WESTBROOK: And the top of Exhibit 10; you see where it says desk audit?

28 SAXON: Oh yeah.

29 WESTBROOK: And so this is something taken from the desk audit, is it not?

30 SAXON: Correct.

1 WESTBROOK: And it, and it lists at the top of that page, I'm on the first page of Exhibit
2 10, it says reporting period and then right under it it says rate period, does
3 it not?
4 SAXON: Yep.
5 WESTBROOK: What is the rate period identified in the desk audit here?
6 SAXON: 11/29/07 through 5/31/08.
7 WESTBROOK: And that's the same one as that Ms. Myers identified is the first rate period,
8 right?
9 SAXON: Yeah.
10 WESTBROOK: Let's turn to Exhibit 11 and the first page again, this is the desk, another
11 desk audit, right?
12 SAXON: Right.
13 WESTBROOK: And the rate period identified there is what?
14 SAXON: 6/1/08 through 9/30/08.
15 WESTBROOK: And that's the same as the second rate period identified by Ms. Myers,
16 right?
17 SAXON: Right.
18 WESTBROOK: And let's go to Exhibit 12, please ma'am. Look on the first page of Exhibit
19 12, another desk audit, right?
20 SAXON: Right.
21 WESTBROOK: And the rate period identified at the top of the page is what?
22 SAXON: 10/1/08 through 9/30/09.
23 WESTBROOK: The same as the, as the other, the third rate period identified by Ms. Myers,
24 correct?
25 SAXON: Correct.
26 WESTBROOK: And these are desk audits. Of course, there's a final audit too after the on-
27 site audit, right?
28 SAXON: Yes.
29 WESTBROOK: Or is it part of the on-site audit? Let's look at Exhibit 1, Petitioner's Exhibit
30 1.
31 SAXON: Okay.

1 WESTBROOK: And you'll see the first page of Exhibit 1 is a cover letter from Mr. Richard
2 Gilbert with the SAO, is that correct?
3 SAXON: Yes.
4 WESTBROOK: And the date is November 22, 2011, right?
5 SAXON: Correct.
6 WESTBROOK: So that's the date of the final audit, is that right?
7 SAXON: Yes sir.
8 WESTBROOK: And let's—I'm going to ask you to turn, these pages that are not numbered,
9 but I think the third page of that exhibit is a table of contents, right?
10 SAXON: Yes sir.
11 WESTBROOK: And just for the sake of expediency, I'm just going to ask you to look at the,
12 on that table of contents, the third entry. It says computation of adjusted
13 reimbursement rate for the contract period and what does it identify as the
14 contract period?
15 SAXON: November 2007 through May 2008.
16 WESTBROOK: And in fact it was November 29, 2007.
17 SAXON: Well, I'm sorry, I didn't—yeah, that was skipped.
18 WESTBROOK: Okay, and again, that's the same as the first rate period identified by Ms.
19 Myers, right?
20 SAXON: Right.
21 WESTBROOK: And the next entry identifies the contract period as being what?
22 SAXON: June 1, 2008 through September 30, 2008.
23 WESTBROOK: Same as Ms. Myers' second rate period, right?
24 SAXON: Yes.
25 WESTBROOK: And the third entry on that table of contents?
26 SAXON: October 1, 2008 to September 30, 2009.
27 WESTBROOK: Okay, October 1, 2008 through September 30, 2009, the same as Ms.
28 Myers' third rate period, right?
29 SAXON: Yes, yes.

1 WESTBROOK: Okay. So with respect to confusion, there's no confusion or inconsistency
2 among Ms. Myers, the desk audit and the final audit as to the dates of those
3 rate periods, is there?
4 SAXON: Correct. And the rate, the rate periods are set that way to make sure you
5 apply the proper set of inflation, you know, all rules and reg's there and
6 liable cost definitions that are in that State Plan.
7 WESTBROOK: All right. Now, Mr. Nickles got you to read that provision in the cost report
8 about the accuracy of data in reports, that they need to be accurate.
9 SAXON: The certification statement.
10 WESTBROOK: The certification statement? I think that is in addition to the certification
11 statement. That was another...
12 SAXON: I'm sorry.
13 WESTBROOK: Isn't that right?
14 SAXON: Yes, that's right. In ours, right.
15 WESTBROOK: Now, you've been at HHS for a long time, haven't you?
16 SAXON: Yeah.
17 WESTBROOK: For a young man like you, you've been there...
18 SAXON: Yeah, yeah.
19 WESTBROOK: ...an especially long time.
20 SAXON: Yeah.
21 WESTBROOK: And I believe you started out in your early days before you became a
22 Program Manager, you were an auditor, weren't you?
23 SAXON: Yes, I was.
24 WESTBROOK: All right. So you've had a lot of experience in Medicaid cost reports?
25 SAXON: Yep.
26 WESTBROOK: And Mr. Saxon, Medicaid Cost Reports that are submitted, it's not unusual
27 that occasionally there are mistakes submitted on it, wouldn't you agree
28 with that?
29 SAXON: Yes.

1 WESTBROOK: All right. You're not aware at this point in time of any charges by the State
2 or any State agency at this point in time against Countrywood or any of its
3 accountants or agents alleging any kind of legal actions, are you?
4 SAXON: No sir. Well, save this, this is one pretty piece of important information. I
5 mean this is a requirement in Medicare and Medicaid reporting.
6 WESTBROOK: I understand that.
7 SAXON: Okay.
8 WESTBROOK: And at the time and if somebody makes, presents false information to
9 Medicare or Medicaid, there are statutes that are out there that allow the
10 government to bring actions against them if they meet certain criteria under
11 those statutes, isn't that correct?
12 SAXON: Yes sir.
13 WESTBROOK: And those, at least to date, no such charges have been brought, have they?
14 SAXON: No sir.
15 WESTBROOK: All right. Now, these audits were not undertaken to the best of your
16 knowledge back in 2011 as part of a fraud investigation, were they?
17 SAXON: Not that I'm aware of.
18 WESTBROOK: And no allegations of fraud have been made, then or now, against...
19 NICKLES: Up to this point in time.
20 WESTBROOK: No allegations have been made of fraud against Countrywood or any of its
21 agents, have—isn't that true?
22 SAXON: Up to this point in time, no.
23 WESTBROOK: All right. And I'm going to object to Mr. Nickles helping to coach the
24 witness and I'm going to ask him not to do that.
25 NICKLES: Oh, I'm not intending to.
26 WESTBROOK: Well...
27 NICKLES: I was only trying to clarify your question.
28 WESTBROOK: Well, I think if my question needs clarifying I will do it or I will do it on
29 instructions from the Hearing Officer not from you, Mr. Nickles.
30 NICKLES: Yes, I apologize.
31 SCHINDLER: That's fine. I'm noting your objection and I will sustain your objection.

1 WESTBROOK: Okay, thank you.
2 SCHINDLER: I don't believe Mr. Nickles intended to coach. I noted it.
3 WESTBROOK: Thank you. Now, you testified in response to questions from Mr. Nickles
4 about an extended rate period.
5 SAXON: Yes sir.
6 WESTBROOK: The Plan that you write, that you're responsible for writing does not say
7 anything about an extended rate period, does it?
8 SAXON: You have to go through the State Plan and read its entirety to understand
9 how those rate periods are acquired. It's very standard for anybody that
10 doesn't change ownership, but there's no way in the world I can write a
11 State Plan that's going to describe every scenario that's going to occur under
12 a change of ownership with dates and stuff. They realize that it takes time
13 from when they file their six month cost report that they have to catch up
14 with the reporting requirements of all these other facilities, so they get the
15 use the current thing while all these other people get to use these other ones
16 and finally they merge and then they start getting on the same cycle as
17 everybody else so.
18 WESTBROOK: All right.
19 SAXON: While I cannot go in there and say that there is a definition that says here
20 are all the different, you know, periods of time you're going to be
21 reimbursed based upon these certain effective dates of these change of
22 ownerships, they understand this is how the system works.
23 WESTBROOK: The term, when you say they understand.
24 SAXON: The providers.
25 WESTBROOK: All right. And so you understand what the providers understand. That's
26 what you're telling me?
27 SAXON: Yes.
28 WESTBROOK: And how many providers are you talking about?
29 SAXON: I would say any of them that deal with Medicaid.
30 WESTBROOK: How many nursing homes are there in that deal with Medicaid in this state?
31 SAXON: Probably 150.

Jeff Saxon - Recross

1 WESTBROOK: Let me finish my question.
2 SAXON: Yes sir.
3 WESTBROOK: How many nursing homes that deal with Medicaid?
4 SAXON: 150.
5 WESTBROOK: And you know what all those providers think?
6 SAXON: I'm not saying I know what all they think but I'm very aware of this policy
7 and I am very aware of the outcry they have, they are starting to put on us a
8 little bit because of that change in ownership policy on a six month cost
9 report.
10 WESTBROOK: And where in the State Health Plan is the term extended rate period used?
11 SAXON: It's not defined but again...
12 WESTBROOK: That's not my question. Is it used? Is the term extended rate period even
13 appear in the State Health Plan?
14 SAXON: It doesn't appear but the providers are aware of the different changes in
15 certain caps, inflation or whatnot. I mean if they just want to get the rate
16 that was originally calculated with no inflation trends or updated staff, we
17 would have been happy to do that. But it benefited them by us doing what
18 we did for them. You're acting as if we penalized them for doing that.
19 WESTBROOK: No further questions. Thank you.
20 SCHINDLER: Any re-cross, Mr. Nickles?
21 NICKLES: Just, just a couple of points of attempted clarification. I'm not going to tell
22 you it's going to be fruitful. Mr. Saxon, I think you have provisions of the
23 State Plan that are contained in an Exhibit from the Petitioner and let's see
24 what exhibit, I think it is, it's in Exhibit Number 7.
25 SAXON: Okay.
26 NICKLES: And look with me if you will at page number 21 at the top of that exhibit,
27 please sir.
28 SAXON: 21?
29 NICKLES: Let's see if that's the one I had. Let's see if I can find it anywhere.
30 SAXON: Which one? What is it talking about? Is it just their information?

1 NICKLES: Payment determination, new facility. It's page 21. All right, sir. Now Mr.
2 Westbrook asked you some questions about the initial reporting period for
3 changes of ownership, is that correct?

4 SAXON: Yes.

5 NICKLES: Does that provision in the State Plan offer any guidance to nursing facilities
6 how that initial period shall be treated?

7 SAXON: Yeah, it does the initial and it also does the seventh month.

8 NICKLES: And if you would look at the second paragraph, just read the first line, it is
9 based on...

10 SAXON: Let me make sure I'm—I'm sorry. Based on a six month projected budget
11 of allowable costs covering the first six months of provider's operation
12 under the Medicaid Program the Medicaid Agency will set an interim rate
13 to cover the first six months of operation or through the last day of six full
14 counting the months of operation.

15 NICKLES: I see and so what does interim rate mean to you?

16 SAXON: Interim means that just a rate that's subject—well, actually it's two
17 meanings I guess in here. This talks about a budget so that will get the—the
18 actual cost report for the same time period and regardless of whether
19 (unclear) all of the budget report we would on the actual report.

20 NICKLES: Okay. So the use of the term interim rate is there—does it distinguish it
21 from anything else? Are other rates interim or are they—are the annual
22 rates characterized as interim?

23 SAXON: Again, this one is, let's see. In this particular wording here, this talks about
24 the interim rate based upon the budget, then there'll be—it talks about
25 submitting an actual cost report later on.

26 NICKLES: Oh, I see. Okay, thank you. Mr. Saxon, you were asked the question
27 whether there's any controversy about the allowability of minor equipment.
28 In this instance, the minor equipment reported on the initial cost report
29 will—the funds will be retained by this facility regardless of disallowance
30 if this is not, if the Petitioner prevails, is that correct?

31 SAXON: That's correct.

Terry Schmoyer - Direct

1 NICKLES: Okay. So it's not the fact that even though that they've admitted that it's,
2 it's improper, they want to keep the money.
3 SAXON: Right. I'm assuming we won.
4 NICKLES: Okay. Thank you. I don't have any other questions for you. Do you want
5 to take a break before we do Terry or do you want to plow through?
6 SCHINDLER: I feel like let's take a lunch break.
7 WESTBROOK: I'm all for that.
8 SCHINDLER: We are off the record. And I believe we were going to see if the Petitioner
9 has another witness to call.
10 WESTBROOK: We do. I'm going to call Terry Schmoyer.
11 SCHINDLER: All right.
12 WESTBROOK: Okay, Mr. Schmoyer, you've already stated your name for the record so tell
13 us what you do for a living.
14 SCHMOYER: I am a Certified Public Accountant. I have a CPA Firm here in Columbia
15 called Schmoyer and Company, CPA's, which I'm a managing partner and
16 primary owner of.
17 WESTBROOK: Before you talk about Schmoyer and Company, let me ask you a little bit
18 more about just yourself. Have long have you been a CPA?
19 SCHMOYER: I've been a CPA since approximately 1993.
20 WESTBROOK: And what states are you certified in?
21 SCHMOYER: South Carolina and Georgia.
22 WESTBROOK: All right. Are you a member of any professional organizations?
23 SCHMOYER: AICPA.
24 WESTBROOK: Which is what?
25 SCHMOYER: The American Institute of Certified Public Accountants and then the South
26 Carolina Association of CPA's.
27 WESTBROOK: All right. Tell us about do you serve on any particular other kinds of
28 organizations, community or charitable organizations you're associated
29 with?
30 SCHMOYER: I serve on the Peer Review Committee for the South Carolina Association
31 of CPA's and that's the Committee that audits other CPA firms so I'm a

1 licensed CPA firm auditor, and I serve on the Finance Committee for the
2 Columbia Chamber of Commerce, the—I'm on the Board of Directors of
3 the Community Foundation of the Midlands, and I Chair the Asset
4 Committee where we manage a hundred million dollar portfolio. I'm on the
5 Audit Committee. I'm on the Leukemia Lymphoma Society's Executive
6 Leadership Team. I'm on the Communities and Schools of the Midlands
7 Board of Directors which is a drop-out prevention program where I'm the
8 Treasurer, Treasurer of the Ben Lippen Booster Club...Which is where my
9 kids go to school.

10 WESTBROOK: What a list.

11 SCHMOYER: Kind of goes—South Carolina—I'm also on the...

12 WESTBROOK: Whoa, whoa, whoa.

13 SCHMOYER: ...yeah?

14 WESTBROOK: Hold on second. Get my question here. Tell me about the South Carolina,
15 about the South Carolina Health Care Association. Are you affiliated with
16 it?

17 SCHMOYER: Yeah, I'm a member of the South Carolina Health Care Association which
18 is the association for nursing homes in South Carolina. And I've served on
19 their Payment for Services Committee for approximately, probably twenty
20 years and that's the committee that works with Health and Human Services
21 on rates, Medicaid rates, changes to rates, policies, allowable costs, things
22 like that.

23 WESTBROOK: Okay. All right, now you said you are managing partner of Schmoyer and
24 Company, right?

25 SCHMOYER: That's correct.

26 WESTBROOK: And tell—what kind of work does Schmoyer and Company do?

27 SCHMOYER: In the Columbia market, we're a full-service CPA firm. We do individual
28 taxes, corporate taxes, tax planning, we do tax credits. We have a small
29 business department where we run corporate payrolls for about fifty
30 companies. We pay people's bills, pay corporate bills, and we do audits for
31 lenders, financial statements, 401K audits, so we're a normal—we have

1 twenty employees. We do all types of public accounting and in the
2 healthcare arena, we're the boutique healthcare firm for South Carolina. As
3 Jeff mentioned, there's about a hundred and fifty nursing homes in South
4 Carolina. We prepare approximately seventy of those Medicaid cost reports
5 a year. They also require Medicare cost reports. We probably prepare over
6 50 Medicare cost reports a year.

7 WESTBROOK: All right. Let me ask you about Medicaid cost reports and just tell me as a
8 layman, what is a Medicaid cost report?

9 SCHMOYER: Medicaid cost report is required to be submitted to the State of South
10 Carolina to set the payment rate for the following year. So you assemble
11 financial information and some non-financial information that they require
12 and you put those together, you can make journal entries that result in
13 adjustments to the cost report for allocating benefits or recording capital
14 costs or things like that, things that are unique to healthcare are on the
15 journal entries. And then we submit that to the State of South Carolina and
16 they use that to set your Medicaid rate for the next year.

17 WESTBROOK: All right. Now you mentioned, I believe you said approximately seventy
18 nursing home clients that you prepare Medicaid cost reports?

19 SCHMOYER: That's correct.

20 WESTBROOK: Is that right? Who is Schmoyer and Company's principle competitor in
21 South Carolina?

22 SCHMOYER: In South Carolina, we have very limited competitors. There's someone in
23 Charleston who may prepare eight reports and there's—and the next, so
24 that's all in South Carolina. I mean there are chains that prepare their own
25 reports but we prepare a large number of them. In North Carolina, there's
26 a CPA Firm called Dixon Hughes and they are based out of Raleigh.
27 They're a national firm and they prepare approximately twenty or less,
28 South Carolina Medicare reports.

29 WESTBROOK: All right.

30 SCHMOYER: We only prepare South Carolina Medicaid reports. We do one Georgia
31 report.

1 WESTBROOK: All right. Now, can you give me an estimate, just give me a rough estimate,
2 of how many cost reports you personally, Medicaid cost reports, you
3 personally have either prepared or supervised over the last twenty, twenty-
4 five years.

5 SCHMOYER: Over a thousand, easily.

6 WESTBROOK: Besides preparing, well, I think you've already talked about other services
7 that your company does. Now, the Petitioner in this case, Mr. Schmoyer, is
8 Countrywood Nursing Center, LLC. What's your relationship with
9 Countrywood?

10 SCHMOYER: Countrywood is a accounting customer of ours.

11 WESTBROOK: All right. And they're a nursing home, right?

12 SCHMOYER: They're a nursing home.

13 WESTBROOK: Where are they located?

14 SCHMOYER: They're located in Hopkins, South Carolina which is near Columbia, out
15 Sumter Highway.

16 WESTBROOK: How big a nursing home is Countrywood?

17 SCHMOYER: Countrywood is probably the smallest nursing home in South Carolina. It
18 has 38 beds.

19 WESTBROOK: All right. How long...

20 SCHMOYER: And a 26 bed assisted living facility.

21 WESTBROOK: That's separate from the 38 nursing home.

22 SCHMOYER: On the same campus.

23 WESTBROOK: Okay. How long has Countrywood been your client?

24 SCHMOYER: They've been my client since the summer of 2007.

25 WESTBROOK: All right. And they are, I believe we established earlier in Mr. Saxon's
26 testimony that they are a successor company to another nursing home
27 company. Tell us about that.

28 SCHMOYER: Countrywood purchased Ridgeview of the Midlands because Ridgeview of
29 the Midlands was in the process of being closed by Medicare and they
30 bought—they came in and bought them. They're a Georgia company.

31 WESTBROOK: Who is a Georgia company?

1 SCHMOYER: The management—the owner of Countrywood owns many facilities in the
2 State of Georgia. This is their only South Carolina location.
3 WESTBROOK: All right. And they purchased this nursing home from Ridgeview, is that
4 what you said?
5 SCHMOYER: Ridgeview of the Midlands.
6 WESTBROOK: All right. Fine. Now is Countrywood paying you for your services working
7 on this appeal?
8 SCHMOYER: They are.
9 WESTBROOK: Tell me about your job. What's your job? How do you view your job duties
10 as Countrywood's accountant?
11 SCHMOYER: In the scope of what?
12 WESTBROOK: In the scope of, well, let's take it back to the scope of preparing their
13 Medicaid cost reports first.
14 SCHMOYER: They hired us to prepare their Medicaid cost reports because they did not
15 have the ability to prepare the reports themselves and they wanted to use
16 someone who is knowledgeable about the South Carolina reimbursement
17 process.
18 WESTBROOK: All right. And you charge them for that I assume, right?
19 SCHMOYER: Sure.
20 WESTBROOK: And what's the scope—how—what are your job duties as Countrywood's
21 accountant, working on this appeal?
22 SCHMOYER: On this appeal, I was hired to explain to them the adjustments that the
23 auditor made to facilitate information to the auditor's office to reduce the
24 adjustments financially to get the number to go down which we did and now
25 to—there's continued disagreement with the issues in appeal, so now I'm
26 here to represent them and to explain what I think the reimbursement
27 processes are for South Carolina.
28 WESTBROOK: All right. And is it, is it one of your goals to try to maximize the revenue of
29 your client, in this case Countrywood?

1 SCHMOYER: I have many goals for them but yeah, that is a goal. They've hired us to
2 provide accurate cost reporting and services and we're trying to do that to
3 the best of our ability.

4 WESTBROOK: All right. Now on Countrywood's six month report, first of all, why did
5 Countrywood file a six month report to start off with?

6 SCHMOYER: Well, in South Carolina when you have a change of ownership, you can
7 have a change of owner, you have the change of ownership, you are entitled
8 to a brand new Medicaid rate because you're going to run the facility
9 differently than the person who previously ran the facility so the State
10 allows you to file a six month report to get a re-based Medicaid rate.

11 WESTBROOK: All right. And that rate stays the same for six months, I believe was...

12 SCHMOYER: That rate stays the same for the first six months of operations, yes.

13 WESTBROOK: And what happens on the first day of the seventh month?

14 SCHMOYER: On the first day of the seventh month, you receive a new rate and that rate
15 has inflation and then it's paid until September 30th.

16 WESTBROOK: All right. And what happens...

17 SCHMOYER: Now because you can change ownership at any time, everyone's,
18 everyone's six month cost report is a different six months.

19 WESTBROOK: I understand. So it's depending on when the change in ownership....

20 SCHMOYER: And this happened where our six months happened to be May and then the
21 seventh month rate started June 1 through September 30.

22 WESTBROOK: And then what happens on October 1st of every year?

23 SCHMOYER: October 1st of every year, the new State Plan comes out and that dictates all
24 the changes to the Medicaid Program and then new rates are issued on
25 October 1st.

26 WESTBROOK: All right. Now in Countrywood's six month's report, Countrywood claims
27 certain costs for patient's furniture. Are you familiar with that?

28 SCHMOYER: Yes.

29 WESTBROOK: Do you recall that? Now that was the cost report that you prepared, you or
30 your company prepared, right?

31 SCHMOYER: Our company prepared that report. I supervised it.

1 WESTBROOK: All right. And at the time that you prepared that, did you have any reason,
2 did you or your company have any reason to believe that the furniture for
3 which those costs were claimed was not necessary?
4 SCHMOYER: No, we did not.
5 WESTBROOK: Is any reason—did you have any reason to believe that those costs were not
6 incurred?
7 SCHMOYER: No, I did not.
8 WESTBROOK: Now do your clients always provide you with backup documentation for all
9 their costs that are claimed on Medicaid cost reports?
10 SCHMOYER: They do not.
11 WESTBROOK: Is backup documentation always required for all costs on Medicaid cost
12 reports?
13 SCHMOYER: Backup documentation is not required for the completion of our process of
14 the report but they will need to retain their backup documentation in
15 accordance with their Medicaid contract.
16 WESTBROOK: Now in this particular case, did Countrywood provide you with any backup
17 documentation for the patient furniture costs?
18 SCHMOYER: They did.
19 WESTBROOK: And did you later request more—did you later request backup for the
20 backup?
21 SCHMOYER: I did.
22 WESTBROOK: And did you get that?
23 SCHMOYER: I did not.
24 WESTBROOK: I want you, what you just said, do you remember testifying at your
25 deposition when Mr. Nickles asked you about that?
26 SCHMOYER: I do not.
27 WESTBROOK: These patient...
28 SCHMOYER: I mean I recommend—I remember the deposition.
29 WESTBROOK: I'm not asking...
30 SCHMOYER: I don't remember every word about it.

1 WESTBROOK: I'm not asking you for every word. Do you remember testifying generally
2 about...
3 SCHMOYER: I did, yes.
4 WESTBROOK: ...another subject?
5 SCHMOYER: I do.
6 WESTBROOK: All right. I want you to pull out your deposition and do you have a copy
7 with you?
8 SCHMOYER: I do not.
9 WESTBROOK: Can I ask—let me give you—hold on, I've got it right here. Do you have a
10 copy?
11 SCHMOYER: Yes.
12 SCHINDLER: Somebody give me this?
13 WESTBROOK: I think Mr. Nickles might have.
14 SCHINDLER: Okay.
15 NICKLES: That's Mr. Saxon's original.
16 WESTBROOK: Oh, that's Mr. Saxon's original.
17 SCHINDLER: Okay.
18 WESTBROOK: The Schmoyer deposition is...
19 SCHINDLER: Okay, well, maybe—I guess this is yours, mine's kind of...
20 NICKLES: No, that's not my copy.
21 SCHINDLER: Okay.
22 WESTBROOK: That's my copy.
23 SCHINDLER: Okay.
24 NICKLES: I think you just did it.
25 WESTBROOK: For...
26 NICKLES: Procedural reasons.
27 WESTBROOK: That's right. There you go. The Schmoyer deposition right now is
28 Petitioner's Exhibit 18 which is in your notebook, Ms. Schindler, and I want
29 to ask you to turn to page 28 of that deposition.
30 NICKLES: Are you asking these questions to refresh his recollection?

1 WESTBROOK: No, I'm actually asking him because I believe that what he just said may
2 have sounded inconsistent with what he said in his deposition. I'm
3 impeaching my own witness.
4 NICKLES: Impeach your own witness?
5 WESTBROOK: Weil, it's a way of—it's an unusual procedure, I might add but I—so maybe
6 a kind way of putting it would be to refresh his recollection. We want an
7 explanation though. I think that's where I'm going. So...
8 SCHINDLER: Page, I'm sorry?
9 WESTBROOK: Page 28.
10 SCHINDLER: 28, okay.
11 WESTBROOK: On page 28, Mr. Schmoeyer, I want to start reading, well, actually, let's start
12 at the bottom of 27 with Line 24 on page 27. I'm going to read the questions
13 that were asked by Mr. Nickles. I'll try to use my best Mr. Nickles' voice
14 and you read your answers, please and then I want to ask you about this.
15 On Line 24, the question is all right, did you attempt to cooperate with the
16 Office of the State Auditor when gathering information that they deemed
17 appropriate to assess the reimbursability of your client's services? Answer?
18 SCHMOYER: I did.
19 WESTBROOK: Question, okay, and did they explain to you that certain costs had not been
20 adequately documented? Answer?
21 SCHMOYER: They did.
22 WESTBROOK: Question, but you already knew that didn't you? Answer?
23 SCHMOYER: I did not.
24 WESTBROOK: Question, you didn't? Answer, it says shaking head. Question, when you
25 got the stuff from your customer and you saw these costs for furnishings
26 and other things, home office and other things like that, you didn't say
27 where is the backup? Answer?
28 SCHMOYER: I did.
29 WESTBROOK: Question, did they provide it to you? Answer?
30 SCHMOYER: They did not.

1 WESTBROOK: Question, okay, so even before the auditors came in here and started looking
2 around, you were aware there was some deficiencies in this particular
3 customer's recordkeeping, is that fair to say? Answer?
4 SCHMOYER: In that instance, yes.
5 WESTBROOK: All right. Now the reason, Mr. Schmoyer, I thought you just testified to me
6 that they did provide you with some backup documentation. Here it looks
7 like you say on line 17, they did not provide you with backup
8 documentation. Can you explain that?
9 SCHMOYER: They did provide backup documentation. When the cost report was
10 prepared, we have to record fixed assets on various forms so I needed
11 backup for the fixed assets that were purchased, so I asked them for
12 documentation to support the fixed assets which I received from them.
13 WESTBROOK: And the fixed assets were, were what?
14 SCHMOYER: Fixed assets were \$68,000 worth of patient room furniture. It was over-bed
15 tables, nightstands, and beds, and those assets were purchased from a related
16 party which is some of the related party testimony I think you've heard
17 today.
18 WESTBROOK: We're going to get into the related party issue in a minute. First I just want
19 to understand about the backup documentation.
20 SCHMOYER: And so I did receive information from them to support the dollar amounts
21 that were recorded on the cost report.
22 WESTBROOK: All right. You did, even though in the deposition you said you did not? Was
23 that, I mean tell me, explain to me why you said they did not in the...
24 SCHMOYER: Because since the cost report was prepared and then we went through the
25 audit, the auditor asked for additional documentation and I did not receive
26 that documentation.
27 WESTBROOK: All right. So...
28 SCHMOYER: But I did receive—I received enough documentation at the time that the cost
29 report was prepared that in my opinion I could support the costs that were
30 claimed.
31 WESTBROOK: All right.

1 SCHMOYER: But then I had no reason to believe that what they were providing me was
2 not correct.

3 WESTBROOK: All right. And then later you requested additional information, backup
4 information? Is that what I understand you to say?

5 SCHMOYER: Well, I told them that at some time in the future, they were going to have to
6 provide, if they were audited, the auditor may ask for additional
7 documentation beyond what you had provided me and they said okay.

8 WESTBROOK: And did the...

9 SCHMOYER: But the question wasn't well, did they provide it? No, they didn't provide
10 it.

11 WESTBROOK: All right.

12 SCHMOYER: But I mean I didn't (unclear) report.

13 WESTBROOK: All right. So they never provided, am I understanding correctly that they
14 never provided you the second round of information you asked for?

15 SCHMOYER: That's correct.

16 WESTBROOK: Okay. Now let's talk about related party. Mr. Nickles spent a good bit of
17 time with questions about that with Mr. Saxon. I want to understand that.
18 First of all, Mr. Schmoyer, is it correct that related party costs which should
19 have been listed on these cost reports were not listed?

20 SCHMOYER: That is correct.

21 WESTBROOK: When did you discover that?

22 SCHMOYER: Yesterday.

23 WESTBROOK: What were the circumstances—and when yesterday did you discover it and
24 how did you discover it?

25 SCHMOYER: Yesterday afternoon, I read the email from Mr. Nickles talking about the
26 issue of oxygen and at the bottom of that email there was made reference to
27 DHHS not being pleased that the related party disclosure was not on the
28 cost report.

29 WESTBROOK: That was an email from Mr. Nickles to who?

30 SCHMOYER: I believe it was to you.

31 WESTBROOK: All right.

1 SCHMOYER: And that was the first time I learned that that line on the report was not
2 completed.
3 WESTBROOK: What did you do when you got that email?
4 SCHMOYER: I pulled the cost report out of my file to see what they were talking about.
5 WESTBROOK: And what did you find out?
6 SCHMOYER: I found that on the cost report, the related party disclosure for the purchase
7 of the equipment was not disclosed.
8 WESTBROOK: Was this an intentional concealment?
9 SCHMOYER: It was not.
10 WESTBROOK: Mr. Schmoyer, have you ever—you've been—I'm sorry, tell me again how
11 long you've been practicing as a CPA?
12 SCHMOYER: I've been practicing in accounting for 25 years, CPA since 1993.
13 WESTBROOK: Have you ever been sanctioned for anything?
14 SCHMOYER: No, I have not.
15 WESTBROOK: Have you ever had any kind of—you haven't—when I say sanctioned I
16 mean in the broad sense of the word, either professionally, by a professional
17 organization or have you ever been charged with a crime or anything related
18 to accounting?
19 SCHMOYER: No.
20 NICKLES: And, and Mr. Westbrook, I can short circuit this if you'd like. If Mr.
21 Schmoyer tells me he relied on his client and he did not personally know
22 this, I have no reason to pursue that. I have no interest in pursuing it.
23 WESTBROOK: Well, let me ask him a few questions about it and we'll see. Now Mr.
24 Schmoyer, this omission and it was an omission, is that correct?
25 SCHMOYER: Yes, it was.
26 WESTBROOK: Was it, the omission due to something your client failed to provide you or
27 was it an omission based on the part of Schmoyer and Company?
28 SCHMOYER: It was an omission on the part of Schmoyer and Company. I mean there
29 are—that cost report is many, many pages long. There are hundreds of
30 things that we put on the report, numbers, adjustments, there's disclosure

1 pages about what your long term bet is. I mean that one line just was not
2 completed.

3 WESTBROOK: And that..

4 SCHMOYER: And is the line supposed to be completed? Yes. Did we forget to complete
5 it? Yes.

6 WESTBROOK: And the certification was inaccurate then, is that correct?

7 SCHMOYER: The certification that the owner signed depending on how you interpret it..

8 WESTBROOK: Okay.

9 SCHMOYER: Could be, I mean I think that the cost report that we completed was
10 materially correct. The disclosure is just words. It had nothing to do with
11 journal entries, nothing to do with reimbursement, and didn't have any other
12 expenses claimed.

13 WESTBROOK: All right. But it was an omission?

14 SCHMOYER: It was an omission.

15 WESTBROOK: Now, here's my question. Did this omission or how did this omission
16 impact the amount of money that Countrywood was paid by Medicaid.

17 SCHMOYER: It did not impact the amount of money that was paid by Medicaid.

18 WESTBROOK: Really?

19 SCHMOYER: I asked my client, when you—the documentation that you gave me to
20 support furniture and equipment, is that what you paid for? Is that your
21 costs? And they said yes.

22 NICKLES: I'm going to object to the introduction of whatever his client may have said
23 to him. I mean his client could have been here to testify. He's not. So...

24 WESTBROOK: Well,...

25 NICKLES: ...if he's obviously...

26 WESTBROOK: ...now, that, that's true and I understand it's hearsay. On the other hand,
27 when you say his client could have been here and he's not, we just found
28 out about this issue last night so it's the first time that we've known about
29 it so—but having said that, let me rephrase my question and see if we can
30 avoid this issue entirely. Without going into what your client told you, Mr.

1 Schmoyer, can you tell me why this omission did not impact the amount
2 Countrywood was paid?

3 SCHMOYER: If you look at the related party, there's columns for how much the cost that
4 the provider paid for the service, how much the cost is that the related party
5 incurred and then if the costs are different, you reduce the costs down or
6 bring the costs up. As you look through the provider to whatever the related
7 party paid for the service so if the, if we bought the equipment for \$68,000
8 and the provider—and the client tells me that is the cost that they paid for it
9 then there's no adjustment, there's no profit in the transaction and it's just
10 disclosure.

11 WESTBROOK: All right. Let me ask you about—let me go back in time to another point in
12 time. Back in 2011 when you first heard from Mr. Warrington at SAO that
13 three of Countrywood cost reports were going to be audited, what did you
14 do when you first heard about that?

15 SCHMOYER: When I received the email from Larry Warrington, which is in one of these
16 exhibits, I saw that there were three cost reports that were being requested
17 to be audited. I knew that you can only audit two so I called the Auditor,
18 his supervisor, Mr. Von Kannel.

19 WESTBROOK: All right. And why did you call him?

20 SCHMOYER: I called him to complain that the audit process as I was explained it by the
21 association...

22 NICKLES: I'm going to object to any type of explanation by any third party. He can
23 speak to what he understood perhaps but not what other people told him.

24 WESTBROOK: Let me respond to that if I can. Rule, bear with me just a moment. It's Rule
25 703. Rule 703 of the South Carolina Rules of Evidence, it talks about basis
26 of opinion testimony by experts. It says, if of a type reasonably relied upon
27 by experts in a particular field in forming opinions or inferences upon the
28 subject, the facts or data need not be admissible in evidence. That's the rule
29 that is routinely used to allow experts to testify about hearsay. That experts,
30 when they rely on—when hearsay is something that they normally rely on,
31 that they can testify about it even though the underlying hearsay itself is not

1 admissible. So I would just ask you to take a look at that and then I would
2 like to follow-up with a question related to this to Mr. Schmoyer, what I
3 would ask him is, is this the type of information that he normally relies on.
4 SCHINDLER: And what was it you were objecting to, Mr. Nickles?
5 NICKLES: Two, two things. One, I don't think any foundation's been laid to ask the
6 question; secondarily, this is he says he heard something from somebody
7 and relied upon it. I don't think any expert can come in here and just say I
8 heard something from somebody I relied upon. That's hearsay, regardless
9 of whether you character—whether you're testifying as a fact witness or
10 offering opinion as an expert.
11 WESTBROOK: I would agree that I haven't laid a foundation for it and that's where I would
12 like to be if I could.
13 SCHINDLER: Well, I'll allow you to lay a foundation.
14 WESTBROOK: All right. And the foundation is this, Mr. Schmoyer, as someone who, whose
15 job in expertise lies in nursing home accounting and cost reporting the way
16 that you've described earlier, and who is a member I believe, as you testified
17 earlier, of the South Carolina Healthcare Association, to what extent do you
18 rely on information provided by the Director of the South Carolina
19 Healthcare Association? To what extent do you rely on that kind of
20 information in forming your opinions related to your business?
21 SCHMOYER: I rely on information that the President of the Association, Randy Lee, tells
22 us. Everyone relies on that information because the Payment for Services
23 Committee where we discuss reimbursement changes and topics, he's the
24 one who speaks with Mr. Saxon to make the changes and implement them
25 and then he reports back to the Committee on what the changes were.
26 WESTBROOK: And the Committee you're talking about is what Committee?
27 SCHMOYER: The South—the nursing home's Payment for Services Committee. It's the
28 Committee on Reimbursement Rates and Processes.
29 WESTBROOK: Is that the Committee you said you had been a member of for...
30 SCHINDLER: For twenty years. I'm a key member of that (unclear).

1 WESTBROOK: Based on that testimony, that foundation, Ms. Schindler, what I would argue
2 is this, that even though Mr. Lee's testimony is hearsay and is not admissible
3 of itself, because it's the type of information that he as an accountant relies
4 on, it is admissible to come in through an expert, based on Rule 703.

5 NICKLES: Well, I think I'm entitled to certain cross-examination before this ruling on
6 that proffer.

7 WESTBROOK: Well, I know. I think that's up to Ms. Schindler whether you're entitled to
8 that or not but I, I'm not offering this as, you know, at this point as a proffer.
9 If it's denied, I obviously will make a proffer, but...

10 SCHINDLER: I think I'll allow the cross-examination and then we'll...

11 WESTBROOK: Okay.

12 NICKLES: Mr. Schmoyer, is it your understanding that Mr. Lee has the authority to
13 alter the South Carolina State Plan?

14 SCHMOYER: He does not have the authority to alter...

15 NICKLES: Does he have the authority to alter any of the language of a contract between
16 the Office of the State Auditor and DHHS?

17 SCHMOYER: He has the authority to negotiate on behalf of the industry.

18 NICKLES: Does he have the authority to alter the language of the plan of a contract?

19 SCHMOYER: No, he doesn't.

20 NICKLES: Does he have the authority to alter the language of a contract between
21 DHHS and any provider other than his own?

22 SCHMOYER: Can you repeat the question?

23 NICKLES: Yeah, does he have the authority to alter the con—language of a contract of
24 any Medicaid provider other than those he may be personally involved
25 with?

26 SCHMOYER: He does not.

27 NICKLES: Okay. Then I'd object to the offering of this testimony. He's trying to get
28 in language concerning an interpretation, alteration, explanation or
29 whatever of documents over which that healthcare association and its
30 director has no control.

31 WESTBROOK: Well, that's not what I'm offering it for.

1 NICKLES: And would appear to (unclear) would be unreasonable, given that
2 knowledge.
3 WESTBROOK: I think unreasonable (unclear). I think that what this is being offered for,
4 the question was, why did you call Mr. Von Kannel and complain about
5 this, and he's explaining why I did it is because I was told by the Director
6 of the Nursing Home Association that I report to that there was an
7 agreement in place only to do two. Now whether that's true or not, whether
8 that is in fact alters the contract is another issue. The issue is why he called
9 him.
10 SCHINDLER: And I do want to hear that. So you can proceed.
11 WESTBROOK: All right. Tell me why you called him.
12 SCHMOYER: I called him because the industry was told that...
13 NICKLES: I'm going to object to industry.
14 SCHMOYER: I was...
15 WESTBROOK: You were told by the, who was, yeah, aside from the industry, be more
16 specific than that.
17 SCHINDLER: What is the basis of your objection?
18 NICKLES: Because industry is an amorphous, undefined term I have heard of identified
19 in a proceeding is as a, any type of known organization is an industry, and
20 I object to the...
21 SCHINDLER: I'll sustain that.
22 NICKLES: I object to the form of the answer.
23 WESTBROOK: Object to the form of the answer.
24 NICKLES: I think it's unresponsive.
25 SCHMOYER: (Unclear) at a Payment for Services Committee Meeting that was held,
26 they're held several times a year, it was announced by Randy Lee...
27 WESTBROOK: And who is Randy Lee?
28 SCHMOYER: Oh, I'm sorry. He's the President of the South Carolina Healthcare
29 Association that he had negotiated with Health and Human Services, Jeff
30 Saxon, who testified today that he did meet with him and met with him,
31 okay, that the contract was changed and they could only audit two reports,

1 and that this was a big success for both parties. It was a success for our
2 industry and a success for their industry because the audit's process had
3 been very, very lengthy in length and now it defined it to be the current rate
4 and the one prior, so all the old audits would be finished up and done and
5 you'd only be responsible for auditing current data and not trying to pick up
6 a backlog of all these audits trying to get everyone done in four years. It
7 was just like they cleaned the slate. So I heard that, everyone heard it and—
8 okay, so anyway, can I move on? So I called Jay...

9 WESTBROOK: All right. I think you've answered my question.

10 NICKLES: I think so.

11 WESTBROOK: And...

12 NICKLES: And maybe a lot more.

13 WESTBROOK: And maybe more. But you certainly...

14 SCHINDLER: What was your objection to everyone, was that—okay.

15 WESTBROOK: We can strike everyone. That is a little broad perhaps.

16 SCHMOYER: I apologize. I don't know what...

17 WESTBROOK: That's okay. Let me go on to my next question, Mr. Schmoyer. Mr.
18 Schmoyer, not only my next question but another subject. Did you
19 recommend Countrywood to hire my law firm, Nelson, Mullins to handle
20 this appeal?

21 SCHINDLER: Yes, I did.

22 WESTBROOK: And I heard through the vine it wasn't because of me. It was because of
23 somebody else.

24 SCHMOYER: It wasn't because of you.

25 WESTBROOK: All right. Tell me who it was.

26 SCHMOYER: In the nursing home industry, use that word, when you have appeals you
27 have to select legal counsel. I can only, I can only file an appeal but I am
28 not a lawyer and I don't count to be a lawyer but I need to a lawyer to take
29 it to a hearing, and so I—there's only two lawyers that I feel comfortable
30 with in town, Jeanne Borne and Bill Prince. This was before I knew who
31 you were. So I contacted Bill Prince and Bill Prince, being a former director

1 of Medicaid has a significant amount of knowledge of the Medicaid
2 Program, how it works. He also knows who the people are at the Agency.
3 During this time period, Agency personnel were changing. Mr. Keck was
4 new. He brought in new people. I don't know all the high-ups so I informed
5 my client that it would be in your best interest, basically through my email,
6 to hire them because he has knowledge, he's honest, people like him and
7 he'll be able to get you a payment term. Now let me explain that. When
8 you're audited and the payback letter is issued, you have to start paying the
9 money back right away. This appeal process today has been, let's see, these
10 reports were issued in 2011 and we're sitting in 2014. The appeal process,
11 you don't wait until the appeal process is completed to settle the amount of
12 money that you owe. Whatever the audit shows, you have to start making
13 that payment now whether we think the audit's right or wrong. Typically
14 the Agency will give you a twelve month payment plan. Well, if you have
15 a \$500,000 audit to pay back and you have the smallest facility in the State
16 of South Carolina, it's really not feasibly financially possible for them to
17 pay \$500,000 or close to \$50,000 a month. They don't even probably get
18 that much money in. So one of the benefits that I—well, not really a benefit,
19 but one of the processes that I engage—told my client to engage Bill Prince
20 to do is, Bill Prince happened to know the Deputy Director, Roy Hess, who
21 was over Finance and he worked out a payment plan that we're still paying
22 today of \$7,000 a month. And we reached a deal that until the appeal's over
23 and the final number is set, we're going to pay \$7,000 a month which we
24 have done all these years until the appeal is resolved because in the interim
25 the facility just couldn't—they couldn't even make payroll if they had to
26 pay that much. So that's the main—that's one of the two reasons why I
27 recommended Mr. Prince.

28 WESTBROOK: What was the other reason?

29 SCHMOYER: The other reason is I need a lawyer to represent the customer. I mean, not
30 me, but the customer needs a lawyer to process the hearing.

1 WESTBROOK: All right. Now, you in your email about Mr. Prince, you talk about his
2 connections. What do you mean by that?

3 SCHMOYER: He knows people at the Health and Human Services. He knows who to talk
4 to to facilitate the payment, this interim payback process.

5 WESTBROOK: All right. Let me ask, Tammie, I have gone back on my word and I would
6 like for you to put one of those demonstratives up, the one about rate
7 periods. I think it's demonstrative 4. Mr. Schmoyer, you were here when
8 Mr. Saxon has a file and in particular you may recall, in fact, why don't
9 you turn, Mr. Schmoyer, to Exhibit 8, Petitioner's Exhibit 8, that's the letter
10 from Deborah Myers, and those three rate periods that appear on the
11 demonstrative there on the easel, those rate periods I believe that Mr. Saxon
12 testified that are there in Ms. Myers' letter. Now the rate period, would you
13 agree with Mr. Saxon's testimony that the rates did not change during those
14 three periods listed there, those three rate periods in Ms. Myers' letter?

15 SCHMOYER: Those rates—each one of those rates had a different, each one of those
16 periods had a different rate to pay.

17 WESTBROOK: All right. Since the term rate period, well, let me ask, I'm sorry, let me back
18 up for a second. Would you agree that the term rate period is not defined
19 anywhere?

20 NICKLES: I object.

21 WESTBROOK: Let me rephrase my question. I'll withdraw that question and rephrase it.
22 Is the term rate period defined in the State Plan?

23 SCHMOYER: No, it is not.

24 WESTBROOK: Now since it's not defined, how do you define it as an accountant?

25 SCHMOYER: I define the rate period as the period as the period of time when the rate is—
26 the payment stays the same.

27 WESTBROOK: And did the payment stay the same from 11/29/07 to 5/31/08?

28 SCHMOYER: Yes.

29 WESTBROOK: And what about 6/1/08 to 9/30/08?

30 SCHMOYER: Yes.

31 WESTBROOK: And what about 10/1/08 to 9/30/09?

Terry Schmoyer - Cross

- 1 SCHMOYER: Yes.
- 2 WESTBROOK: All right. When did the SAO issue final audits? Do you need to jog your
- 3 memory on that?
- 4 SCHMOYER: November 22, 2011.
- 5 WESTBROOK: All right. And when was the close of the first rate period of their...
- 6 SCHMOYER: The first rate period...
- 7 WESTBROOK: Look on the...
- 8 SCHMOYER: ...on the exhibit.
- 9 WESTBROOK: ...on the exhibit, yeah.
- 10 SCHMOYER: The very first one is November 29, 2007 through May 31, 2008.
- 11 WESTBROOK: All right. So what's three years from May 31st of 2008?
- 12 SCHMOYER: May 31, 2011.
- 13 WESTBROOK: All right. And what's the close of the second rate period identified?
- 14 SCHMOYER: Second rate period went from June 1st of '08 through September 30 of '08.
- 15 WESTBROOK: And three years from September 30, '08 is what?
- 16 SCHMOYER: September 30th of 2011.
- 17 WESTBROOK: And the close of the third rate period is what?
- 18 SCHMOYER: The third rate period is October 1 of 2008 through September 30 of 2009.
- 19 WESTBROOK: All right. And three years from September 30, 2009 is?
- 20 SCHMOYER: September 30th '12.
- 21 WESTBROOK: All right. And once again, when were the final audit reports issued here?
- 22 SCHMOYER: November 22nd of '11.
- 23 WESTBROOK: Okay. And so the audit reports were issued within three years of the close
- 24 of how many of those three rate periods up here?
- 25 SCHMOYER: Well, you're supposed to issue the audit reports within three years of the
- 26 end of the rate period.
- 27 WESTBROOK: That's what I'm asking you.
- 28 SCHMOYER: And that only—they didn't meet the first two. They met the third one.
- 29 WESTBROOK: Right, that's, that's what I was asking. Thank you, Mr. Schmoyer. I don't
- 30 have any other questions.

1 NICKLES: Okay. Mr. Schmoyer, you have testified that you are familiar with the cost
2 reporting process in the State South Carolina Medicaid Program, correct?

3 SCHMOYER: That's correct.

4 NICKLES: And previously we've had Mr. Saxon look at a couple of cost reports. I want
5 to hand one of those to you and ask if you recognize it and this is in our
6 Exhibit Number 2, in our pre-hearing brief, pre-hearing brief, Exhibit
7 Number 2. Are you familiar with that document, Mr. Schmoyer?

8 SCHMOYER: This is the Medicaid cost report for Countrywood for the first six months of
9 operation.

10 NICKLES: Obviously. And is it your testimony that your firm was responsible for the
11 accounting work that is reflected in this document?

12 SCHMOYER: It is not.

13 NICKLES: Okay, and why is it?

14 SCHMOYER: We...

15 NICKLES: What, if anything, did you have to do with this report?

16 SCHMOYER: We prepared the report based on the accounting records provided to us by
17 Countrywood.

18 NICKLES: Okay. Did that include a home office report to Medicare from the owners
19 of these facilities?

20 SCHMOYER: It did not.

21 NICKLES: You have since seen that Medicare report, have you not?

22 SCHMOYER: I'm—I'm not sure if I have or not.

23 NICKLES: Well, are you aware that the home office for the ownership of this facility
24 did file a Medicare home office cost report?

25 SCHMOYER: They filed a Medicare home office—well, I'm not aware that they filed it.

26 NICKLES: Okay. So you've never seen it, they've never told you that they did? Is that
27 your testimony?

28 SCHMOYER: I don't know where you're going with this.

29 NICKLES: I'm not going anywhere but trying to get an answer from you.

30 SCHMOYER: All right. Rephrase the question, please.

1 NICKLES: You're familiar with the document that's called a Medicare home office
2 cost report...
3 SCHMOYER: Yes.
4 NICKLES: ...are you not?
5 SCHMOYER: Yes sir.
6 NICKLES: And if you are in the business of providing Medicare services as well as
7 Medicaid services, doesn't the Federal government require you to file such
8 a report?
9 SCHMOYER: They do.
10 NICKLES: And do you file such reports for any of your clients?
11 SCHMOYER: I do.
12 NICKLES: Okay. And in those Medicare home office cost reports, isn't it required that
13 the responding entity identify related organizations?
14 SCHMOYER: On the Medicare cost report it is.
15 NICKLES: Okay. And so do you know whether or not the home office for this facility,
16 your client Countrywood, reported to the Federal government in its home
17 office cost report that indeed it did have related party transactions with
18 regard to the purchase of equipment?
19 SCHMOYER: I do not.
20 NICKLES: You do not.
21 SCHMOYER: Can I explain?
22 NICKLES: Well, let me ask a couple of questions and if that doesn't explain it, maybe
23 you would like to. When you are going in to do a cost report, don't you
24 confer with your client about their related facilities and other entities?
25 SCHMOYER: I do.
26 NICKLES: And indeed on the cost report that you have in front of you, it has a laundry
27 list of related facilities, does it not?
28 SCHMOYER: They do, they have many facilities.
29 NICKLES: Many, many facilities. So this would be a sophisticated provider of
30 Medicare and Medicaid services, fair to say?
31 SCHMOYER: Fair to say.

1 NICKLES: Okay. So is it surprising to you that when you go in and this is—say this is
2 the first report you're doing for this organization, correct?

3 SCHMOYER: It is.

4 NICKLES: And you know that they have all these related facilities and you know they
5 participate in the Medicare Program and you know that they have to file a
6 home office cost report, you don't even ask to examine that to see if there
7 are consistencies or inconsistencies in the information they provided to you?

8 SCHMOYER: Okay, South Carolina requires you to submit home office cost information
9 for reimbursement which is labeled here on page 3 of the home office line.

10 NICKLES: Correct.

11 SCHMOYER: This particular—South Carolina will accept a Medicare report or they will
12 accept a report from another state. I can't recall which report was used.
13 Some years they used Florida, some years they used Georgia, some years
14 they used South Car—they used the Federal report so there was a home
15 office cost report used. We relied on it and we submitted it to Health and
16 Human Services, but I can't remember whether it was the Medicare or
17 Georgia.

18 NICKLES: So...

19 SCHMOYER: So (unclear) answer your question.

20 NICKLES: ...did you rely upon it and you submitted it to DHHS?

21 SCHMOYER: I didn't.

22 NICKLES: Did you examine it to see whether they were any inconsistencies in the
23 identification of related organizations or the transactions among related
24 organizations in those two reports?

25 SCHMOYER: I did not.

26 NICKLES: Okay. And that's not a part of your due diligence, is it...

27 SCHMOYER: It is not.

28 NICKLES: ...providing the report? Okay.

29 SCHMOYER: What we do is we take the cost report, we look for things that may impact
30 South Carolina and we make adjustments for South Carolina adjustments.

1 NICKLES: And if we look at page 30 of the document that you have in front of you
2 here, and it says entry number 3 to expense minor equipment purchases are
3 less than \$5,000.

4 SCHMOYER: Correct.

5 NICKLES: And there's an entry for minor nursing equipment there of \$58,833.00,
6 correct?

7 SCHMOYER: Yes.

8 NICKLES: Okay. And that is an entry that was subject to examination during the audit
9 review process, correct?

10 SCHMOYER: Yes.

11 NICKLES: And Mr. Westbrook reminded you of your testimony that we had back in
12 August during your deposition, correct?

13 SCHMOYER: Yes.

14 NICKLES: When you were questioned about information provided to you in support of
15 this purchase, correct?

16 SCHMOYER: Purchased these assets.

17 NICKLES: Yeah. And your testimony at the time was it came to your attention that
18 they did not have the documentation necessary to support the
19 reimbursement of this equipment. Wasn't that your testimony?

20 SCHMOYER: In the context of after the Auditor's Office did their audit.

21 NICKLES: Okay, well, of course when you were deposed back on August the 8th that
22 was just a little over a month ago, correct?

23 SCHMOYER: Correct.

24 NICKLES: And the question then as Mr. Westbrook said, so when you got the stuff
25 from your customer, this is page 28 of your deposition, and saw the cost for
26 furniture and other things, home office and other things like that, didn't you
27 say where are the backup? Your answer was, I did. Did they provide it to
28 you? They did not. And then the next question, okay, so even though before
29 the auditors came in here and started looking around, you were aware that
30 there were deficiencies in this customer's, particular customer's
31 recordkeeping, is that fair to say? You say, in this instance, yes, correct?

1 So it was before the auditors came in and said where is the documentation,
2 that you were aware that they hadn't properly documented this cost, correct?
3 SCHMOYER: No, that's not correct. I (unclear) misspoke there.
4 NICKLES: So but you were, you were under oath?
5 SCHMOYER: Yes sir.
6 NICKLES: And we were in a conference room much like this.
7 SCHMOYER: And there were many, many confusing questions asked not necessarily...
8 NICKLES: Okay.
9 SCHMOYER: I'd like to explain...
10 NICKLES: Well, let...
11 SCHMOYER: Can I explain the process...
12 NICKLES: I don't know.
13 SCHMOYER: ...what happened?
14 NICKLES: Let me, let me make sure because I want to know—I want to read this to
15 you. I want you to tell me every word you did not understand. Okay, so
16 even before the auditors came in here and started looking around, you were
17 aware that there were some deficiencies in this particular customer's
18 recordkeeping, is that fair to say? Okay. What word did you not understand
19 there? What was confusing to you about that question?
20 SCHMOYER: The context of whether it was before the cost report, during the cost report
21 preparation process or in today's time when we did not have the backup
22 documentation that the auditor wanted.
23 NICKLES: Okay. So I guess you are stating now that you anticipated before the auditors
24 came in that gee whiz, this stuff's on the cost report, I better get it
25 documented and you found out you couldn't do it?
26 SCHMOYER: No.
27 NICKLES: No? Okay.
28 SCHMOYER: You want me to explain?
29 NICKLES: You know, I'm happy for you to explain, Mr. Schmoyer.
30 SCHMOYER: Okay. What happened is when the cost report was prepared, I asked for
31 backup documentation on the purchase of fixed assets. I received backup

1 documentation from my client. It was an invoice purchased from a related
2 entity. That related entity was Cimarron Properties. That invoice was—
3 when I received that invoice, it told me what was purchased, how much it
4 was, and that's what we filed on the cost report. I had no reason to doubt
5 that my client was not giving me the correct information. Can I finish?
6 NICKLES: Sure.
7 SCHMOYER: That cli—Cimarron Properties, as you can see from the report in the list of
8 all the facilities, they own a lot of facilities. They purchase many beds. They
9 told me they did a group purchase of many beds for many facilities and they
10 shipped so many beds that they needed to this facility. I said did, well did
11 you invoice it at cost? They said yes.
12 NICKLES: I object. I mean Mr. Schmoyer, you're getting far afield from...
13 SCHMOYER: I'm going to tell you what happened. So then I...
14 WESTBROOK: Wait, Mr. Schmoyer. Just hold on a second, please. He's got an objection
15 here. I want to respond to his objection quickly.
16 SCHINDLER: And what is your objection?
17 NICKLES: Well, that's he trying to, from this expansive explanation which I'm kind
18 enough to allow him to do, to get in hearsay information saying he said, she
19 said, stop. I mean we've been through that. The Rules of Evidence do apply.
20 He's not offering this as opinion. He's offering it for the purpose of fact
21 and he can't do that, bring in information from a third party as a fact basis.
22 This has nothing to do with his opinion about anything.
23 WESTBROOK: Can I respond?
24 SCHINDLER: Yes.
25 WESTBROOK: Mr. Nickles asked Mr. Schmoyer a series of questions about his deposition
26 testimony and Mr. Schmoyer answered to most of these questions a short
27 yes or no answer or something similar to yes or no two or three times he
28 said can I explain and Mr. Nickles said wait until I finish this line of
29 questions and then you can explain. He's certainly entitled to explain his
30 explanation.
31 NICKLES: What is it that he's explaining?

1 WESTBROOK: What I understood the purpose of his testimony is to explain the discrepancy
2 in his deposition testimony, why he was, if he was confused, if he was
3 confused why he was confused, why he gave the answer he did which is
4 different from the answer he gave today on direct examination. That's what
5 he needs to explain. I don't know if he needs to go into hearsay to do that
6 or not but he needs to be able to give an explanation as to why he answered
7 the way he did in the deposition.

8 SCHINDLER: And I'd like to hear that explanation too. Just try and avoid hearsay.

9 SCHMOYER: I'm not a lawyer so I'm having a hard time with the speaking part of it but,
10 okay. I received an invoice from my customer about what was purchased.
11 I asked them if they purchased it, if they marked it up to themselves. They
12 said no. So there was no adjustment that we posted to the cost report for—
13 to remove costs so if you—if the related party, if you buy something, if you
14 buy the equipment for \$68,000 and then your related party sells it to you for
15 \$100,000, you can't claim the profit so you have to reduce it down to cost
16 which is part of the disclosure. In this case, it was purchased for the same
17 amount because I asked. Okay. Then, and I was good and we filed the
18 report. I told my client South Carolina, this report is subject to audit. This
19 is your only South Carolina facility but you need to know in South Carolina
20 they audit and when they audit they audit deeply, okay? And so I said I'm
21 going to need you to find out where you purchased all those beds from,
22 allocate—how they were allocated amongst all the different buildings that
23 got beds, because someday you're going to need that. I did not receive the
24 backup but I didn't feel like I needed it at that time because I thought after
25 my conversation with them, the documentation was available, okay? This
26 is in 2007. Audit gets completed in 2011. It's four years later. I asked my
27 client, okay, now they want the backup, we need it. The auditor is asking
28 for the backup. They said the vendor that we bought it from is no longer in
29 business.

30 NICKLES: That's again...

31 SCHMOYER: And we don't have it.

1 WESTBROOK: I think he's—is that your explanation?

2 SCHMOYER: Yeah.

3 WESTBROOK: All right. Good. Thank you.

4 NICKLES: Okay. Tell me the name of that related entity that you just mentioned,

5 Cimarron?

6 SCHMOYER: Cimarron Properties.

7 NICKLES: Do you see that related...

8 SCHMOYER: That is the related party disclosure that I forgot to add.

9 NICKLES: Oh, number 10. That's why Cimarron's not on there?

10 SCHMOYER: Correct. That should have been listed on page...

11 NICKLES: You said you...

12 SCHMOYER: ...3 under expenses.

13 NICKLES: Yeah, okay. And you found that out in 2007?

14 SCHMOYER: Say that one more time?

15 NICKLES: You say you had that discussion in 2007?

16 SCHMOYER: When we prepared the report in 2007.

17 NICKLES: What's the date that it was signed? 5/12/09? Two years later?

18 SCHMOYER: Okay. Then we must have had the conversation in 2—when the report was

19 prepared in 2008.

20 NICKLES: Okay, so it wasn't in 2007 as you recalled a minute ago. It's now 2008 or

21 2009?

22 SCHMOYER: That's correct.

23 NICKLES: And you had another opportunity to disclose this, did you not, in the year

24 cost report that was issued and that is the one from November 29, '07 to

25 September 28, '09?

26 SCHMOYER: That's correct.

27 NICKLES: And it was the same...

28 SCHMOYER: Oversight.

29 NICKLES: Oversight, okay. You will agree, will you not, Mr. Schmoyer that all of the

30 costs reported in the initial cost report are included in the annual cost report?

31 SCHMOYER: That's correct.

1 NICKLES: That's correct. And you will agree that the periods of time addressed in
2 these two reports run concurrently, not consecutively. That the second
3 report consumes the first report?
4 SCHMOYER: The first report is for six months. The second report includes the first report
5 and it's following, all right, September 30th.
6 NICKLES: And you have no objection to the auditors reviewing the costs reported in
7 the twelve month report?
8 SCHMOYER: I do not.
9 NICKLES: Okay. Now you heard Mr. Saxon's testimony about the timeframes that the
10 initial cost report set the rates for, says an extended period of time, you were
11 here when he testified, is that correct?
12 SCHMOYER: I was here.
13 NICKLES: All right. And you were familiar with the South Carolina Medicaid Program
14 according to your testimony long before you filled out or had filled out the
15 cost reports in issue in this case, correct?
16 SCHMOYER: Correct.
17 NICKLES: You had done thousands of them, correct?
18 SCHMOYER: Over a thousand.
19 NICKLES: And you knew that the initial cost report was going to have an impact on
20 the reimbursement for a period that extended beyond its reported dates,
21 correct?
22 SCHMOYER: That cost report sets rate periods in the future beyond that report.
23 NICKLES: Okay. And the cost report here, the initial cost report, you said that there are
24 rate periods but really, Mr. Schmoyer, you know that the difference in those
25 rates is not difference in costs reported but the State Plan that happened to
26 be in operation at the time, correct?
27 SCHMOYER: The State Plan dictates when the rate periods will start.
28 NICKLES: Okay. And those rates are all governed by and dependent upon the report,
29 correct?
30 SCHMOYER: No. The rates use the report for their cost but each rate varies based on the
31 language in the State Plan.

1 NICKLES: And you said that you didn't want to have to go back and deal with stale
2 issues and old reports and you wanted to have more current information
3 being examined by the auditors, is that a fair characterization of your
4 testimony?

5 SCHMOYER: No. I don't understand.

6 NICKLES: Well, I mean I thought I heard you testify that oh my goodness, we're
7 having all these problems with all these old records and things and we had
8 to go back and oh, woe is me, that wasn't your testimony?

9 SCHMOYER: The nursing home industry brought it to the attention of Health and Human
10 Services that they wanted the audit process to be two cost reports. I was not
11 involved in that.

12 NICKLES: You weren't involved—weren't there, didn't participate?

13 SCHMOYER: I did not participate in that negotiation.

14 NICKLES: So all this is just coming through other people to you, correct?

15 SCHMOYER: It was announced by the President of the Association.

16 NICKLES: Okay. And in this particular instance, all the costs and annual report have—
17 are reported also in the six month report, correct? It has just a few more?

18 SCHMOYER: Those are two separate cost reports.

19 NICKLES: Well, let me ask you this...

20 SCHMOYER: But they overlap the calendar.

21 NICKLES: They overlap the calendar?

22 SCHMOYER: The six month report is through May 31st, then you file a cumulative 9/30
23 report which goes from November 1st of the 20—November the 29th through
24 September 30th of 2008 so one is a six month and one is...

25 NICKLES: But you're not telling the Hearing Officer, are you, that you are, you're
26 changing what you reported in six months when you put it in the twelve
27 month? You didn't do that did you?

28 SCHMOYER: To my knowledge it's not changed.

29 NICKLES: It's not changed. You testified that in your opinion, the failure to reveal this
30 related party had no financial consequence in this proceeding. Is that your
31 testimony?

1 SCHMOYER: That's correct.

2 NICKLES: But Mr. Schmoyer, you know that the auditors can't take the word of your
3 client even though you may choose to, you know that, don't you?

4 SCHMOYER: They take the word of customers all the time.

5 NICKLES: In a related party transaction, you knew...

6 SCHMOYER: I can't speak to related party transactions.

7 NICKLES: You can't? You can't?

8 SCHMOYER: Not with all my clients, no.

9 NICKLES: Okay. All right. You never had an auditor to come in and say to you, this is
10 a related party transaction, show me the actual cost? That's never happened
11 to you?

12 SCHMOYER: No, it happens.

13 NICKLES: It happens pretty regularly, doesn't it?

14 SCHMOYER: They ask for support for all costs, not just related party transactions.

15 NICKLES: Including related party transactions, correct?

16 SCHMOYER: Sure.

17 NICKLES: Okay. So and documentation is the obligation of the service provider,
18 correct? Isn't that one of the obligations in order to obtain reimbursement,
19 is to have documents to support that reimbursement?

20 SCHMOYER: That's correct.

21 NICKLES: Okay. And so in the, in this instance, knowing as you know now, that these
22 transactions were with a related party and knowing, as you know now, that
23 they're not adequately documented, they could not have been responsibly
24 reported for reimbursement, could they?

25 SCHMOYER: I believe that they can be, yes.

26 NICKLES: Okay. So even if you know it's related party and you don't disclose it and
27 even though you don't have the documents, you think it's okay to put it in
28 the cost report? Is that your testimony?

29 SCHMOYER: My testimony is in this instance on that, I had the documentation that I felt
30 was necessary to file that report appropriately and had my client to sign that
31 report.

1 NICKLES: And it was adjusted and disallowed...

2 SCHMOYER: Unfortunately, four years later at the audit, they weren't able to provide the
3 documentation that they said that they had when it was reported because the
4 vendor went out of business.

5 NICKLES: How, how long are you supposed to maintain records?

6 SCHMOYER: Six years.

7 NICKLES: Six years. Six years longer than four years?

8 SCHMOYER: They're required to maintain it for six years. But you—one thing to
9 remember is there are many, many costs on that cost report for payroll, all
10 types of expenses that we don't verify everything that's in the report.

11 NICKLES: So we should just give you a pass because you believed your customer?

12 SCHMOYER: Every cost report that is filed is filed without verifying every single check
13 if we're not audited.

14 NICKLES: Every one is subject to audit. That's what the (unclear) is.

15 SCHMOYER: We're subject to audit but we as preparers don't audit all the numbers when
16 they're prepared.

17 NICKLES: So you just take a risk that they may get audited and you may get caught
18 but there is a risk benefit ratio that you (unclear).

19 SCHMOYER: That's not true. Every time you prepare a report, you can't have absolute
20 proof from your customer that—you have to rely on what they give you,
21 just like you do when you prepare your tax (unclear) rely on for audited
22 financial statements.

23 NICKLES: Mr. Schmoyer, in your email to your customer here back when you were
24 lobbying for Mr. Prince to represent the customer, you said you had other
25 customers who want this issue addressed as well, correct?

26 SCHMOYER: We have other customers that had the same audit issue.

27 NICKLES: Are other customers also paying you today to represent their interest in this
28 proceeding?

29 SCHMOYER: Yes.

30 NICKLES: Okay.

31 SCHMOYER: They're my current—they are my customers.

1 NICKLES: Okay. So more than just Countrywood is paying you to advocate this
2 position, is that correct?

3 SCHMOYER: I have more than one customer that has engaged me to try and explain to
4 the State why they think their position is correct.

5 NICKLES: Why they think your position is correct?

6 SCHMOYER: No, they think their position is correct.

7 WESTBROOK: Objection. Objection to the characterization. He came up with this.

8 NICKLES: Well, I mean I read...

9 WESTBROOK: It says it in the contract.

10 NICKLES: I read your email saying, looka here guys, if we win this, we can save half
11 of our pay back. I mean that's what you were...

12 SCHINDLER: I don't understand what your objection is

13 WESTBROOK: My objection is to the characterization of the question that, that Mr.
14 Schmoyer came up with this position. He said—he tried to say it was—this
15 position he said and Mr. Nickles said it's your position, you're the one that
16 came up with it. And my objection is no, the position is that the contract
17 says they're—it says what it says. That's our position. That's not a position
18 Mr. Schmoyer came up with. He's addressing it.

19 SCHINDLER: All right. And Mr. Nickles, what are—you have to say that your (unclear)?

20 NICKLES: His email speaks for itself and I'll (unclear).

21 WESTBROOK: That's fine.

22 SCHINDLER: So are you withdrawing that question?

23 NICKLES: I will be pleased to withdraw it. You don't dispute that you sent an email
24 to Mr. Hagan and Mr. Hicks back on December 29th of 2011, do you?
25 You've seen that email.

26 SCHMOYER: Can I see it today?

27 NICKLES: Sure.

28 SCHMOYER: Yes, this is an email that I sent to them.

29 NICKLES: All right, sir. And in this email which is Exhibit Number 4 to our Pre-
30 hearing Brief, you're sending it to Bob and Jerry, Bob being Hagan and
31 Jerry being Hicks, is that correct?

1 SCHMOYER: That's correct.

2 NICKLES: And tell me who they are?

3 SCHMOYER: Bob Hagan is the owner of the facility and Jerry Hicks is basically the CFO

4 type of the...

5 NICKLES: Okay. When you say facility, you mean all these folks that are listed on the

6 second page of the...

7 SCHMOYER: I know he owns a hundred percent of Countrywood. I don't know how—

8 he somehow owns all those others as well but I don't know what percentage.

9 NICKLES: So while Countrywood itself may be small, the operation that owns and runs

10 Countrywood is far from small?

11 SCHMOYER: That's correct.

12 NICKLES: Okay. Who are William Haselden, Joe Hunt and Wendell Phillips?

13 SCHMOYER: William Haselden is one of my employees. Joe Hunt's the administrator of

14 the facility, and Wendell Phillips works at the home office.

15 NICKLES: So you're sending this email to Hicks and Hagan and copying it to those

16 other folks?

17 SCHMOYER: Correct.

18 NICKLES: It indicates in this email that during this process, there'll be a step where

19 you will meet with the auditor and go and provide additional documentation

20 for them to review. Were you afforded that opportunity?

21 SCHMOYER: Yes, I was.

22 NICKLES: And did you provide additional documentation for the auditors?

23 SCHMOYER: Lots of information.

24 NICKLES: And were some of the adjustments modified as a result of that presentation?

25 SCHMOYER: There were many adjustments modified in our favor, which we're

26 appreciative of.

27 NICKLES: Okay. In fact, I think that there's an email to you and I'll show it to you,

28 from Larry Warrington as recently as August of 2012 which indicates that

29 there was some information sharing even as late as a month ago, I mean a

30 year ago, correct? A couple of years ago, I'm sorry. My calendar is not

31 what it used to be. But there was information sharing going on?

1 SCHMOYER: Sure, yeah.
2 NICKLES: And you said you're appreciative of that.
3 SCHMOYER: Yeah.
4 NICKLES: And that even though your—the on-site had concluded, even though
5 adjustments had been entered based upon your client's failure to produce
6 documents to support their claimed costs, the auditors left that open so that
7 during this process, if there was documentation to support your claimed
8 costs, they would review it and consider it. Is that fair?
9 SCHMOYER: Yeah, we felt like every audit adjustment that was made was resolved to the
10 extent that could be revised and the only remaining issues are the ones that
11 are in the appeal which does not include equipment.
12 NICKLES: I asked you during your deposition, Mr. Schmoyer, and I believe you and
13 Mr. Westbrook may have covered this ground briefly, you were engaged by
14 this customer early in the process to provide assistance in documenting cost
15 related to South Carolina Medicaid Program. Is that..
16 SCHMOYER: And we were engaged to prepare their Medicaid cost reports.
17 NICKLES: Well, I mean isn't that a form of documenting their services under the
18 Medicaid Program?
19 SCHMOYER: It depends on the context of your question.
20 NICKLES: Okay. And you were not initially engaged to offer any opinions in this
21 proceeding. Your engagement with them precedes that service that you're
22 providing now, correct?
23 SCHMOYER: I don't understand the question.
24 NICKLES: Okay. I guess, I'll make it clearer if I can. When you were first engaged
25 by this customer, you were engaged specifically for the purpose of
26 preparing these cost reports, correct?
27 SCHMOYER: That is correct.
28 NICKLES: Okay. So your opinions that you're offering here today grow out of that
29 customer service relationship, correct?
30 SCHMOYER: They asked me for my opinions about the audit process and I gave them to
31 them.

1 NICKLES: Okay.

2 SCHMOYER: If I understand what you're saying.

3 NICKLES: Well, I asked you the question. Let me make sure, I maybe was clearer on

4 August 8th. You're not engaged by the customer specifically for the purpose

5 of providing opinions. They grew out of your relationship with your

6 customer. Is that correct? And your answer on that day was, correct. Is it

7 still your answer today?

8 SCHMOYER: Repeat—can I read it?

9 NICKLES: Yeah, sure. Page 30, lines 18-23.

10 NICKLES: And we can back it up to say page 30, line 8.

11 SCHMOYER: Okay, I'm on page 30.

12 NICKLES: Yeah. Line 8. Okay, in so doing you occasionally act as advocate for your

13 customer in dealing with issues both with auditors and DHHS. Mr.

14 Westbrook objects to the form. And I say would that be fair? And you say,

15 that's correct. See that?

16 WESTBROOK: I'll object to the form. Thank you very much. I want to preserve my

17 objection. It's a leading question then and it's a leading question now.

18 Thank you.

19 NICKLES: Well, he's—I think he is, I'm entitled to leading...

20 WESTBROOK: You were entitled to lead him then, not, I mean you're entitled to lead now

21 not then.

22 NICKLES: Well, I'm leading him now.

23 WESTBROOK: I'm confused over the timeframe.

24 NICKLES: And question okay, so you're not engaged by your customer specifically for

25 purposes of providing opinions. They grew out of your relationship with the

26 customer, is that correct? Correct.

27 SCHMOYER: Correct.

28 NICKLES: All right. So we're clear about that. You were asked a question on page 32

29 of your deposition. Is there any document other than the document provided

30 to Mr. Saxon in his deposition upon which you rely for your opinions in this

31 matter? The answer was no. Is it still no? You relying on...

1 SCHMOYER: What page are you on?
2 NICKLES: Page 32, lines 6-9. You're relying on the State Plan and contracts, correct?
3 SCHMOYER: Are there any documents other than the documents provided that you rely
4 for your opinion in this matter? As far as documents go, there are no other
5 documents.
6 NICKLES: Okay. And then I asked you questions about your dealings with Mr. Saxon
7 and your understanding of the State Plan. Let's turn to page 33, first line.
8 If I have a question about reimbursement, I read through the entire plan.
9 There is no index.
10 SCHMOYER: That is correct.
11 NICKLES: You were aware of that when you were providing services to this client,
12 were you not?
13 SCHMOYER: Sure.
14 NICKLES: Okay. And you said you've read it many times.
15 SCHMOYER: I have.
16 NICKLES: And that it's an organic document. It changes every year.
17 SCHMOYER: It does.
18 NICKLES: And a part of your professional abilities is to try to keep up with the changes,
19 correct?
20 SCHMOYER: It is.
21 NICKLES: It says you deal with Mr. Saxon. I asked if you respect his professionalism
22 and you said very much so.
23 SCHMOYER: I do.
24 NICKLES: And his knowledge?
25 SCHMOYER: I do.
26 NICKLES: Okay. Would it be fair to say in talking about reimbursement for the South
27 Carolina Medicaid Program, there's probably nobody that has more
28 expertise than Jeff Saxon? Your answer was, yes.
29 SCHMOYER: There is no one who has more knowledge that I talk to. We don't always
30 agree on our interpretations but he's extremely knowledgeable.

1 NICKLES: And Mr. Schmoyer, I wouldn't expect you to agree with him on every
2 occasion. But you acknowledge that he is experienced and knowledgeable
3 in these matters, correct?

4 SCHMOYER: Correct.

5 NICKLES: Okay. Give me just a couple of minutes.

6 SCHINDLER: We are off the record. I think we'll take a five minute break.
7 Now that we are back on the record, I just want to quickly say that before
8 the last break we were joined by the Division Director for the Division of
9 Appeals and Hearings, Shealy Reibold. She was just observing the hearing
10 and I wanted to make sure no one had an objection to her observing.

11 NICKLES: No, no objection.

12 SCHINDLER: All right. Thank you.

13 NICKLES: Mr. Schmoyer, in your examination by Counsel for the Petitioner you were
14 asked questions about some information you received from Randy Lee. Do
15 you remember those questions?

16 SCHMOYER: Yes.

17 NICKLES: Okay. When did you receive that information from Randy Lee?

18 SCHMOYER: Sometime in the late 1990's.

19 NICKLES: Can you, can you identify it by year?

20 SCHMOYER: Not specifically but I would say the late 1990's.

21 NICKLES: So the late 1990's. Did you ever see any minutes or any written reports that
22 you relied upon in conjunction with your earlier testimony?

23 SCHMOYER: I relied upon him telling us that the change in the cost report process was to
24 two cost reports and I thought it was validated because in my experience,
25 most of the audits since then were audits of only two cost reports, in the
26 succession that he told me about.

27 NICKLES: So you're not aware of any occasion other than the present one where there
28 have been audits of more than two reports?

29 SCHMOYER: I am aware of seven audits of providers that had audits where three reports
30 were audited and nine reports for hospitals where three audits were audited
31 in the last ten years.

Terry Schmoyer - Redirect

1 NICKLES: And have you done any research to determine whether or not there have
2 been others than your clients who have received audits on more than two
3 reports during that period of time?
4 SCHMOYER: I have.
5 NICKLES: And that's your recollection?
6 SCHMOYER: No, I actually went on the website and looked at every audit that was issued
7 in the last ten years and sorted them myself to count how many had been
8 audited three times.
9 NICKLES: Okay.
10 SCHMOYER: And those numbers were the instances that I saw.
11 NICKLES: Okay. Those are all the questions I have at this time.
12 SCHINDLER: All right. Mr. Westbrook, re-direct?
13 WESTBROOK: Just a couple. Mr. Schmoyer, Mr. Nickles asked you about other nursing
14 homes that you are representing in addition to Countrywood. He asked you
15 two or three questions about that. Do you recall those questions?
16 SCHMOYER: Yes, I do.
17 WESTBROOK: I wanted to follow-up just to make sure I understood your testimony. Are
18 any other nursing homes paying you for representing Countrywood in this
19 appeal?
20 SCHMOYER: No.
21 WESTBROOK: Only Countrywood is paying you for representing Countrywood in this
22 appeal?
23 SCHMOYER: That's correct.
24 WESTBROOK: All right. You have other nursing home clients that I understand you to say
25 that have a similar issue or the same issues that we're debating here today?
26 SCHMOYER: As of today, I have one other client that has the same issue that's in appeals.
27 WESTBROOK: All right. Now, let's go to your deposition for a minute, if you could turn
28 to your deposition and I think that's Petitioner's 18 or 17, one or the other.
29 18? Okay, 18, and turn to page 32. Mr. Nickles asked you a question about
30 32. Bear with me for just a minute. Okay. On 32, I think Mr. Nickles asked
31 you in the deposition, he asked you are there documents other than the

1 documents provided to Mr. Saxon on which you rely for your opinion, and
2 in your deposition you said no and I think he asked you is that still true
3 today, are there any other documents that you rely on. Do you recall that?
4 SCHMOYER: There are no other written documents I'm aware that I rely on.
5 WESTBROOK: Well, Mr. Schmoyer, let me ask you to turn over and this is the second time,
6 not only the first time but the second time I'm going to have to impeach my
7 own witness.
8 SCHMOYER: (Unclear).
9 WESTBROOK: This is presid..Mr. Schmoyer, you are doing great. Let me put it in a kinder
10 way. I'm going to refresh your recollection and turn over to page 41, please,
11 where Mr. Nickles says, all right, those are all the questions I have at this
12 time and then Mr. Westbrook asked you some questions starting on page
13 41, line 12.
14 SCHMOYER: Okay.
15 WESTBROOK: See if you can find that, okay?
16 SCHMOYER: I do.
17 WESTBROOK: Let me know when you have that.
18 SCHMOYER: I'm here.
19 WESTBROOK: And I really don't want to have to read through these three pages. Why don't
20 you take a moment to familiarize yourself with those pages 41, 42, and 43,
21 and then I'm going to ask you a question or two about those, okay?
22 SCHMOYER: Okay.
23 SCHINDLER: Let me pause the record for a moment while you're...
24 WESTBROOK: ...43 of your deposition. I asked you about some additional documents that
25 you relied on for opinion and I believe your testimony (unclear) to those
26 questions was you did rely on those additional documents, is that correct?
27 SCHMOYER: I relied on the documents in the Motion for Partial Summary Judgment.
28 WESTBROOK: In the documents that are...
29 SCHINDLER: I'm sorry, I am so sorry to interrupt. I did not turn the recorder back on.
30 WESTBROOK: All right. I'll think of a better way to ask that question.

1 SCHINDLER: You can go ahead. We are back on the record, and I apologize for having
2 missed recording the question so you will have to restate that.
3 WESTBROOK: All right. Mr. Schmoyer, on page 32 of your deposition, Mr. Nickles had
4 asked you if, whether the documents, certain documents were all the ones
5 that you relied on in forming your opinions, and I believe you said in your
6 deposition that was true. And on pages, let me finish, but on pages 41
7 through 43, I asked you about some additional documents and you agreed
8 that you also relied on those, is that correct?
9 SCHMOYER: That is correct.
10 WESTBROOK: And so is the testimony in the deposition on pages 41 through 43 correct?
11 SCHMOYER: Yes.
12 WESTBROOK: All right. No further questions. Thank you.
13 SCHINDLER: All right. Mr. Schmoyer, you got any re-cross?
14 NICKLES: No.
15 SCHINDLER: You do not? All right. Mr. Westbrook, do you have any other witnesses?
16 WESTBROOK: No ma'am.
17 SCHINDLER: Are the parties ready to make their closing statements?
18 WESTBROOK: I guess so.
19 NICKLES: I assume so.
20 SCHINDLER: All right. Then please proceed.
21 WESTBROOK: All right. I would ask under Rule 42 Mr. Nickles go first with his closing. I
22 think I'm entitled to be the last according to the rule.
23 NICKLES: He has the option to open or close. He's correct.
24 WESTBROOK: I would like to hear what Mr. Nickles has to say.
25 NICKLES: He wants to close in full. Thank you for your attention today. I know that
26 we've been using words sometimes that have no meanings to the witnesses
27 that may not be as familiar to you, and for that reason I would encourage
28 you when you are contemplating this case and deliberating and making the
29 decision on this case that you carefully examine the exhibits that the parties
30 have presented to you because those documents do speak much louder than
31 our words and much more clearly than our words do today. And those

1 documents will show you that in the South Carolina Medicaid Program,
2 according to the State Plan which is the bible for this program, that all cost
3 reports are subject to examination. Those are limited only by time, not by
4 number. Certainly, if the Nursing Home Association or any of its advocates
5 who obviously are not here today to speak for themselves had wanted to
6 include in the contract between the Auditor's Office and DHHS a clear limit
7 on the Auditor's opportunity to examine cost reports, it would have done
8 so. But there is no such limiting language. Now of course we have a
9 Petitioner here who is advocating to impose a limit on the Office of the State
10 Auditor and what that office can review. That limit is inconsistent with the
11 plain language of the State Plan and as you heard from the Petitioner's
12 witness, inconsistent with his obligation to maintain records, records which
13 must be maintained at a minimum for six years. The records in this case as
14 you heard from the Petitioner's witness, were well within that period of
15 time. Now, so we have this public policy in South Carolina and it's
16 articulated in the contract that it's to serve the interest of the people and to
17 make sure that Medicaid Services provided in this State are adequately
18 documented, earned, and paid for. The State has no objection to paying for
19 those services that are reasonable, necessary, documented services. You
20 heard the admissions in this case that taking an example out of the cost
21 reports here that you've seen, the initial six month report and the year report
22 which all the testimony is includes the same information as that initial
23 report, as a glaring omission. Now let's say that we accept the
24 representation by the Petitioner that this was a mere oversight. It doesn't
25 excuse the absence of that information. In fact, the admission of the
26 oversight amplifies the need to have the opportunity to examine the records
27 so that the State knows what it's paying for and that's what the audits are
28 for so the State will know what it's paying for. You heard the testimony
29 today from both witnesses that at the desk review, the information contained
30 in the reports is accepted as true and complete. Well, how do we find out
31 that information's not true and complete? Through an audit process,

1 through going on-site and examining documents, and lo and behold in this
2 process, a report that is not in contest here, an annual report for the period
3 November 29, 2007 to September 30, 2008 contains what we note is a
4 glaring omission resulting in a huge payment to this provider, a payment
5 that they don't want to repay. That's why we're here. This is a case about
6 money. This is a case about a Petitioner wanting to hold on to money it
7 knows it doesn't deserve. And how do they do that? By saying that oh,
8 even though the State Plan says that all cost reports are subject to audit, even
9 though the contract says I have to maintain my records for six years, even
10 though there is nothing in the contract between the provider and the Agency,
11 DHHS, which would limit its access to reports based upon a number of
12 reports is based on time alone. Even though that's the case, what they want
13 to do is insinuate themselves into a contract between two State agencies in
14 which they had a common interest in obtaining information and making sure
15 that the public is well served. So let's say that you are considering or it is
16 being considered whether to accept the opinions, the reading, the
17 explanation, the interpretation of these documents by the Petitioner. Well,
18 let's consider the source. The admission is that is their objective to keep as
19 much money as they can. That's their objection, okay. They want to read
20 these things in their favor. Well, they can't be read in their favor because
21 they're not parties to this, okay? They're not participants in the contract
22 between the Auditor's Office and DHHS. It's what those two parties
23 understand, DHHS and the Auditor, as to what is the responsibility, and did
24 you hear any testimony that there is a limitation, that there's an intent, that
25 there's a desire that serves the public to artificially limit the opportunity of
26 the auditors to examine records to determine whether or not they've been
27 properly documented? No. You haven't heard that. And what you've heard
28 instead was oh, we made a mistake. It was an oversight. Had we done it
29 properly, we probably wouldn't have done it the way we did and I, the
30 person that is preparing this is no, I just accept what my customer tells me.
31 Well, unfortunately, that's not enough. And that's not what Federal law

1 requires. That's not what the State Plan requires. It's not what the contracts
2 require. The contracts require that they scrupulously adhere to the
3 requirements for obtaining reimbursement for Medicaid Services and by
4 their own admission, they didn't. And by their own admission it's revealed
5 in a contract that they do not, a, a, cost report that they don't claim has any
6 deficiency in it. And starts when? November 29, 2007, the day that this
7 facility entered the Medicaid Program. What they want you to do is pretend
8 that this document doesn't exist. They want you to ignore this document
9 even though the same costs are contained in one that they say oh, we have
10 no problem with that. They want to draw an artificial curtain here to say
11 that, you know, we won. This is not a game of hide and seek. It's not a
12 game of hiding costs, hiding, you know, what the sources of cost is and then
13 getting to keep it. That's not fair, it's not proper, and it's not in—it's not
14 consistent with the State Plan guiding principles or the contracts. The
15 second argument that is made is a wait a minute, we got you again. You
16 didn't provide this audit report for the first period within three years. But
17 wait a minute, what all the testimony is, is that this report established the
18 rates for periods up to and including 9/30/08, 09, excuse me, see I get
19 confused, 9/30/09. That's the consistent testimony. That's what everybody
20 says. And why? Because the State Plan provides this great benefit to those
21 who enter the programs to allow them to do an initial report, it's even called
22 an initial report, it's a preliminary report. It's something that starts the
23 process and it's known it's going to have an extended life. And even though
24 all of the rates are governed by these costs, there's no question about that,
25 the only adjustments to the rates are based upon changes in the State Plan,
26 not new costs, not new reports, not new activity, they're based on the initial
27 report and they say well, even though that's the case we, we want you to
28 turn back the clock. We want you to artificially divide this into little
29 segments so that we can keep money that we didn't earn. That's what this
30 case is about, keeping money that isn't earned. Now, I know that the
31 Petitioner's going to say well, you know, look at these letters. What do they

1 say? They say contract periods. And you know what, that's what they say
2 but these are people talking to each other about things they all know. It's
3 just shorthand. Okay? It's nothing more than that. It is somebody showing
4 you in a shorthand fashion, an abbreviated fashion what you're going to get
5 during these periods of time, but does it mean that the cost report that was
6 initially entered did not set those rates? No, it doesn't. It just is a notice to
7 you of the amount of money you're getting on an interim basis, and the use
8 of the language in there cannot and does not deviate from or do violence to
9 the State Plan or the contracts. You can't do it. It's merely a ploy in study,
10 sending information to someone in the industry that they believe know what
11 it means and it has no magical significance which is what the Petitioner
12 would have you believe here. So, you know, could, could the State have
13 communicated more clearly in that document? Yeah, it could have. Was
14 anybody confused by it? No, not at all. Does it impact the contract and the
15 State Plan? Not on your life. So that's where we are. We have a situation
16 which I think both sides have attempted to brief in a way that's
17 understandable to you. I think that the documents do speak for themselves.
18 I find it unusual that the, the expert can remember something that happened,
19 well, remember something happened but can't remember when it happened
20 or where it happened or any of that kind of stuff, but convenient can
21 remember something he said that did happen that he somehow is, he can't
22 rely upon because he's not a party to the contracts. So who do we have
23 here? We have Jeff Saxon who is established to be the most knowledgeable
24 person, the drafter of the contract, the drafter of the State Plan, saying one
25 thing and the advocate who wants to save his client money saying another
26 thing. And you can see the inconsistencies, I mean even Mr. Westbrook
27 had to point out the inconsistencies in his own expert's testimony, and he
28 was doing that in a kind way to deflate the significance of those
29 inconsistencies and Mr. Westbrook's a very artful attorney. He did it in
30 expert fashion. I was almost persuaded by it but it doesn't make the
31 inconsistency any less inconsistent. It doesn't make the change any less

1 changed. What we have here is a situation in which Mr. Saxon has from
2 day one, been consistent, straight-forward, relying upon the plain language
3 of the plans and the contracts and implementing a process consistently. And
4 there's no reason today to deviate from that. There's no reason that this
5 Petitioner who is hiding from a related party relationship, whether
6 intentionally or not, and I'll accept Mr. Schmoyer's representation he didn't
7 know it, but I can't accept representation that his client didn't know they
8 were dealing with themselves. Most people know if they're buying stuff
9 from themselves. And you know, they have responsibility of telling Mr.
10 Schmoyer that and before they sign off on this, they're responsible for
11 reading this and they say oops, gee whiz, we didn't put this Cimarron in
12 there. I don't see that name on the related facilities on either one of these
13 cost reports. We probably should tell Mr. Schmoyer that. Well, they didn't,
14 they don't deserve the money, they shouldn't be able to keep the money,
15 and this very twisted argument that somehow allowing or telling the auditor
16 you have to look at two contracts means you can't look at more than two is
17 inconsistent with every other aspect of the contracts and the plans as we
18 have identified in our written materials to you. Thank you so very much.
19 Keep in mind that the reason that Mr. Westbrook gets to talk to you second
20 is cause he has the burden of proof. He has the burden of proof, okay, and
21 can't meet it. As hard as he might try, he just can't. Thank you.

22 WESTBROOK: Well, I'm going to try to do it. Despite what Mr. Nickles says, I would add
23 that we're not in a criminal case so it's not beyond a reasonable doubt. It's
24 the preponderance of the evidence. Which means just a tiny bit more. So
25 that's my burden and I think we've done it and I want to try to summarize
26 why I believe that. First of all, a couple of things Mr. Nickles said I'm going
27 to kind of touch on. It's true my client would like to keep as much money
28 as they deserve, that's true. It's just like the Department of Health and
29 Human Services and Mr. Saxon wants to keep every bit of money they can
30 for Medicaid, so I think we're operating on an even playing field there. I
31 believe that Mr. Schmoyer testified that he respected and liked Mr. Saxon

1 as I do and that he was—that no one was more knowledgeable than he was.
2 I don't recall him saying, Mr. Nickles upped that just a little bit saying he
3 was the most knowledgeable person in the State. I think what Mr. Schmoyer
4 said there's nobody more knowledgeable than he was, and he also
5 mentioned that even though he was, he was a knowledgeable guy who he
6 respected, I think the implication, I can't remember exactly his words were
7 but that's doesn't mean he's infallible. We all can be wrong and it's our
8 position that Mr. Saxon's wrong in this case and so is Mr. Nickles. Now
9 the only testimony about the impact of this related party omission, the only
10 evidence that was presented at this hearing that's been presented in this
11 appeal about the impact of that was Mr. Schmoyer's testimony that it had
12 no impact. There's no other—you know, Mr. Nickles testified on his own
13 but he's not a witness. He's, you know, his questions aren't evidence and
14 there was no evidence that this impacted, you know, Mr. Nickles' main
15 theme in his closing was how we want to keep all these ill-gotten gains as a
16 result of this omission, but the evidence was it had no impact on the amount
17 of money that was paid to Countrywood so I would like you to keep that in
18 mind. Now let me try if I can to sort of, sort of summarize and go through
19 our twisted argument, to use Mr. Nickles' characterization of it. Let me see
20 if I can untwist it a little bit and I'm afraid to do that I'm going to have to
21 stand up, but I'm not going to do anything violent or too traumatic. I just
22 want to get over because I know Tammie's tired of being confused and
23 abused by me. As I've said, you know, in my opening, Ms. Schindler, we
24 have two claims based on two different contracts, not two claims but two
25 issues based on two different contracts that they're separate, you know.
26 They stand or fall, you know, separate from each other because they're,
27 they're, they're two different contracts and what we have tried to show
28 throughout this is consistent with what Mr. Nickles said in his opening, we
29 believe the contracts stand on their own language. We're not trying to
30 introduce evidence to say well, if you look over here at this other document
31 or this plan or another part of the contract or, or any other kind of email

1 that's out there, that'll, that'll explain what it means. No. Let's just look at
2 what the contract itself says and we'll start with the SAO Contract. Again,
3 this is from exhibit, our Exhibit 4. Nursing facility agreed upon procedure
4 requires. Mr. Saxon testified that agreed upon procedures is a—that's a
5 funny word I'm not used to but he said well, that includes audits. So it
6 includes audits and audit reviews. First sentence, well, how can that be less
7 ambiguous, how can it be any clearer maybe is a better way to say it. How
8 can it be clearer? The SAO will perform agreed upon procedures involving
9 two cost report periods. Now it goes on to say, it's not on the foam board
10 but you remember from the contract, the Exhibit 4, this is number 1, the 1,
11 2, 3 and number 4 and number 4 at the bottom says, these restrictions,
12 obviously meaning the 1 through 3, it would cause them restrictions. It's
13 not that it's two's a minimum. There's no suggestion, the word minimum's
14 not in here, there's no implication that two, you start at two and you can go
15 off into three, four, five or six or whatever because these are res—it's a
16 restriction. That's what the language of the contract says. And it says if
17 restrictions—these restrictions apply to all cases except for the allegations
18 of fraud. Now there's been no evidence at all that at the time they did these
19 investigations there were any allegations of fraud, in fact, despite
20 insinuations by Mr. Nickles, there have been no allegations of fraud now,
21 you know. The testimony of the evi—there's been no evidence presented
22 that anybody from Countrywood or any of Countrywood's agents have
23 received any kind of charges or allegations or questions from any State or
24 Federal agency about fraud. Fraud's not in the picture. They did these two,
25 they did these three cost report audits because they did three cost report
26 audits, not because of any investigation of fraud. With respect to the six
27 year requirement that's also a part of that contract, sure you've got to
28 maintain your records for six years, but you have to construe different parts
29 of a contract so they make sense together and one doesn't contradict the
30 other. You have to maintain records for six years probably because if
31 they're going to have a fraud investigation at some point if allegations of

1 fraud come up and they want to investigate, then you have them. That
2 would certainly make sense and make it consistent with the sentence I just
3 read that they're only—that, that, the SAO Contract, the SAO can audit two
4 cost report periods. Now it goes on to say which two cost report periods. It
5 says the cost report in effect when the field work was initiated, and it's not
6 in dispute when the field work was initiated. That's set by Petitioner's
7 Exhibits 5 and 13. It was in the summer of 2011. And the cost report period
8 that was in effect then, Mr. Saxon testified; was this cost report period right
9 here, 10/1/08 to 9/30/09. That was his testimony. And then the SAO
10 Contract says the two cost report period you can audit, SAO, is this one, the
11 one in effect when the field work was initiated and the preceding one,
12 11/29/07 to 9/30/08. Mr. Saxon agreed with that. That leaves this one out,
13 the six month cost report period. Let me make it clear. It's not our position
14 that you can't audit six month cost report periods. Sure SAO can audit six
15 month cost report periods if they want to but they waited too late in this
16 case. They had—they waited to initiate their field work in July of 2011 and
17 based on this contract, if you initiate your field work in July of 2011, these
18 are the two that you can audit, that's what the contract says, there on page
19 4 of Exhibit 4. They waited too late. If they'd started earlier, sure they could
20 have done that one. But they didn't. Now there's a practice that SAO may
21 have, there was some evidence of that and some testimony about that. There
22 may be a practice at SAO or in conjunction with or acting by themselves in
23 conjunction with the DHHS or acting by themselves of auditing more than
24 two cost reports. But the fact that that's their practice or their sometime
25 practice, doesn't negate the fact that the contract says two cost reports in
26 perfectly clear language. Now the question that we discussed before any of
27 the testimony started today about third party beneficiary that Mr. Nickles
28 came back to in the closing, the question is I think a pure legal question, I
29 believe, whether Countrywood has any right, has any rights under this
30 contract. As Mr. Nickles said we're not a party to it, we didn't negotiate it
31 except for the, except for the key provision which came about as a result of

1 negotiations between the Healthcare Association and DHHS. Mr.
2 Schmoyer testified about that and Mr. Saxon's testimony was consistent
3 with that. He said that that sentence came into being in the 1998 SAO
4 Contract after negotiations between the Deputy Director and the Director of
5 DHHS and the President of the Healthcare Association. That's what Mr.
6 Saxon testified to. He said those negotiations took weeks, maybe months.
7 They were face to face meetings and phone conversations and a result of
8 those, he used the word discussions, as a result of those discussions, that
9 language was put in there and Mr. Schmoyer said yeah, the President of our
10 association made a big announcement and you bet he remembers it, he
11 remembers it because it was important. He thought it was very important
12 and you remember important things, even if they were in the late 90's.
13 That's why he remembered it. But it goes back to the question what rights
14 do we have, does Countrywood have under this contract between these two
15 State agencies? Well, if that provision is a result of negotiations between
16 the nursing home industry, the association that represents the nursing home
17 industry in South Carolina, the vast majority of all the nursing homes in
18 South Carolina and DHHS, if that provision is a result of that, then clearly
19 it benefits nursing homes in South Carolina. Clearly nursing homes in
20 South Carolina are the intended beneficiaries of that provision and that's
21 why we have a right, why we have rights, when I say we, Countrywood and
22 other nursing homes, have rights under this SAO Contract. Another way of
23 looking at it is standing. This is another purely legal issue. There wasn't
24 really any testimony on standing today. That's a pretty solid legal concept
25 but Mr. Nickles and I have taken different positions about this in our briefs.
26 Standing is a flexible concept the courts say and you can have standing to
27 sue somebody else, even if it involves a contract to which you're not a party,
28 under the public interest exception to standing, the public interest doctrine.
29 And what the cases say is that under the, if, if, if a matter, if a legal matter
30 raises, has an issue of public importance that affects not just the parties of
31 the contract or the parties involved in the tort or whatever the counterclaim

1 is, but involves a larger section of the public, then that member of the public
2 may have standing. The key according to the case law is, is resolution
3 needed for future guidance? That's the phrase. Is resolution needed for
4 future guidance? Here you have testimony from Mr. Schmoyer saying he
5 has other clients. In fact Mr. Nickles brought that out in his questions. Do
6 you have other clients with the same issue, other nursing homes with the
7 same issue? It's going to be appealed over and over again. Resolution is
8 needed for future guidance on this. That's why nursing homes have rights
9 under this contract. I mean just think about it. Not from a legal perspective
10 for a minute, but just from a practical point of view, that two State agencies
11 who are getting together, they sign a contract that's a public document and
12 then they don't abide by the contract. They say well, it says two but we like
13 to do three. That's our, sort of our history of doing it, we do three even
14 though it says two. Going to the second argument, rate period is contract
15 period but we'll sort of define rate period as an extended period that's not
16 mentioned anywhere in the contract or the plan. Where you have two State
17 agencies who signed a contract that don't abide but it, a public contract and
18 it's for the benefit of a particular industry, here Medicaid nursing homes,
19 sure Medicaid nursing homes have rights under that contract. They're
20 intended beneficiaries for that contract and that's why we're raising that
21 issue under that contract. Now obviously there's a second contract. There's
22 a Facility Contract of which Countrywood is a party. That's Exhibit 6,
23 Petitioner's Exhibit 6. Facility contract, time limit for issuance of the final
24 audit report, any disallowance pursuant to an on-site audit shall be made in
25 the final audit report which shall, not maybe, shall be issued within three
26 years of the close of the contract period. If you want to know what contract
27 period means, it says go back and check the definition section and we did,
28 and it says in the definition section it defines contract period as the rate
29 period as defined in the State Health Plan. Now Mr. Schmoyer testified that
30 rate period's not defined in the State Health Plan. Mr. Saxon, I had to pull
31 and tug but that eventually was his testimony as well and that's what he

1 testified at his deposition. Rate period is not defined in the State Plan. So
2 contract period means rate period, whatever that means. Now the position
3 of the Department is that rate period in this case is extended, this grand rate
4 period of about two years or almost two years, but there's nowhere in the
5 State Plan, in that contract, in the SAO Contract, in any regulation, there's
6 been no evidence submitted anywhere in any written document that talks
7 about an extended rate period. The only document that talks about that is
8 Mr. Nickles' legal briefs. That's where that phrase first appeared, extended
9 rate period. All the documents that we received from, that Countrywood
10 received from DHS, what am I saying, HHS, and the SAO, I'm getting my
11 acronyms mixed up, in this case were consistent in identifying the rate
12 periods. They all, Ms. Myers' letter, the desk audits, and the final audits,
13 ah, that's not it, that'd be this one, rate periods, identified these three rate
14 periods, they all did. Now Mr. Nickles says, ah, they just, these are just
15 folks, they're just talking, you know, just people talking to each other. Well,
16 you know, I beg to differ. These are formal reports. This is the desk audits,
17 the final audits, and a letter from Mr. Saxon's right-hand person, Deborah
18 Myers. These aren't just folks talking. These are formal documents, formal
19 reports. They all identify the same rate period, those three right there, and
20 so under the Facility Contract the final audit has to be issued three years
21 from the close of the rate period. Now of these three rate periods, three
22 years from here is May of 2011, three years from here is September of 2011,
23 and three years from here is September of 2009. They were issued, excuse
24 me, September of 2012 would be three years from here. They were issued
25 in November of 2011 so they're within three years of this one but not of
26 these two. So under the Facility Contract, they're untimely. So whether
27 you look at the SAO Contract that says you can only do two cost reports or
28 whether you look at the Facility Contract that says you have to do, issue the
29 final audit within three years of the rate period, it's untimely. These aren't
30 correct. Now I don't think it's twisted argument. I think it's a pretty clear
31 argument. I mean lord knows I may not have presented it clearly but when

1 you, when you, as I know you will and probably already have, when you sit
2 down and read the briefs, read the testimony, I think the argument is
3 extremely clear and it's based on the contractual language. It's not based
4 on interpretation. It's not based on practice. It's not based on what Mr.
5 Saxon or Mr. Von Kannel do or have done in the past as their practice, it's
6 based on contracts. And that's what has to be decided on. I appreciate, as
7 Mr. Nickles said, your great attention today. You've obviously been taking
8 a lot of notes and listening with care to a matter that is as Mr. Nickles said
9 involves some, some terms that maybe aren't certainly in my experience
10 part of everyday use and we, like Mr. Nickles I appreciate your attention to
11 that. That's all I have to say. Thank you.

12 SCHINDLER: Thank you. Thank you to everyone who's—I appreciate your efforts to
13 make a kind of a convoluted appeal understandable. Back to the
14 housekeeping things, did you say that you did want a chance to go through
15 those depositions and submit what sections you want me to consider?

16 NICKLES: What I would like to do is if it's okay with Mr. Westbrook is to just give us
17 some time to look at it. I'm doubtful that we're going to have too many,
18 well, disagreements about what's in the record.

19 WESTBROOK: I think we'll be able to work it out just fine. We just need to get together.

20 SCHINDLER: Okay, so...

21 NICKLES: I think we said fifteen days.

22 SCHINDLER: How about October 3rd? Can you have that to me?

23 WESTBROOK: Sure.

24 SCHINDLER: All right. So getting back to our objections, I had seventeen listed. Did either
25 of you keep up with how many objections there were?

26 WESTBROOK: I think Ms. Harris did.

27 HARRIS: I had nineteen.

28 SCHINDLER: Nineteen. That's what Mr. Smith had. Somehow I'm missing two. Can you
29 tell me which ones I haven't ruled on?

30 HARRIS: You've either ruled on every one or the parties rephrased their question.

31 SCHINDLER: I, that's what I...

1 HARRIS: So you've ruled on everything that I...

2 SMITH: Is there actually one, the parole evidence rule, I think you said you'd reserve

3 that for your...

4 SCHINDLER: Okay.

5 HARRIS: That it would go to, while you were writing you would look at the probative

6 value.

7 SCHINDLER: That's, that's right.

8 HARRIS: So that one, that one you ruled on but it's left to a process...

9 SCHINDLER: Yeah.

10 HARRIS: ...so that's correct.

11 SCHINDLER: Okay, so I thought I'd kind of, okay, great. All right. Then assuming that

12 all the exhibits the parties wanted entered in the record have been presented

13 today other than whatever happens with that deposition.

14 NICKLES: That's correct.

15 SCHINDLER: I'd like each party to submit a draft decision to me. I'm going to say thirty

16 days by October 17th. Would that allow you enough time to...

17 NICKLES: It depends on how specific you want those drafts to be. Certainly they can't

18 be as specific as we might like unless there's a transcript to the proceeding

19 available to us, so what we have—what I've done in other instances is, you

20 know, if it's your pleasure simply to present, you know, orders without

21 reference to the record. That could be done within that period of time. If

22 you want a reference to the record, I think we need thirty days from the

23 delivery of the transcript in order to present that form of order to you.

24 SCHINDLER: Okay.

25 NICKLES: So it's—that's your call as to how you—what you want. If you want us to

26 present essentially draft orders based upon, you know, our post-hearing

27 briefs so to speak in order form, we can do that without the transcript but if

28 you want it to be...

29 SCHINDLER: Yeah.

1 NICKLES: ...something that is based upon testimony that was presented, my memory
2 is not what it once was and I can't tell you that I would be able to recall all
3 the testimony.
4 SCHINDLER: I'll accept the post-hearing brief because I'll have the record that I can refer
5 to the recording whenever I need to so.
6 NICKLES: Okay.
7 WESTBROOK: And I think what, I mean what I would probably do I mean obviously I'll
8 do it how ever you want to is if I feel solid enough in my memory, I might
9 say well, as Mr. Saxon testified but obviously I won't have the page
10 number or anything like that.
11 NICKLES: Yes. I mean I think that we can do our best to present the testimony as we
12 recall it to be.
13 SCHINDLER: And I think that's acceptable.
14 WESTBROOK: You did concede, didn't you, at one point?
15 SCHINDLER: I think it's time to go off the record.
16 NICKLES: All right. Thank you very much and that's the 17—you said 17th?
17 SCHINDLER: The 17th...
18 NICKLES: For the order?
19 SCHINDLER: ...for the order and October 3rd,
20 NICKLES: Okay.
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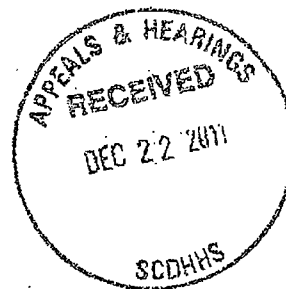


Schmoyer and Company, LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 16, 2011

Appeals and Hearings
SC Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Re: AC # 3 - RDM-J8 - CountyWood Nursing Center, LLC
Cost report YE 9/30/09



Dear Hearing Officer:

On behalf of our client, CountryWood Nursing Center, LLC, we are appealing the State Auditor's Office report for the September 30, 2009 cost reporting period. Specifically, we are appealing the following adjustments:

Adjustment #1, 2, 12 (DAV Calculation)

The historical cost depreciation schedule and DAV limitation was amended to conform to the prior State audit. We would like the opportunity to review the cost of capital revisions to ensure they agree to the DHHS amendment filed.

Adjustment #3 (Medical Director)

This adjustment removed all of the providers Medical director fees. It is our position that these expenses are necessary and reimbursable and we request an opportunity to provide additional information to support the amounts in question.

Adjustment #5 (OTC drugs)

This adjustment removed most of the providers OTC drugs. It is our position that these expenses are necessary and reimbursable and we request an opportunity to provide additional information to support the amounts in question.

Adjustment #7, 6 (Nursing Salary and benefits)

This adjustment reclassified certain nursing and DON salary and benefits to the assisted living wing. We request the opportunity to inquire of management regarding the need for such a reclassification disallowance.



Adjustment #8 (Home Office Costs)

This adjustment removed all management fee expenses associated with Putnam Council. It is our position that these expenses are reimbursable in accordance with the State plan and we request these costs be allowed based on the home office cost report submitted.

Adjustments #9 and 10 (Step Down)

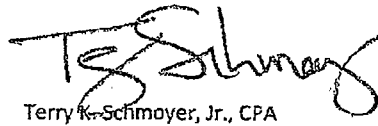
It is our position that these adjustments contain incorrect allocation statistics and direct allocations, some based on the prior operator. We request an opportunity to provide additional information to support the amounts in question.

Adjustment #9 (Special Services Cost Adjustment)

This adjustment removed expenses that were deemed to be reimbursed by other pay sources for PT/OT/ST Therapy, Oxygen and IV Therapy. It is our position that these expenses are reimbursable in accordance with the State plan and we request an opportunity to provide additional information to support the amounts in question.

Thank you for your consideration of our concerns and objections.

Sincerely,



Terry K. Schmoey, Jr., CPA

TKS:enm

cc: Mr. Jeff Saxon, Bureau Chief
Department of Health and Human Services

Mr. Jay Von Kannel, Manager
Office of the State Auditor

Mr. Bob Hagan, Member
CountryWood Nursing Center, LLC

Mr. Jerry Hicks, CPA
Hicks and Clark, LLC





Schmoyer and Company, LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 16, 2011

Appeals and Hearings
SC Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Re: AC # 3 - RDM-J8 - CountyWood Nursing Center, LLC
Cost report YE 9/30/08



Dear Hearing Officer:

On behalf of our client, CountryWood Nursing Center, LLC, we are appealing the State Auditor's Office report for the September 30, 2008 cost reporting period. Specifically, we are appealing the following adjustments:

Adjustment #1, 2, 14 (DAV Calculation)

The historical cost depreciation schedule and DAV limitation was amended to conform to the prior State audit. We would like the opportunity to review the cost of capital revisions to ensure they agree to the DHHS amendment filed.

Adjustment #3, 4, 6, 9, (General Lack of Documentation)

These adjustments removed invoices and expenses due to a lack of adequate documentation. It is our position that the expenses removed in these adjustments are reimbursable and we request an opportunity to provide additional information to support the amounts in question.

Adjustment #7 (Medical Director)

This adjustment removed all of the providers Medical director fees. It is our position that these expenses are necessary and reimbursable and we request an opportunity to provide additional information to support the amounts in question.

Adjustment #8 (OTC drugs)

This adjustment removed most of the providers OTC drugs. It is our position that these expenses are necessary and reimbursable and we request an opportunity to provide additional information to support the amounts in question.



Adjustment #10 (Nursing Salary)

This adjustment reclassified certain nursing and DON salaries to the assisted living wing. We request the opportunity to inquire of management regarding the need for such a reclassification disallowance.

Adjustment #11 (Home Office Costs)

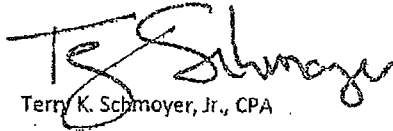
This adjustment removed all management fee expenses associated with Putnam Council. It is our position that these expenses are reimbursable in accordance with the State plan and we request these costs be allowed based on the home office cost report submitted.

Adjustments #12 and 13 (Step Down)

It is our position that these adjustments contain incorrect allocation statistics and direct allocations, some based on the prior operator. We request an opportunity to provide additional information to support the amounts in question.

Thank you for your consideration of our concerns and objections.

Sincerely,


Terry K. Schmoeyer, Jr., CPA

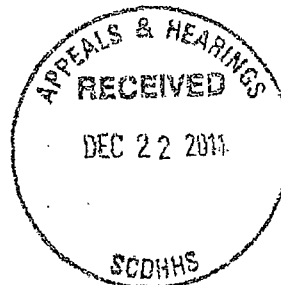
TKS:enm

cc: Mr. Jeff Saxon, Bureau Chief
Department of Health and Human Services

Mr. Jay Von Kannel, Manager
Office of the State Auditor

Mr. Bob Hagan, Member
CountryWood Nursing Center, LLC

Mr. Jerry Hicks, CPA
Hicks and Clark, LLC



R0212

R0248



Schmoyer and Company, LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 16, 2011

Appeals and Hearings
SC Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206



Re: AC #3 - RDM-E8 - CountyWood Nursing Center, LLC
Cost report YE 5/31/08

Dear Hearing Officer:

On behalf of our client, CountryWood Nursing Center, LLC, we are appealing the State Auditor's Office report for the May 31, 2008 cost reporting period. Specifically, we are appealing the following adjustments:

Adjustment #1, 2, 15, 16 (DAV Calculation)

The historical cost depreciation schedule and DAV limitation was amended to conform to the prior State audit. We would like the opportunity to review the cost of capital revisions to ensure they agree to the DHHS amendment filed.

Adjustment #3, 4, 6, 7, 10, (General Lack of Documentation)

These adjustments removed invoices and expenses due to a lack of adequate documentation. It is our position that the expenses removed in these adjustments are reimbursable and we request an opportunity to provide additional information to support the amounts in question.

Adjustment #8 (Medical Director)

This adjustment removed all of the providers Medical director fees. It is our position that these expenses are necessary and reimbursable and we request an opportunity to provide additional information to support the amounts in question.

Adjustment #9 (OTC drugs)

This adjustment removed most of the providers OTC drugs. It is our position that these expenses are necessary and reimbursable and we request an opportunity to provide additional information to support the amounts in question.



Adjustment #11 (Nursing Salary)

This adjustment reclassified certain nursing and DON salaries to the assisted living wing. We request the opportunity to inquire of management regarding the need for such a reclassification disallowance.

Adjustment #12 (Home Office Costs)

This adjustment removed all management fee expenses associated with Putnam Council. It is our position that these expenses are reimbursable in accordance with the State plan and we request these costs be allowed based on the home office cost report submitted.

Adjustments #13 and 14 (Step Down)

It is our position that these adjustments contain incorrect allocation statistics and direct allocations, some based on the prior operator. We request an opportunity to provide additional information to support the amounts in question.

Audit conducted outside of the SAO/ DHHS contract

We appeal all disallowances included within this entire audit report AC # 3-RDM-E8 that relate to all Rate Periods 11/29/07-9/30/09 because the cost report is outside of the scope of the contract between the SC State Auditor's office and DHHS. It is our understanding that the Auditor's office is under a specific contract arrangement that dictates they are allowed to audit a Medicaid Cost Report that is currently paying a Rate and the cost report immediately prior. The provider was contacted in the summer of 2011 to have its September 30, 2009 cost report audited. The audit report immediately prior is September 30, 2008, which was also audited. Accordingly, it is our opinion that the audit report for the period ended May 31, 2008 is outside the scope of the current DHHS contract. We inquired of the auditor if DHHS requested that the May 31, 2008 report be audited based on alleged improprieties and they said it had not.

Expired rate periods with in this audit report

We appeal all disallowances included within audit report AC # 3-RDM-E8 that relate to Rate Periods 11/29/07-9/30/08 because the final audit report for these rate periods was not issued in a timely manner.

Pursuant to the provider's Contract between the South Carolina Department of Health and Human Services and CountryWood Nursing Center, LLC, a final audit report must be issued within three years of the close of the contract period in question. See Article V., Section F. at p. 8 of the provider contract, which defines the timely issuance of an audit report and Article II at p. 2 that defines what the audit contract period is. The final audit report for the rate periods ending 9/30/08 was not issued until November 22, 2011, which was 52 days too late. The final audit report for the rate periods of 11/29/07 - 9/30/08 should have been issued within three years, or no later than 9/30/11. We therefore request that all disallowances for rate period 11/29/07 - 9/30/08 be deleted and any accounts receivable related to this rate period be rescinded.

Thank you for your consideration of our concerns and objections.

Sincerely,


Terry K. Schmoyer, Jr., CPA

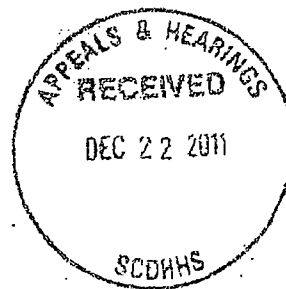
TKS:enm

cc: Mr. Jeff Saxon, Bureau Chief
Department of Health and Human Services

Mr. Jay Von Kannel, Manager
Office of the State Auditor

Mr. Bob Hagan, Member
CountryWood Nursing Center, LLC

Mr. Jerry Hicks, CPA
Hicks and Clark, LLC



CountryWood
Medicaid Cost report audit.

8/11/2011

Cost Report Period
11/29/2007 5/31/2008

Rate Period
11/29/2007 5/31/2008
6/1/2008 9/30/2008
10/1/2008 9/30/2009

Contract Period
Expiration Date
5/31/2011
9/30/2011
9/30/2012

11/29/2007 9/30/2008

10/1/2009 9/30/2010

<< Open Cost report - the contract "One Prior"

10/1/2008 9/30/2009

10/1/2010 9/30/2011

<<< MCD Audit started Aug 2011

Note:

SAC Audit was started

Aug 2011



R0252

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP
Attorneys and Counselors at Law
1320 Main Street / 17th Floor / Columbia, SC 29201
Tel: 803.799.2000 Fax: 803.255.5506
www.nelsonmullins.com

Alice V. Harris
Tel: 803.255.9487
Fax: 803.255.5506
alice.harris@nelsonmullins.com

October 10, 2012

Hand Delivered

Betsy Schindler, Hearing Officer
South Carolina Department of Health
& Human Services
Division of Appeals and Hearings
Post Office Box 8206
Columbia, SC 29202-8206

RE: AC #3-RDM-J8; AC #12-AUD-010
AC #3-RDM-J9; AC #12-AUD-011
AC #3-RDM-E8; AC #12-AUD-012
Our File No. 39092/09000



Dear Ms. Schindler:

Enclosed for filing in the above-referenced matter are the original and one copy of Petitioner's Motion for Partial Summary Judgment. Please return a clocked-in copy to us.

By copy of this letter to counsel, we are hereby serving them with a copy of this document.

Very truly yours,

A handwritten signature in dark ink, appearing to read 'A. V. Harris', written over a horizontal line.

Alice V. Harris

AVH:ckh

Enclosures

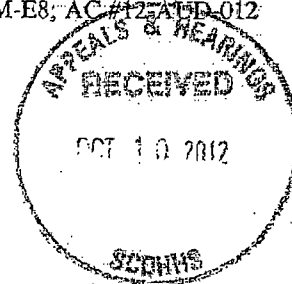
cc: Terry K. Schmoyer (via email)
W. Allen Nickles, III, Esq. (via email)
Richard G. Hepfer, Esq. (via email)
Byron Roberts, Esq. (via email)



With offices in the District of Columbia, Florida, Georgia, Massachusetts, North Carolina, South Carolina, Tennessee and West Virginia

Countrywood Nursing Center, LLC,) AC #3-RDM-J8; AC #12-AUD-010
) AC #3-RDM-J9; AC #12-AUD-011
 Petitioner,) AC #3-RDM-E8; AC #12-AUD-012
)
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 v.)
)
)
 South Carolina Department of Health)
 and Human Services,)
)
)
 Respondent.)

APPEALS & HEARINGS
RECEIVED
OCT 10 2012



The Petitioner Countrywood Nursing Center, LLC ("Countrywood") hereby submits a Motion for Partial Summary Judgment and requests a hearing in front of a South Carolina Department of Health and Human Services ("SCDHHS") hearing officer to address the legal issues raised in this motion. For the reasons set forth below, Countrywood requests that partial summary judgment be granted because the State Auditors Office ("SAO") failed to issue certain audit reports in a timely manner in accordance with the SAO's obligations explicitly set forth in its contract with SCDHHS and as explicitly set forth in the contract between Countrywood and SCDHHS. Countrywood also requests that partial summary judgment be granted because the SAO exceeded its authority delegated by SCDHHS when it conducted audits of three, instead of two, contract periods.

Under Rule 56 of the South Carolina Rules of Civil Procedure, summary judgment is appropriate if there is "no genuine issue as to any material fact" and the moving party shows that it is entitled to judgment as a matter of law. "Under Rule 56(c), the party seeking

summary judgment has the initial responsibility of demonstrating the absence of a genuine issue of material fact." *Sides v. Greenville Hosp. System*, 607 S.E.2d 362, 364 (S.C. App. 2004). Once the moving party carries its initial burden, the opposing party must come forward with specific facts that a genuine issue of fact remains for trial. *Id.* In determining whether triable issues of fact exist, the evidence and factual inferences must be viewed in the light most favorable to the nonmoving party. *Wogan v. Kunze*, 666 S.E.2d 901, 903 (2008).

"The purpose of summary judgment is to expedite disposition of cases which do not require the services of a fact finder." *Wogan v. Kunze* at 903-904. "The construction and enforcement of an unambiguous contract is a question of law, and can be properly disposed of at summary judgment." *Hansen ex rel. Hansen v. United Services Auto. Ass'n*, 565 S.E.2d 114, 116 (S.C. App. 2002).

II. The Contracts at Issue in this Appeal Must be Construed According to Terms the Parties Used and According to the Plain Terms of the Contracts

A hearing officer, sitting in the capacity as the decision maker in this matter, does not have the authority to alter a contract either by construction or by making new contracts for the parties. See *C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission*, 373 S.E.2d 584, 587 (S.C. 1988). Instead, the hearing officer must interpret the contract made by the parties, regardless of the wisdom or folly, unreasonableness, or failure of the parties to guard their rights. See *id.* Furthermore, when a contract is unambiguous, clear, and explicit, it must be construed according to the terms the parties have used, to be understood in the plain, ordinary, and popular sense. *Id.* at 586. "Extrinsic evidence giving the contract a different meaning from that indicated by its plain terms is inadmissible." *Id.*

III. The SAO Failed to Issue Final Audit Reports in a Timely Manner

a. The Cost Report Auditing Process

Countrywood is a skilled nursing facility that participates as a provider of services with the South Carolina Medicaid Program. Nursing facilities such as Countrywood are required to report costs on a Uniform Cost Report form provided by SCDHHS. The submission of cost reports is required by the South Carolina Medicaid State Plan under Title XIX of the Social Security Medical Assistance Program ("S.C. State Plan") and Countrywood's Medicaid provider contract with SCDHHS. *See* S.C. State Plan, Attachment 4.19-D I.)(attached as Exhibit A). *See also* Countrywood Provider Contract, Exhibit B at Article III-IV (incorporating the State Plan by reference into the Provider Contract).

The State Plan provides that "Nursing facilities must report their operations from October 1 through September 30 on a fiscal year basis." *See* S.C. State Plan, Attachment 4.19-D I.A)(attached as Exhibit A). The rate cycle is October 1 through September 30 and is recomputed every 12 months, utilizing cost reports submitted in accordance with Section D.I. of the S.C. State Plan. *See id.* at 4.19-D I.A) & III. A prospective rate for reimbursement is established for each nursing facility separately, based on the facility's cost report developed pursuant to the methodology in the S.C. State Plan. *See id.* at III. A.

The cost reports submitted by Countrywood are subject to desk reviews and onsite audits by SCDHHS, as the South Carolina Medicaid Agency. *See id.* at 4.19-D II. SCDHHS as the South Carolina Medicaid Agency contracts with the SAO to conduct onsite audits of skilled nursing facility cost reports. The contract between SCDHHS and SAO is attached as Exhibit C.

The contract between SCDHHS and SAO states that the term "agreed upon procedures" are procedures performed by an independent auditor to determine if the rate or amount of

reimbursement to a provider of Medicaid services complies with the S.C. State Plan, the contract between SCDHHS and the Medicaid provider, and applicable state laws and regulations. *See id.* at Article II. The SAO is responsible for conducting "agreed-upon procedures engagements" of Medicaid cost reports for nursing facilities. *See id.* at Article III. A-B. The Section titled "Nursing Facility Agreed-Upon Procedure Requirements" stipulates that "[t]he SAO will perform agreed-upon procedures involving two cost report periods." *See id.* at Article III. D.1.

For non-hospital based nursing facilities such as Countrywood, the cost report periods are defined in the contract between SCDHHS and SAO as "the cost report period which was used to set the provider's Medicaid rate in effect at the time of the filed work for the engagement is initiated, plus the preceding cost report period." *See id.* at Article III. D.1. The contract further stipulates the SAO is required to issue final audit reports no later than three (3) years after the end of the closed rate period that is associated with the preceding cost report period. *See id.*

In addition, SCDHHS entered into a Provider Contract with Countrywood. *See* Countrywood Provider Contract at Exhibit B. Among other terms, the Provider Contract provides for auditing procedures conducted by SCDHHS, including the conduct of onsite audits. *See id.* Article V. The Provider Contract stipulates a "Time Limit for Issuance of the Final Audit Report" related to the onsite audits of cost reports. *See id.* Article V., Section F. The section specifying a time limit for final audit reports provides that any disallowance made pursuant to an onsite audit report, "shall be issued within three (3) years of the close of the contract period . . ." *Id.* The term "contract period" is defined in the Provider Contracts for this Section as "the rate period as defined by South Carolina State Plan." *Id.* at Article II.

It is important to note that for purposes of when the final onsite audit must be issued, the Provider Contract defines the term "contract period" as the "rate period." The Definitions section of the Provider Contract states for only the section relating to the timing of the issuance of the final onsite audit report (Article V, Section F), "contract period" is the "rate period." Countrywood Provider Contract Exhibit B at Article II. The term "contract period" is defined for Article 1 of the Provider Contract only as the effective date of the contract through the expiration date (Article 1 relates to the effective dates of the Provider Contract). *See id.* For Article IV, Section E only (relating to "Similar Service Rates," not at issue here), the Provider Contract provides "the contract period will be defined as the rate period(s) applicable to the cost reporting period used to establish the Medicaid rate." *See id.*

b. The SAO Did Not Issue Certain Audit Reports in a Timely Manner

The SAO conducted audits of the cost reports at issue in the current appeals.¹ *See* Appeal letters submitted by Countrywood to SCDHHS. The rate periods audited for Countrywood are set forth in the accounts receivable letter dated December 16, 2011 (attached as Exhibit D). The Rate Periods for the audits are as follows:

<u>Rate Period</u>	<u>Audited Rate</u>
11/29/07-05/31/08	\$129.21
06/01/08-09/30/08	\$134.74
10/01/08-09/30/09	\$135.11
10/01/09-09/30/10	\$135.20
10/01/10-04/07/11	\$137.14
04/08/11-09/30/11	\$133.03

See Exhibit D. The start and end dates for each rate period are clearly delineated, as well as the audited rates for each rate period. As noted previously, the term "contract period" is

¹ The provider involved in this appeal cooperated with the audits in question, provided all data and information requested by SCDHHS and the SAO, and did not act in any manner to effect or delay the issuance of the final audit reports.

defined in the Provider Contracts as the rate period for the purposes of the issuance of the final audit reports. *See* Countrywood Provider Contract, Exhibit B at Article V., Section F.

The Definitions section of the Provider Contract states for only the section of the contracts relating to the timing of the issuance of the final onsite audit report, "contract period" is the "rate period." *See* Countrywood Provider Contract Exhibit B at Article II. Pursuant to the clear terms of the Provider Contract, the term "contract period" is not defined as the effective date of the contract through the expiration date, because this definition is used only for Article 1 of the Provider Contract. *See id.* Moreover, the term "contract period" does not mean "the rate period(s) applicable to the cost reporting period used to establish the Medicaid rate" because that definition pertains to only Article IV, Section E. *See id.*

Certain of the final audit reports issued by SAO were not issued within three years of the closed rate periods, as required by the SAO's contract with SCDHHS and Countrywood's contract with SCDHHS. *See* Contract between SCDHHS and SAO, Exhibit C at Article III. D.1; *See* Countrywood Provider Contract, Exhibit B at Article V., Section F. Instead, the final audit reports were issued in an untimely manner, as follows:

Pursuant to the S.C. State Plan, the SAO conducted audits for the rate periods as follows: 11/29/07-05/31/08; 06/01/08-09/30/08; 10/01/08-09/30/09; 10/01/09-09/30/10; 10/01/10-04/07/11; 04/08/11-09/30/11.

The SAO issued final audit reports on 11/22/2011 for these rate periods. The cover letters from the SAO reflecting the issuance date of 11/22/2011 for these reports are attached as Exhibit E. For the rate period 11/29/07-05/31/08, the final audit reports should have been issued no later than 05/31/2011. For the rate period 06/01/08-09/30/08, the final audit reports should have been issued no later than 09/30/2011.

The SAO failed to comply with the requirement that final audit reports must be issued within three years of the end of the closed rate period. Since the final audits for the rate periods outlined above were not issued within the three years as required by the SAO's contract with SCDHHS and Countrywood's contract with SCDHHS, all disallowances identified in the audits reports for these periods should be dismissed and any accounts receivables related to these rate periods be rescinded.

c. SCDHHS is Not Entitled to Recoup Funds Based on Final Audit Reports Issued Outside Contractual Deadlines

The South Carolina Supreme Court issued a decision in a situation very similar to this matter in *C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission*, 373 S.E.2d 584 (S.C. 1988). In *C.A.N. Enterprises* a nursing home and the S.C. Health and Human Services Finance Commission ("State") entered into a contract which provided for payment and reimbursement for Medicaid benefits. *See id.* at 585. The contract allowed for audits during the contract period and for a period of three years after the contract. *Id.* The State conducted a post-contract audit of the nursing home's cost information but did not issue its final audit report disallowing \$24,080.00 until after three years after the contract period. *Id.*

The South Carolina Supreme Court concluded in *C.A.N. Enterprises* that "[b]ecause the contract provides that audits, which we interpret to mean audit reports, must be completed within three years from the termination of the contract, and since the audit report was not submitted to Oakmont until after the three years expired, we hold the State is not entitled to recoup the funds disallowed in its final audit report." *Id.*

The issues presented for summary judgment are governed by the SAO's contract with SCDHHS and Countrywood's contract with SCDHHS, which provide for final audit reports

issued by the SAO to be issued within three years after the end of the closed rate period that is associated with the preceding cost report period. *See* Contract between SCDHHS and SAO, Exhibit C at Article III. D.1; Countrywood's Provider Contract, Exhibit B at Article V., Section F. Here, where the SCDHHS did not issue its final audit report within the three-year time frame, SCDHHS is not entitled to recoup funds disallowed in its final audit report, just as the Court held in *C.A.N. Enterprises*.

IV. The SAO Exceeded Its Authority By Auditing Three Contract Periods

In addition to the grounds set forth above, Countrywood requests that partial summary judgment be granted because the SAO conducted an audit of three contract periods and exceeded its authority by conducting the third contract period audit.

The cost reports submitted by Countrywood are subject to desk reviews and onsite audits by SCDHHS, as the South Carolina Medicaid Agency. *See* S.C. State Plan, Attachment 4.19-D II at Exhibit A. SCDHHS as the South Carolina Medicaid Agency contracts with the SAO to conduct onsite audits of skilled nursing facility cost reports. *See* contract between SCDHHS and SAO at Exhibit C.

Article III, Section (D) (1), SAO Responsibilities of the contract between SCDHHS and SAO, states as follows: "1. The SAO will perform agreed-upon procedures involving two cost report periods. For non-hospital based/related nursing facilities, the periods will be defined as the cost report period which was used to set the provider's Medicaid rate in effect at the time the field work for the engagement is initiated, plus the preceding cost report period." *See* Exhibit C.

The SAO audited the cost report 10/1/08-9/30/09 which set the rate for the time the SAO initiated the field work. The attached e-mail from Mr. Lawrence Warrington, CPA, audit supervisor for the SAO, to Mr. Terry Schmoyer dated July 15, 2011 reflects that the SAO

initiated its audit work in July of 2011. See e-mail from L. Warrington to T. Schmoyer at Exhibit F. In that case, under the provisions of the contract set out above, the SAO was entitled to also audit the preceding cost report period of 11/29/07-9/30/08. However, in addition, the SAO also audited a third cost report period of 11/29/07-5/31/08. The audit of the third cost report period was outside the purview of the SAO's authority as defined in its contract with SCDHHS. See contract between SCDHHS and SAO at Exhibit C.

The cover letters to the audit reports at Exhibit E reflect the impact of the unauthorized auditing of the cost report period of 11/29/07-5/31/08 as follows:

- A. The 10/1/08 – 9/30/09 report was used to set the rate covering contract periods beginning 10/1/10:

<u>Rate Period</u>	<u>Audited Rate</u>
10/01/10-04/07/11	\$137.14
04/08/11-09/30/11	\$133.03

- B. The 11/29/07 – 9/30/08 report was used to set the rate covering contract periods beginning 10/1/09:

<u>Rate Period</u>	<u>Audited Rate</u>
10/01/09-09/30/10	\$135.20

- C. The 11/29/07 – 5/31/08 report was used to set the rates covering contract periods beginning 11/29/07:

<u>Rate Period</u>	<u>Audited Rate</u>
11/29/07-05/31/08	\$129.21
06/01/08-09/30/08	\$134.74
10/01/08-09/30/09	\$135.11

See Audit Cover Letters at Exhibit E and Accounts Receivable letter at Exhibit D. The third cost report period of 11/29/07 – 5/31/08 setting rate periods of 11/29/07-05/31/08, 06/01/08-09/30/08, and 10/01/08-09/30/09 was outside of the work scope authorized by SCDHHS in the

contract between the SAO and SCDHHS. See contract between SCDHHS and SAO at Exhibit

C.

Where the SAO acted outside of the contract between the SAO and SCDHHS, SCDHHS is not entitled to recoup funds disallowed related to the third rate period of 11/29/07 – 5/31/08 in its final audit report.

V. Request for Relief

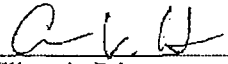
Countrywood is subject to an expensive and timely appeal on the issues set forth in the contested audit reports. The appeal of audit reports not issued in a timely manner and outside of the authority given to the SAO imposes an undue burden and expense on Countrywood to produce detailed information to support its claims. An award of partial summary judgment on the issues presented in favor of Countrywood will also serve to expedite this matter and narrow the issues involved in these appeals.

Counsel for Countrywood has conferred in good faith with counsel for the SCDHHS in unsuccessful attempts to resolve the issues raised in this motion.

As a matter of law, the SAO did not issue final audit reports for the rate periods in question within the three-year period required by the SAO's contract with the SCDHHS and Countrywood's Provider Contract. See Exhibits B and C. We therefore hereby request that the hearing officer issue a summary judgment finding that the SAO did not issue final audit reports for the rate periods in question within the required three-year period and dismiss the audit reports for the periods outlined herein.

In addition, as a matter of law, the SAO exceeded its authority by adding a third contract period. We therefore hereby request that the hearing officer issue a summary judgment finding that the SAO exceeded its authority when it audited a third contract period and dismiss the audit reports for the periods outlined herein.

NELSON MULLINS RILEY & SCARBOROUGH LLP

By: 

William A. Prince
SC Bar No. 4576
Alice V. Harris
SC Bar No. 66223
1320 Main Street / 17th Floor
Post Office Box 11070 (29211-1070)
Columbia, SC 29201
(803) 799-2000

Attorneys for Petitioner

Columbia, South Carolina

October 10, 2012

CERTIFICATE OF SERVICE

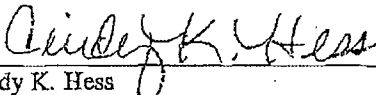
I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Countrywood Nursing Center, LLC, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified to the following address(es):

Pleadings: **PETITIONER'S MOTION FOR PARTIAL SUMMARY JUDGMENT**

Counsel Served: W. Allen Nickles, III, Esq.
Nickles Law Firm, LLC
1519 Richland Street
Columbia, SC 29201

Richard G. Hepfer
Deputy General Counsel
South Carolina Department
of Health and Human Services
1801 Main Street, 11th Floor
Post Office Box 8206
Columbia, SC 29202-8206

Byron Roberts, Esq.
South Carolina Department
of Health and Human Services
1801 Main Street, 11th Floor
Post Office Box 8206
Columbia, SC 29202-8206


Cindy K. Hess
Administrative Assistant

October 10, 2012

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

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

I. Cost Finding and Uniform Cost Reports

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

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

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

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

SC 10-006

EFFECTIVE DATE: 10/01/10

RO APPROVED: 02/02/11

SUPERSEDES: SC 06-013

- C) Nursing facilities are required to list the cost of the various services provided under the plan in accordance with the Medicaid Agency's cost reporting format. However, facilities providing services not covered by the plan will be required to use a step down method of cost finding as described in 42 CFR 413.24(d)(1) to apportion cost between the services covered and the services not covered by the plan before listing the cost of the various services provided under the plan. Services not covered by the plan include, but are not limited to, private pay wings of a facility which participates in the Medicaid (XIX) Program. In regard to stepping down capital related cost and maintenance cost of a private pay wing, the facility must allocate capital related cost (depreciation, interest, etc.) and maintenance cost directly associated with the wing in lieu of using square footage as the statistical base for allocating total capital costs and maintenance costs of the facility.
- D) Nursing facilities are required to report cost on a Uniform Cost Report form provided by the Medicaid Agency. All Uniform Cost Reports must be filed with the Medicaid Agency no later than January 1. However, a thirty (30) day extension of the due date may be granted for good cause. Effective for the cost reporting period ending September 30, 2001, nursing facilities will be required to submit their financial and statistical report using the SENIORS software program. Hospital based/related nursing facility cost reports will be due no later than 30 calendar days after the due date of the hospital's Medicare cost report.

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

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

SC 10-006

EFFECTIVE DATE: 10/01/10

RO APPROVED: 02/02/11

SUPERSEDES: SC 07-007

C) All nursing facilities are required to retain all financial and statistical records for each cost reporting period, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least six (6) years following the end of the contract period for which the cost report was used to set this rate. These records must be made available upon demand to representatives of the Medicaid Agency, or the State Auditor, or the Centers for Medicare and Medicaid Services. The Medicaid Agency will retain all cost reports for six (6) years after the end of the contract period for which the cost report is used to set the rate. If any litigation, claim, negotiation, or other action involving the records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular six (6) year period, whichever is later.

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

- 1) Allowable costs are determined in accordance with Title XIX of the Social Security Act, 42 CFR USCA 1396, et seq. and Federal Regulations adopted pursuant to the Act; the Medicaid Agency regulations; Title XVIII of the Social Security Act, 42 CFR USCA 1395 et seq., Federal regulations adopted pursuant thereto and HIM-15, except those provisions which implement Medicare, retrospective, as opposed to Medicaid's prospective, reimbursement system or those provisions which concern the relationship between the provider and Medicare intermediary or are modified by this Plan.
- 2) Bad debts, charity and courtesy allowance shall not be included in allowable costs except that bad debts that are attributed to cost sharing amounts as defined in 42 CFR 447.50 and 447.59 shall be allowable.
- 3) Allowable cost shall be categorized as follows: (The application is defined in Section III, Payment Determination).

SC: MA 03-014

EFFECTIVE DATE: 10/01/03

RO APPROVED: 05/26/04

SUPERSEDES: MA 02-006

a) Cost Subject to Standards:

- i) General Services: Nursing, Social Worker, and Activity Director and related cost.
- ii) Dietary
- iii) Laundry, Maintenance, and Housekeeping
- iv) Administration and Medical Records & Services

b) Cost Not Subject to Standards:

- i) Utilities
- ii) Special Services
- iii) Medical Supplies and Oxygen
- iv) Property Taxes and Insurance -- Building and Equipment
- v) Legal Fees

- c) Cost of Capital: The cost of capital reimbursement plan effective July 1, 1989 replaces the prior cost of capital and return on equity policy with one that reimburses costs on the basis of market returns for the current reasonable value of the assets. The plan reduces the wide disparity in the cost of capital payments for basically the same service and makes the cost of capital payment fairer to all participants in the program. The plan also bases reimbursement on investments in facilities of reasonable quality, and does not provide incentives for investment in unnecessarily expensive facilities.

The first step of the plan estimates a reasonable fair market rental value for nursing home beds and assigns each facility a "Deemed Asset Value" based on its number of beds and the fair market rental value of a bed. Secondly, each facility is assigned a "Deemed Depreciated Value" for its assets equal to its Deemed Asset Value less actual accumulated depreciation that the provider has reported in accordance with Medicare/Medicaid guidelines. The next step is to determine a market rate of return that will provide the incentives required to keep the industry reimbursement for the cost of capital will be the return on the Deemed Depreciated Value, expressed in terms of patient days.

SC: MA 99-012
EFFECTIVE DATE: 10/01/99
RO APPROVED: 03/10/00
SUPERSEDES: MA 98-009

This cost of capital methodology replaces the prior reimbursement for interest and return on equity. Reimbursement rates for leased facilities are limited to a factor based on the return for the Deemed Depreciated Value of the leased facilities and costs associated with facility leases will not be reimbursed separately. Lease costs associated with equipment rentals (separate from a facility lease) will be reflected in the affected cost centers. Effective October 1, 1993 non-related party home office building rent expense will be classified in the administrative cost center. Depreciation expense applicable to related party home office rental transactions will continue to be classified under cost of capital. The State will continue to provide a reimbursement for actual depreciation based on the original cost of the asset for those facilities put into operation prior to July 1, 1989. A facility's accumulated depreciation will be grandfathered in for that facility in the event of a sale or lease to a new operator. The Deemed Asset Value will be adjusted each year for inflation. The maximum increase that will be allowed will be reflected in the index of home owner's rental value, based on increases in the index of home owner's rental value over the latest three calendar years, as computed by the Division of Research and Statistics of the Budget and Control Board, based on the latest data published by the Bureau of Labor Statistics. However, a lesser amount of inflation may be granted by the Medicaid agency due to compliance with the Medicare upper limits test. 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).

1) Calculation of Base Period Asset Cost

To avoid the problem of market distortions, this plan selects the average of original costs for facilities established during 1980 and 1981 as the "Original Asset Cost" for determining the fair market rental value for a comparable service during federal cost year 1987-1988. Asset values are those reported by the operators on their original filings. Those two years were the latest prior to the freeze on the value of resales and the limit on interest and depreciation reimbursements. Two years, instead of one, were selected in order to broaden the size of the sample, and to obtain a fairer estimate of the base costs.

SC: MA 99-012

EFFECTIVE DATE: 10/01/99

RO APPROVED: 03/10/00

SUPERSEDES: MA 97-008

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

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

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

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

3) Calculation of "Deemed Depreciated Value"

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

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

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

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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 96%.

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	<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.

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

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

5) Additions To Facilities After 1981

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

6) Computation of Cost of Capital

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

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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%. 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.

SC: MA 00-015

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RO APPROVED: 03/08/01

SUPERSEDES: MA 99-012

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>	<u>X 1.49</u>
Deemed Asset Value FY 87-88	\$ 23,271
<u>Number of Beds</u>	<u>X 100</u>
Deemed Asset Value of Facility	2,327,100
Improvements Since 1981	0
<u>Accumulated Depreciation</u>	<u>(356,827)</u>
Deemed Depreciated Value	1,970,273
<u>Market Rate of Return</u>	<u>X 9.8%</u>
Annual Return for Facility	193,087
<u>Facility @ 98% Capacity*</u>	<u>35,770</u>
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%.

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RO APPROVED: 03/08/01
SUPERSEDES: MA 99-012

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.

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

d) 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:

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RO APPROVED: 03/10/00

SUPERSEDES: MA 95-018

- a) Depreciation expense of the prior owner.
- b) Interest expense which will be limited to the prior owner's expense.
- c) Prior owner's equity in the facility.

However, in the event of a sale or lease on and after July 1, 1989, the provider's (new owner) capital related cost will be limited to the cost of capital reimbursement received by the prior owner (i.e., cost of capital payment for the new owner will be the same as the old owner). No revaluation of assets will be recognized by the South Carolina Medicaid Program as a result of a sale.

No recapture of depreciation will be necessary from the prior owner unless the prior owner used accelerated depreciation in excess of the allowable straight line depreciation, or depreciation was overstated over the allowable straight line depreciation because of the application of a shorter useful life in calculating the depreciation.

II. Auditing

- E) All cost reports will be desk reviewed by the Medicaid Agency. The Provider will be notified of the desk review exceptions and the provider has the right to respond within fifteen (15) days.
- F) All cost reports are subject to on-site audit. Any overpayments determined as a result of on-site audits will be collected after issuing the final audit report and accounted for on the CMS-64 report no later than the second quarter following the quarter in which the final audit report is issued. The provider has the right to appeal the final audit decision through the appeal process. The appeal decision will be binding upon the SCDHHS.

III. Payment Determination

The rate cycle will be October 1 through September 30 and will be recomputed every twelve (12) months, utilizing the cost reports submitted in accordance with Section I, Cost Finding and Uniform Cost Reports, of the Plan.

SC: MA 05-008
EFFECTIVE DATE: 10/01/05
RO APPROVED: 11/16/05
SUPERSEDES: MA 04-007

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. Effective for services provided on and after April 8, 2011, these nursing facilities will receive ninety-seven percent (97%) of the October 1, 2010 weighted average industry rate. 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%.

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SUPERSEDES: SC 10-006

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REPORTING PERIOD: 10/01/08 through 09/30/09 DATE EFF. 04/08/12

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

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		0.00	0.00	
DIETARY		0.00	0.00	
LAUNDRY/HOUSEKEEPING/MAINT.		0.00	0.00	
SUBTOTAL	0.00	0.00	0.00	0.00
ADMIN & MED. REC	0.00	0.00	0.00	0.00
SUBTOTAL	0.00	0.00	0.00	0.00
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		0.00		0.00
SPECIAL SERVICES		0.00		0.00
MEDICAL SUPPLIES AND OXYGEN		0.00		0.00
TAXES AND INSURANCE		0.00		0.00
LEGAL COST		0.00		0.00
SUBTOTAL		0.00		0.00
GRAND TOTAL		0.00		0.00
INFLATION FACTOR	2.00%			0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)			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
REIMBURSEMENT RATE UNDER OCTOBER 1, 2010 METHODOLOGY				0.00
REIMBURSEMENT RATE @ 97% OF OCT. 1, 2010 METHODOLOGY				0.0

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RO APPROVED: 06/29/11

SUPERSEDES: SC 10-006

- B. 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.

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SUPPERSEDES: SC 09-007

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.

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4. For costs not subject to standards, the cost determined in step 2 will be allowed in determining the facility's rate.
5. Accumulate costs determined in steps 3 and 4.
6. Inflate the cost in step 5 by multiplying the cost in step 5, by the inflation factor. The maximum inflation factor that can be used will be that provided by the State of South Carolina Division of Research and Statistical Services and is determined as follows:
 - a. Proxy indices for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.) during the third quarter of 2010 were weighted by the expenditure weights of the long term care facilities. These eleven weighted indices are summed to one total proxy index for the third quarter of 2010.
 - b. Proxy indices are estimated for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.), during the third quarter of 2011 and then weighted by the same expenditure weights as in step a. These weighted proxy indices were summed to one total proxy index for the third quarter of 2011.
 - c. The percent change in the total proxy index during the third quarter of 2010 (as calculated in step a), to the total proxy index in the third quarter of 2011 (as calculated in step b), was 4.1%. Effective October 1, 2010 the inflation factor used was 2.0%.
7. The per patient day cost of capital will be calculated by dividing capital cost as determined under I.(F)(c) of this plan by actual patient days. However, if the facility has less than 96% occupancy, actual days will be adjusted to reflect 96% occupancy.
8. Cost Incentive - General Services, Dietary, and Laundry, Housekeeping, and Maintenance

If the facility's actual allowable costs for these three cost centers are below the sum of these three allowable cost standards, the facility will be eligible for a cost incentive of an amount equal to the difference between the sum of the standards and the sum of the facility's actual costs, up to 7% of the sum of the standards.
9. Profit will be allowed if the provider's allowable cost is lower than the standard as follows:
 - a. Administration and Medical Records & Services - 100% of difference with no limitation.

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SUPERSEDES: SC 09-007

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

10. For rates effective October 1, 2010, the provider's reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive and profit.
11. For rates effective for services provided on and after April 8, 2011, the provider's reimbursement rate will equal to 97% of the rate calculated in step 10.

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. Effective for transactions occurring on and after April 8, 2011, nursing facilities that qualify for a new facility rate via 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 will receive 97% of the rate calculated in accordance with the October 1, 2010 reimbursement methodology.

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

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

Based on a six (6) month's projected budget of allowable costs covering the first six months of the Provider's operation under the Medicaid program, the Medicaid agency will set an interim rate to cover the first six (6) months of operation or through the last day of the sixth (6th) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate

except that all standards to be used will be one hundred twenty percent (120%) of the standards for the size of facility to adjust for lower initial occupancy. The one hundred twenty percent (120%) adjustment is determined by considering the average eighty percent (80%) occupancy for the first six (6) months of operation of a new facility versus the minimum of ninety-six percent (96%) occupancy required for all facilities that have been in operation for more than six (6) months. Within ninety (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date.

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

- b) Payment for the first six months will be retrospectively adjusted to actual costs not to exceed 120% of the standards and actual occupancy.
- c) No inflation adjustment will be made to the first six (6) months cost.
- d) Effective on the first (1st) day of the seventh (7th) month of operation through the September 30 rate, the per diem costs effective July 1, 1994 will be adjusted to reflect the higher of:
 - 1. Actual occupancy of the provider at the last month of the initial cost report; or
 - 2. 90% occupancy.

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

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

A change in ownership will be defined as a transaction that results in a new operating entity. A purchase of the leased fixed assets by a lessee (owner of operating entity) will not be considered a change of ownership unless allowable Medicaid capital costs will be reduced (i.e., purchase price less than historical costs). Each change of ownership request will be reviewed individually to determine whether a six-month cost report will be required.

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SUPERSEDES: SC 10-006

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.

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SUPERSEDES: SC 08-017

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

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

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

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

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

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

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

4. 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.

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

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

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

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

G. Payment Determination for ICF/MR's

1. All ICF/MR's shall apply the cost finding methods specified under 42 CFR 413.24(d) to its allowable costs for the cost reporting year under the South Carolina State Plan. ICF/MR facilities will not be subject to the allowable cost definitions Q (A) through Q (K) as defined in the plan.
2. All State owned/operated ICF/MR's are required to report costs on the Medicare Cost Reporting Form 2552. For cost reporting periods beginning on or after July 1, 1986, all other ICF/MR's which are not operated by the State (S.C. Department of Disabilities and Special Needs) will file annual financial and statistical report forms supplied by the Medicaid Agency. All cost reports must be filed with the Medicaid Agency within one hundred twenty (120) days from close of each fiscal year.
3. ICF/MR's will be reimbursed on a retrospective cost related basis as determined in accordance with Medicare (Title XVIII) Laws, Regulations, and Policies adjusted for services covered by Medicaid (Title XIX).

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

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

- a) Room and board including all of the items necessary to furnish the individual's room (luxury items/fixtures will not be recognized as an allowable cost). 42 CFR \$483.470(b), (c), (d), (e), (f), and (g)(1).
- b) Direct care and nursing services as defined for each living unit of the facility. 42 CFR \$483.460(c).
- c) Training and assistance as required for the activities of daily living, including, but not limited to, toileting, bathing, personal hygiene and eating as appropriate. 42 CFR \$483.440(a).
- d) Walkers, wheelchairs, dental services, eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. If any of these services are reimbursable under a separate Medicaid program, the cost will be disallowed in the cost report (effective for cost reporting periods beginning July 1, 1989).
- e) Maintenance in good repair of dentures, eyeglasses, hearing aids, braces, and other aids prescribed for a resident by an appropriate specialist effective for cost reporting periods beginning July 1, 1989. 42 CFR \$483.470(g)(2).
- f) Therapy services including, but not limited to, speech, recreation, physical, and occupational, as prescribed by the resident's individual habilitation plan. 42 CFR \$483.430(b).
- g) Transportation services as required to provide other services including vehicles with lifts or adaptive equipment, as needed. The cost of ambulance services will not be included as part of allowable costs.
- h) Psychological services as described in 42 CFR \$483.430(b)(1) and (b)(5)(v).
- i) Recreational services as described in 42 CFR \$483.430(b)(1) and (b)(5)(viii).
- j) Social services as described in 42 CFR \$483.430(b)(1) and (b)(5)(vi).

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- 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 SCDDSN 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.

Effective for services provided on and after April 8, 2011, the swing bed rate will equal 97% of the October 1, 2010 swing bed rate.

I. Intensive Technical Services Reimbursement

Effective December 1, 2006, an enhanced rate of \$364.00 per patientday will be available for nursing facility level of care recipients who require more intensive technical services (i.e., those recipients who have extreme medical conditions which requires total dependence on a life support system). Effective for services provided on and after April 8, 2011, the enhanced rate will be \$353.08. In order to develop this rate, the SCDDSN reviewed budgeted cost information relating to the

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

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

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

K. Essential Public Safety Net Nursing Facility Supplemental Payment

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

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

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(1) Qualifications

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

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

and one of the following criteria:

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

(2) Upper Payment Limit Calculation

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

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

(3) Payment Methodology

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

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

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

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

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

L. Payment Assistance

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

M. Upper Limits

- 1. The Medicaid Agency will not pay more than the provider's customary charge for private-pay patients except governmental facilities that provide services free or at a nominal charge. These facilities will be reimbursed on a reasonable cost related basis.
- 2. Any limitation on coverage of cost published under 42 CFR 413.30 and 413.35 will be applied to payments for long-term care facility services.

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3. The cost of services, facilities and supplies furnished by organizations related by common ownership or control will not exceed the lower of the cost to the organization or the price of comparable services, facilities or supplies purchased elsewhere. The Medicaid Agency's cost report requires related organizations and costs to be identified and certified.
4. The Medicaid Agency may not pay more in the aggregate for long term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. If it is determined that SCDHHS is paying more in the aggregate for long term care services, then the Medicaid rate for each facility will be limited to the Medicare rate retroactive to the beginning of the contract period. Upper Payment Limits will be calculated and tested against the following three groupings - State owned/operated; Non-state owned/operated governmental facilities; and Privately owned/operated facilities.

N. Provider Participation

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

O. Payment in Full

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

P. Medicare Part A Coinsurance Days

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

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Q. Allowability of Certain Costs

A) Auto Expense:

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

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

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

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

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

B) Dues

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

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C) Legal Fees

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

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

D) Travel

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

E) Director Fees

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

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

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

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

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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.

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

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

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

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

1. The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent. No individual will have more than one full time equivalent (40 hour per week) job recognized in the Medicaid program.
2. No assistant operating executive will be authorized for a chain with 257 beds or less.

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

H) Management Fee

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

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

I) Other Benefits

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

J) Payroll Taxes and Benefits

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

K) Routine Laundry Services

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

SC 10-006

EFFECTIVE DATE: 10/01/10

RO APPROVED: 02/02/11

SUPERSEDES: SC 08-017

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 colusurance 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 FTE 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.

SC 10-006

EFFECTIVE DATE: 10/01/10

RO APPROVED: 02/02/11

SUPERSEDES: SC 08-017

N) Eden Alternative Expenses

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

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

O) Quality Initiatives Grant Awards

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

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

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

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RO APPROVED: 02/02/11
SUPERSEDES: SC 09-007

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

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

1. Insurance purchased from a commercial insurance company which provides coverage after a deductible or coinsurance provision has been met;
2. Insurance purchased from a limited purpose insurance company (captive);
3. Total self insurance; or
4. A combination of purchased insurance and self-insurance.

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

- No more than twelve months of claims expense will be allowed during a full cost reporting period;
- Professional liability punitive damage awards are not considered an allowable cost for South Carolina Medicaid reimbursement purposes.
- Effective October 1, 2007, free standing nursing facilities as well as chain nursing facilities must ensure that South Carolina specific data is used in claiming allowable insurance costs for its South Carolina nursing facilities.
- For cost reporting periods beginning on or after October 1, 2007, when a change is made from commercial insurance to one of the alternatives listed above or from one alternative to another, the provider must document and submit to the SCDEHS a comparative analysis which shows that the provider's choice results in a reasonable cost for the coverage offered and that the extent of the coverage is consistent with sound management practices. The provider's comparative analysis must be performed every three (3) years to assure consistent

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EFFECTIVE DATE: 10/01/10

RO APPROVED: 02/02/11

SUPERSEDES: SC 09-007

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

- 7 Providers that are currently operating under insurance coverage other than commercial insurance are required to perform a comparative analysis every three (3) years to assure consistent application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider must provide these analyses for review by the SCDHHS and/or the SAO. The analyses must include the information as reflected in HIM-15, section 2162.C. An insurance survey will be mailed to all contracting providers no later than March 31, 2008 to determine those providers that will be required to perform the comparative analysis and when it will be due.
- 8 Effective October 1, 2007, providers cannot switch between claims paid and claims paid with incurred but not reported expenses (IBNR) factor without prior authorization from the SCDHHS.

Insurance Purchased from a Commercial Insurance Company

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

Insurance Purchased from a Limited Purpose Insurance Company (Captive)

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

Total Self-Insurance

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

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RO APPROVED: 02/02/11
SUPERSEDES: SC 09-007

insurance test while those not specifically identified will be considered an administrative cost. In the event that the provider does not meet all of the "self-insurance" criteria as established in HIM-15, section 2162.7, the provider's allowable Medicaid reimbursable costs associated with insurance coverage will be limited to one of the following options:

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

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

Professional Liability Expense Only - Pool Payments

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

This payment will be made via a gross adjustment and Medicaid's portion of this payment will be determined based upon the Medicaid occupancy of the nursing facility during the cost-reporting period in which the claim is paid. Effective for professional liability claim payments made on and after April 8, 2011, only 97% 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.

SC 11-006

EFFECTIVE DATE: 04/08/11

RO APPROVED: 06/29/11

SUPERSEDES: SC 10-006

CONSENT TO ASSIGNMENT

WHEREAS, the South Carolina Department of Health and Human Services, 1801 Main Street, Post Office Box 8206, Columbia, South Carolina, 29202-8206, hereinafter referred to as "SCDHHS", entered into a contract with Ridgeview of the Midlands d.b.a. Ridgeview Manor Nursing Facility, 1645 Ridge Road, Hopkins, South Carolina, 29061, therein referred to as "Provider", with provider number 0787NF and Contract Number C 1 3733 N, on October 1, 2006, for the purchase and provision of Nursing Care.

NOW THEREFORE, SCDHHS and the below named Provider hereby consents to the assignment of all interests, rights, liabilities, responsibilities and obligations of the above named Provider, including any obligations under the Provider number stated above, under the above mentioned contract, together with any and all appendices and addenda thereto, for the remaining contract period to Countrywood Nursing Center, L.L.C., 1645 Ridge Road, Hopkins, South Carolina, 29061, provider number 0946NF, and Contract Number C 1 4877 N.

IN WITNESS WHEREOF, SCDHHS and below named Provider agree to the above referenced assignment as of the twenty-ninth day of November 2007.

SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES
"SCDHHS"

COUNTRYWOOD NURSING
CENTER, L.L.C.
"PROVIDER"

BY:

Emma Forkner
Emma Forkner
Director

BY:

Larry Haynes
Authorized Signature

Larry Haynes
Print Name

WITNESSES:

Sharon Glendon
Shondalyn Peltz

WITNESSES:

Marcell R. White
Danella J. Ashburn

CONTRACT

BETWEEN

THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

RIDGEVIEW OF THE MIDLANDS DBA RIDGEVIEW MANOR NURSING FACILITY

FOR THE PURCHASE AND PROVISION OF

NURSING CARE

DATED AS OF

OCTOBER 1, 2006

C 13733 N

R0307

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TESTIMONIUM.

20.

CONTRACT

BETWEEN

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

RIDGEVIEW OF THE MIDLANDS DBA RIDGEVIEW MANOR NURSING FACILITY

FOR THE PURCHASE AND PROVISION OF NURSING CARE.

This contract is entered into as of the first day of October 2006, by and between the South Carolina Department of Health and Human Services, 1801 Main Street, Post Office Box 8206, Columbia, South Carolina, 29202-8206, hereinafter referred to as "SCDHHS" and Ridgeview of the Midlands d.b.a. Ridgeview Manor Nursing Facility, 1645 Ridge Road, Hopkins, South Carolina, 29061, hereinafter referred to as "Provider".

RECITALS

WHEREAS, SCDHHS is the single state agency responsible for the administration in South Carolina of a program of Medical Assistance under Title XIX of the Social Security Act.

WHEREAS, the United States Department of Health and Human Services has allocated funds under Title XIX of the Social Security Act to SCDHHS for the provision of nursing care for eligible persons in accordance with the South Carolina State Plan for Medical Assistance.

WHEREAS, the Provider represents and warrants that it meets applicable standards as a provider of nursing care as specified by Title XIX of the Social Security Act, federal regulations promulgated pursuant thereto, and the South Carolina State Plan for Medical Assistance.

WHEREAS, the Provider desires to participate in the provision of nursing care under Title XIX of the Social Security Act.

NOW, THEREFORE, the parties to this contract, in consideration of the mutual promises, covenants, and stipulations set forth herein, agree as follows:

ARTICLE I

CONTRACT PERIOD

This Contract shall take effect as of October 1, 2006, and shall continue in full force and effect through September 30, 2011 unless otherwise terminated in accordance with Article VII hereof.

ARTICLE II

DEFINITIONS

As used in this contract, the following terms shall have the following meanings:

CMS: Centers for Medicare and Medicaid Services

Contract Period: For purposes of Article I only, the contract period shall be the effective date of the Contract through expiration date as stated. For purposes of Article IV, Section E only, the contract period will be defined as the rate period(s) applicable to the cost reporting period used to establish the Medicaid rate(s). For purposes of Article V, Section F only, the contract period will be the rate period as defined by the South Carolina State Plan.

Cost: The dollar amount of an expense to the Provider for the provision of any service pursuant to this contract.

DBA: Doing Business As

DHEC: South Carolina Department of Health and Environmental Control

FFP (Federal Financial Participation): Any funds, either Title or grant, from the Federal Government.

GAO: General Accounting Office

HIPAA: Health Insurance Portability and Accountability Act

HIM-15: A manual of guidelines and policies to implement Medicare regulations setting forth principles to determine the reasonable cost of Provider services. A "Provider Reimbursement Manual" published by the HCFA, publication HIM-15.

IMD: Institution for Mental Diseases

NF: Nursing Facility

NPI: National Provider Identifier

OBRA 87: Omnibus Budget Reconciliation Act of 1987.

OBRA 90: Omnibus Budget Reconciliation Act of 1990.

Ownership Interest: The possession of significant stock, an equity in the capital, or any interest in the profits of the Provider. For further definition see 42 CFR 455.101 (2004, as amended).

PEN: Parenteral and Enteral Nutrition.

Private Pay Resident: A nursing facility resident whose care is paid for by non-governmental funds. Governmental funds include, but are not limited to, Title XVIII payments, Title XIX payments, and Veterans Administration payments.

Program: The method for provision of Title XIX services to South Carolina recipients as provided for in the South Carolina State Plan for Medical Assistance and SCDHHS regulations.

Provider: The licensed and certified entity which operates a nursing facility.

Rate: The payment per recipient, per day to be made to a Provider for the contract period in accordance with the reimbursement methodology in the State Plan.

Recipient: A person receiving services from the Provider who has been determined eligible to receive services as provided for in the State Plan.

Routine Services: Regular room, dietary, and nursing services; minor medical and surgical supplies; and the use of equipment and facilities.

SCDHHS: South Carolina Department of Health and Human Services.

SCDHHS Appeal Regulations: Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 or S.C. Code Regs. 126-150 et seq. and S.C. Code Ann. §§1-23-310 et seq. (1976, as amended).

Social Security Act: Title 42, United States Code, Chapter 7, as amended.

South Carolina State Plan for Medical Assistance (The State Plan): A plan approved by the Secretary of USDHHS which complies with 42 USCA 1396a, and provides for the methodology for furnishing services to recipients pursuant to Title XIX.

Title XVIII: Title 42, United States Code, Chapter 7, subchapter XVIII, as amended. (42 USCA 1395 et seq.)

Title XIX: Title 42, United States Code, Chapter 7, subchapter XIX, as amended. (42 USCA 1396 et seq.)

USDHHS: United States Department of Health and Human Services.

Uniform Financial and Statistical Report: A formal statement made in a manner and form in accordance with this contract and as prescribed by SCDHHS of the costs of the Provider in operating the business of the Provider.

ARTICLE III

SCOPE OF SERVICES AND PROVIDER'S RESPONSIBILITY

The Provider agrees to provide skilled and/or intermediate nursing care as certified and in accordance with the terms of this contract. It is the responsibility of the Provider to pay all such costs associated with nurse aide training, testing and re-certification. It is the responsibility of the provider to pay all such costs associated with feeding assistant training. The provider must maintain documented proof of nurse aides' certification and training and feeding assistant training, as applicable, and report costs in such detail as described in the Nursing Aide Training and Testing Cost Center Chart of Accounts in the SENIORS cost reporting software. Nurse Aide training and testing costs will be cost settled each year beginning with the FYE September 30, 2003 cost reports. Feeding Assistant training costs will be cost settled each year beginning with the FYE September 30, 2004 cost reports. The SCDHHS will use patient days to determine Medicaid's share of the C.N.A. training and testing costs and the feeding assistant training costs to be reimbursed by the South Carolina Medicaid Program. This contract expressly incorporates by reference: (1) Title XIX of the Social Security Act, 42 USCA 1396 *et seq.*, OBRA '87, and federal regulations adopted pursuant to the Acts; (2) SCDHHS regulations; (3) Intermediate Sanctions for Medicaid Certified Nursing Home Act (Title 44, Chapter 6, Article 4 of the South Carolina Code of Laws); (4) the State Plan; (5) Medicaid Provider Manual - Nursing Facility Services; (6) SCDHHS Medicaid Nursing Home Accounting and Reporting Manual; (7) all applicable provisions of OBRA 90 regarding advance directives; and (8) Title XVIII of the Social Security Act, 42 USCA 1395 *et seq.*, federal regulations adopted pursuant thereto and HIM-15, except those provisions which implement Medicare's retrospective, as opposed to Medicaid's prospective, reimbursement system, or those provisions which concern the relationship between the Provider and Medicare intermediary or are modified by the State Plan or the terms of this contract. Should any of the above referenced statutes, regulations, policies, or manuals be amended during the life of this contract, said amended provisions, except where otherwise provided, shall become immediately applicable and binding upon the Provider.

ARTICLE IV

CONDITIONS FOR REIMBURSEMENT BY SCDHHS

SCDHHS agrees to purchase from the Provider and to pay for the services provided pursuant to this contract. The Provider and SCDHHS hereby agree that the total per diem rate per patient day, as determined in accordance with the provisions of the reimbursement methodology outlined in the State Plan, shall be the sum set forth on the Computation of Reimbursement Rate which shall be provided by the SCDHHS Division of Long Term Care Reimbursements. The Provider agrees that this rate shall be adjusted downward if not in compliance with the aggregate Medicare rates as required by 42 CFR 447.253 and 447.272 (2004, as amended). The Provider expressly understands that the total per diem rate is subject to audit and may be adjusted to a lower or higher amount. Claim for payment must be made in accordance with SCDHHS procedures and on such forms and in the manner prescribed by SCDHHS.

A. Clearance from the Office of Civil Rights

Certification for participation in the Medicare and Medicaid programs is contingent upon the Provider obtaining clearance from the Office for Civil Rights. If the Office for Civil Rights' approval has not been obtained prior to the effective date of this contract and if the Office for Civil Rights' approval is not obtained, reimbursement will be recouped as of the effective date of this contract.

B. Payment in Full

Payment by SCDHHS for services to a recipient under this contract, plus any co-payment required by SCDHHS to be paid by the recipient, shall constitute payment in full to the Provider and the Provider shall not bill, request, demand, solicit or in any manner receive or accept payment or contributions from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient except as may otherwise be allowed under federal regulations or in accordance with SCDHHS policy. Any collection of payment or deposits in violation of this section shall be grounds for termination of this contract and reimbursement for any services to recipients made after such collection or attempt to collect may be denied by SCDHHS and shall be subject to recoupment for any recipient payment made.

C. Third Party Liability

The Provider must make all reasonable efforts to collect from any health insurance policy a Medicaid recipient may have. Any payment from the insurance company must be shown on the Medicaid claim when submitted to SCDHHS or refunded to SCDHHS up to the amount of the payment if already paid. The Provider shall further contact the Director of Third Party Liability, SCDHHS, if contacted by an attorney for claim information and medical records concerning a Medicaid recipient. SCDHHS shall be advised in writing by the Provider upon receipt, or the potential for receipt, of any income or resources for the recipient within ten (10) calendar days of the Provider acquiring knowledge of such income or resources. SCDHHS or its designee shall have full access to financial records to determine if the third party collections have been refunded to Medicaid in accordance with this section. Failure by the Provider to collect available third party payments may result in recoupment of these payments by SCDHHS.

D. Conformity to Policies and Procedures

No payment by SCDHHS shall be made for services to a recipient unless the Provider has strictly conformed to the policies and procedures of SCDHHS including, but not limited to, recipient admissions, authorization for service and certification of service. All Medicaid recipients shall be certified for a level of care, either skilled or intermediate, before payment for service is authorized. The provision of services shall be in accordance with all applicable federal and state rules, regulations, and guidelines. Authority to certify level of care for the South Carolina Medicaid Program is retained solely by SCDHHS or its designees.

E. Similar Service Rates

The Provider agrees that the rate charged to SCDHHS for service to an eligible Medicaid recipient under this contract will not be greater than that charged for a similar service to a private pay patient. Any and all amounts received by the Provider from SCDHHS for services under this contract in excess of those rates charged to private pay patients for similar services for the contract period shall be subject to recoupment by SCDHHS through withholding and offset or any other appropriate means.

F. Billing for Dual Eligibility

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, specialty beds, 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. Pursuant to this, 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. However, when ancillary service costs are reimbursed as a 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.

Failure of the Provider to implement billing procedures for dually eligible ancillary services from the Medicare Program by January 1, 1995 will result in an adjustment to allowable costs.

G. Certification for Services

A physician must certify in accordance with federal regulations, that each recipient requires either skilled or intermediate services. Failure to comply with these regulations may subject the Provider to recoupment for recipient days not covered by physician certification. This recoupment cannot be levied by the Provider against the recipient.

H. Disallowances and Deferrals (Applies to state agencies only.)

SCDHHS shall notify the Provider of all federal disallowances and deferrals incurred by SCDHHS as a result of services rendered by the Provider for which the Provider was appropriated state funds. The Provider and SCDHHS shall prepare an appropriate response for submission to the appropriate federal agency. These disallowances shall be funded with non-federal Provider funds.

I. Public Funds as the State Share of Federal Financial Participation (if applicable)

To be considered as the State's share in claiming FFP, public funds must meet the conditions specified in accordance with Federal Regulation 42 CFR 433.51 (2004), as amended.

J. Donations (If applicable)

The Provider agrees to comply with 42 CFR 433 Subpart B, (2004), as amended, regarding any and all donations made by the Provider pursuant to this contract.

ARTICLE V

AUDITS AND RECORDS

All audits shall be performed in accordance with the generally accepted auditing standards of the American Institute of Certified Public Accountants. In the event that an audit report contains audit exceptions or disallowances, it is agreed by the parties hereto that the following procedures shall be used in making the appropriate audit adjustment(s):

A. Notice of Exceptions, Disallowances

Upon completion of a field audit, the Provider shall be furnished a written notice containing the adjustment for each exception and a statement of the amount adjusted for each exception. Either SCDHHS, the State Auditor's Office, or their designee shall make this determination. Such notice shall further state the adjusted per diem rate as a result of the audit. The total sum overpaid or underpaid shall be determined by taking the difference between the adjusted per diem rate and the contract rate and multiplying that difference by total eligible patient days covered. Either SCDHHS or the State Auditor's Office shall determine this total sum. In the case where a provider is overpaid, such payment is due to SCDHHS in the full amount of the sums overpaid within thirty (30) calendar days after receipt of the notice. In the case where a Provider is underpaid, the SCDHHS will submit a credit adjustment for payment purposes. Notice shall be sent to the Provider by certified mail. Audit disallowances shall be accepted as final unless appealed within thirty (30) calendar days after receipt of the notice of disallowance in accordance with SCDHHS appeals procedure. Payment shall be made within thirty (30) calendar days from the receipt of the notice of disallowance.

B. Disallowances - Appeals

In the event the Provider disagrees with the audit exceptions and disallowances, it may seek administrative appeal of such matters in accordance with the SCDHHS appeals procedures. Judicial review of any final agency decision pursuant to this contract shall be in accordance with S.C. Code Ann. §1-23-380 (1976, as amended) and shall be the sole and exclusive remedy available to either party except as otherwise provided herein. Provided, however, any administrative appeal shall be commenced by written notice as required by the SCDHHS appeals procedures.

In the event the Provider fails to file an appeal within thirty (30) calendar days of the challenged agency action or decision, any issue which could have been raised in such an appeal shall be final and not subject to challenge by the Provider in any other administrative or judicial proceeding.

C. Disallowed Sums, Set-off

Any provisions for appeal notwithstanding, the Provider and SCDHHS agree that should any audit(s) result in disallowance to the Provider, SCDHHS is authorized to recoup within thirty (30) calendar days from receipt of the notice of disallowance any and all funds owed to SCDHHS by means of withholding and/or offsetting such funds against any and all sums of money for which SCDHHS may be obligated to the Provider under this or any previous, current, and/or future contract.

D. Interest Provision - Provider (Does not apply to state agencies.)

The Provider and SCDHHS further agree that, in addition to the amount disallowed by audit being repaid to SCDHHS in accordance with this Article, the Provider shall pay interest on the disallowed amount with said interest accruing from the thirtieth (30th) calendar day following the date of receipt by the Provider of the final audit report. The interest to be paid by the Provider to SCDHHS shall be at the current prime rate plus two percentage (2%) points as established on the thirtieth (30th) calendar day following the issuance of the final report.

E. Interest Provision - SCDHHS

SCDHHS shall not pay interest on any monies due the Provider whether as a result of audit, underpayment, invalid action, final administrative or judicial decision, or any other contingency.

F. Time Limit for Issuance of the Final Audit Report

Any disallowance made pursuant to an on-site audit shall be made in the final audit report, which shall be issued within three (3) years of the close of the contract period, provided, however, if an audit was commenced prior to the expiration of the three (3) year period but a final audit report was not issued within three (3) years of the close of the contract period due to any fault of, or interference by, the Provider, then SCDHHS or its designee, shall have a reasonable time to complete the audit and make any appropriate disallowance of such Provider. (See Article II for the definition of the contract period per facility.)

G. Accuracy of Data and Reports

The Provider agrees that the Uniform Financial and Statistical Report, all statements, reports and claims, financial and otherwise, shall be certified as true, accurate, and complete, and the Provider shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this contract, and SCDHHS policy. The Provider further agrees to submit a Uniform Financial and Statistical Report, which shall be signed by the owner, not later than ninety (90) days after the end of the fiscal year end

(September 30). If such report, properly executed, has not been submitted by the aforementioned date, SCDHHS shall withhold all funds, or any portion thereof as determined by the Director of SCDHHS, due to the Provider until such report is properly submitted. However, a thirty (30) day extension of the due date 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 date. Sections of the Uniform Financial and Statistical Report which require disclosure of related parties and debts must be completed by the Provider in their entirety.

1. Maintenance of Records

The Provider must maintain an accounting system with supporting fiscal records adequate to assure that claims for funds are in accordance with this contract and all applicable laws, regulations, and policies. The Provider further agrees to retain all financial and programmatic records, supporting documents, statistical records, and other records of recipients relating to the delivery of nursing care under this contract, and as further required by SCDHHS, for a period of six (6) years after the last payment made under this contract (including any amendments and/or extensions to the contract). If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. This provision is applicable to any subcontractor and must be included in all subcontracts. (See Article II for the definition of the contract period per facility.)

2. Inspection of Records

At any time during normal business hours and as often as SCDHHS, the State Auditor's Office, the Office of the Attorney General, the Comptroller General, GAO, and USDHHS and/or any of the designees of the above may deem necessary during the contract period (including any amendments and/or extensions to the contract) and for six (6) years thereafter, the Provider shall make all program and financial records and service delivery sites open to the representatives of USDHHS, the Comptroller General, GAO, the State Auditor, the State Attorney General's Office, SCDHHS and/or any designees of the above. SCDHHS, USDHHS, the Comptroller General, GAO, the State Auditor's Office, the Office of the Attorney General and/or the designees of any of the above shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with Provider clients and employees and do on-site reviews of all matters relating to service delivery as specified by this contract. If any litigation, claim or other action involving the records has been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. This provision is applicable to any subcontractor and must be included in all subcontracts. (See Article II for the definition of the contract period per facility.)

3. Client Access

The Provider must allow immediate access to a resident's individual physician, the State Long Term Care Ombudsman, and/or any representative of USDHHS, SCDHHS, the Department of Mental Health, the Department of Disabilities and Special Needs and any other representative of the State involved in the care of the resident to such resident at any given time.

4. Exchange of Information

The Provider authorizes and consents to the free exchange of all information which is common to Title XIX and Title XVIII, both to and from the Title XVIII Fiscal Intermediary. Such information includes, but is not limited to, cost reports, audit reports and salary scales. The Provider agrees that no further separate authorizations shall be required and the Provider's Title XVIII Fiscal Intermediary is authorized pursuant to this provision of this contract to release and provide, upon request of SCDHHS, copies of such records, information, data, reports, and all other documents as shall be required. The Provider agrees to furnish SCDHHS, upon request, all records, surveys, audits, reports, and other information provided to the Provider by the Title XVIII Fiscal Intermediary.

5. Ownership Information (Does not apply to state agencies)

In accordance with 42 CFR 455.104 (2004, as amended), the Provider agrees to provide full and complete ownership and disclosure information with this contract and to report any ownership changes within thirty-five (35) calendar days to SCDHHS, Division of Contracts. Failure by the Provider to disclose this information shall result in termination of this contract.

6. Information Related to Business Transactions (Does not apply to state agencies)

The Provider agrees to furnish to SCDHHS or to USDHHS information related to significant business transactions as set forth in 42 CFR 455.105 (2004, as amended). Failure to comply with this section may lead to denial or termination of Provider participation.

ARTICLE VI

PERSONAL NEEDS FUNDS

Residents have the option to deposit their personal funds with the Provider and the Provider shall be responsible for safeguarding and accounting for these funds. The Provider must have written authorization from the resident, or a responsible person in the event the resident is not capable or is incompetent to give authorization, for handling of the personal funds.

The Provider must administer the personal needs funds of each Medicaid recipient in accordance with the provisions of the Medicaid Provider Manual – Nursing Facility Services and all applicable federal and state laws and regulations. Personal needs funds are to be used for the recipient's needs not related to a Title XIX covered service and shall be kept in a separate bank account, or savings and loan account to be established by the Provider. Where OBRA 87 amended any of the above provisions, the provisions of OBRA 87 shall prevail.

ARTICLE VII

TERMINATION OF CONTRACT

A. Termination for Lack of Funding

The parties hereto covenant and agree that their liabilities and responsibilities, one to another, shall be contingent upon the availability of federal and state funds for the funding of the Title XIX Program and that this contract shall be terminated if sufficient funding is not available. SCDHHS shall have the sole discretion for determining the availability of such federal and state funds.

B. Termination for Noncompliance with the Drug-Free Workplace Acts

In accordance with S.C. Code Ann §44-107-60 (1976, as amended), and 45 CFR Part 76, Subpart F (2004, as amended), this contract is subject to immediate termination, suspension of payment, or both if the Provider fails to comply with the terms of the State or Federal Drug-Free Workplace Acts.

C. Termination for Breach of Contract

This contract may be canceled and terminated by either party at any time within the contract period whenever it is determined by such party that the other party has materially breached or otherwise materially failed to comply with its obligations hereunder. This Section applies to all of the amended and additional requirements of OBRA 87 including the preadmission screening and annual resident review requirements as to both Medicaid and non-Medicaid patients and all of the amended and additional requirements of OBRA 90 regarding advance directives.

D. Termination for Breach of Previous Contracts or Non-payment of Previous Audit Exceptions

This contract may be canceled and terminated by SCDHHS at any time within the contract period if the Provider, after exhaustion of all administrative and judicial appeals, has failed to make payment in full to SCDHHS for audit disallowances pursuant to any previous contract between the parties or if the Provider has failed to comply with the maintenance and inspection of records requirements of any previous contract between the parties.

E. Insolvency (Does not apply to state agencies)

This contract is voidable and subject to immediate termination by SCDHHS upon the Provider's insolvency, including the filing of proceedings in bankruptcy.

F. Contravention of Collection of Payments or Failure to Disclose Information

This contract may be canceled and terminated by SCDHHS at any time should the Provider fail to meet the specific conditions applicable to collections of payments in accordance with Article IV, Section B of this contract or the conditions for disclosure in accordance with Article V, Section G, Subsections 5 and 6 of this contract.

G. Termination for Loss of Licensure or Certification (If applicable).

In the event that the Provider loses its license to operate as a nursing facility from the South Carolina Department of Health and Environmental Control, this contract shall terminate as of the date of delicensure. Further, should the Provider lose its certification to participate in the Title XVIII and/or Title XIX program, as applicable, this contract shall terminate as of the date of such decertification. Further written notification of termination under this Section may be sent but is not required.

H. Termination by Either Party

Either party may terminate this contract upon providing the other party with thirty (30) days written notice of termination. Such termination shall be sent by Certified Mail, Return Receipt Requested, and be effective thirty (30) days after the date of receipt.

I. Notice of Termination

In the event of any termination of the contract under this Article, the party terminating the contract shall give notice of such termination in writing to the other party. Notice of termination shall be sent by certified mail, return receipt requested. If terminated pursuant to Sections G and/or D of this Article, termination shall be effective thirty (30) days after the date of receipt unless otherwise provided by law. If terminated pursuant to Sections A, B, E, and/or F of this Article, termination shall be effective upon receipt of such notice. **This Section does not apply to Section G of this Article.**

J. Care of Recipients after Notice of Termination

In the event that this contract is terminated prior to its expiration date, it shall be the Provider's responsibility to assess each patient's/resident's continuing care needs. If continuing health care in the facility is not necessary, the attending physician must discharge the patient/resident. For patients/residents needing continuing nursing home care, the Provider's patient care responsibility shall not terminate until appropriate alternate placement is effected. However, until actual discharge of the patient, the Provider shall continue to be reimbursed under this contract for each patient receiving care as long as FFP is available. The Provider and SCDHHS shall cooperate to expeditiously find alternate placement for patients after termination of this contract.

ARTICLE VIII

APPEALS PROCEDURES

If desk review adjustments are made by SCDHHS to the Provider's cost report, the Provider may submit objections in writing to SCDHHS and request a reconsideration of the desk review adjustments within fifteen (15) days of written notice from SCDHHS. SCDHHS will review the information and make any applicable adjustments which it feels are necessary and notify the Provider of such. Any adjustment to the per diem rate shall have no effect upon cost standards.

If any dispute shall arise under the terms of this contract, the sole and exclusive remedy shall be the filing of a Notice of Appeal within thirty (30) days of receipt of written notice of SCDHHS's action or decision which forms the basis of the appeal. Administrative appeals shall be in accordance with SCDHHS's regulations R 126-150, et seq., Code of Laws of South Carolina (1976), Volume 27, as amended, and in accordance with the Administrative Procedures Act, §§ 23-310 et seq., Code of Laws of South Carolina (1976), as amended. Judicial review of any final SCDHHS administrative decisions shall be in accordance with § 23-380, Code of Laws of South Carolina (1976), as amended.

ARTICLE IX

COVENANTS AND CONDITIONS

In addition to all other stipulations, covenants, and conditions contained herein, the parties to this contract agree to the following covenants and conditions:

A. Applicable Laws and Regulations:

The Provider agrees to comply with all applicable federal and state laws and regulations including constitutional provisions regarding due process and equal protection of the laws and including, but not limited to:

1. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970, as amended (U.S.C. 7401, et seq.).
2. Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 CFR Part 80 (2004, as amended). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80, the Provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
3. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e) in regard to employees or applicants for employment.

4. Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. 794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84, (2004, as amended).
5. The Age Discrimination Act of 1975, as amended, (42 U.S.C. 6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.
6. The Omnibus Budget Reconciliation Act of 1981, P.E. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.
7. Americans with Disabilities Act (42 U.S.C. Sections 12101 et seq.), and regulations issued pursuant thereto, 42 CFR Parts 35 and 36 (2004, as amended).
8. Drug Free Workplace Acts, S.C. Code Ann. §§44-107-10 et seq. (1976, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 76, Subpart F (2004, as amended).

B. Employees of Provider

No services required to be provided under this contract shall be provided by anyone other than the Provider or the Provider's subcontractor (with the approval of SCDHHS).

C. Employment of Personnel

In all hiring or employment made possible by or resulting from this contract, the Provider agrees that (1) there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin, and that (2) affirmative action shall be taken to insure that applicants are employed and that employees are treated during employment without regard to their handicap, age, race, color, religion, sex, or national origin. This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Provider further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, or national origin. All inquiries made to the Provider concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the Provider concerning employment made possible as a result of this contract shall conform to federal, state, and local regulations.

D. Information on Persons Convicted of Crimes

The Provider agrees to furnish SCDHHS or to the USDIHHS information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII), Medicaid (Title XIX), or the Social Services Block Grant program as set forth in 42 CFR 455.106 (2004, as amended). Failure to comply with this requirement may lead to termination of this contract.

E. Insurance (Does not apply to state agencies.)

The Provider shall maintain, throughout the performance of its obligations under this contract, a policy or policies of Worker's Compensation insurance with such limits as may be required by law, and a policy or policies of general liability insurance insuring against liability for injury to, and death of, persons and damage to, and destruction of, property arising out of or based upon any act or omission of the Provider or any of its subcontractors or their respective officers, directors, employees or agents. Such general liability insurance shall have limits sufficient to cover any loss or potential loss resulting from this contract.

It shall be the responsibility of the Provider to require any subcontractor to secure the same insurance as prescribed herein for the Provider. In addition, the Provider shall indemnify and save harmless SCDHHS from any liability arising out of the Provider's untimely failure in securing adequate insurance coverage as prescribed herein. All such coverages shall remain in full force and effect during the initial term of the contract and any renewal thereof.

F. Proof of Insurance (Does not apply to state agencies.)

Any time, at the request of SCDHHS or its designee, the Provider shall provide proof of insurance as required in the insurance section of this Article whereby the Provider shall be the named insured on the insurance policy or policies.

G. Safeguarding Information

The Provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX services in accordance with 42 CFR Part 431, Subpart F, (2004, as amended), SCDHHS's regulations R. 126 - 170, et seq., Code of Laws of South Carolina (1976), Volume 27, as amended, and all other applicable state and federal laws and regulations and shall restrict access to, and use and disclosure of, such information in compliance with said laws and regulations.

H. Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

I. Restrictions on Lobbying

In accordance with 31 U.S.C. 1352, funds received through this contract may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all subcontractors.

J. Debarment/Suspension (Does not apply to state agencies.)

The Provider agrees to comply with the applicable provisions of 45 CFR Part 76 (2004, as amended), pertaining to debarment and/or suspension.

K. Reporting of Fraudulent Activity

If at any time during the term of this contract, the Provider becomes aware of or has reason to believe by whatever means that, under this or any other program administered by SCDHHS, a recipient of or applicant for services, an employee of the Provider or SCDHHS, and/or subcontractor or its employees, have improperly or fraudulently applied for or received benefits, monies, or services pursuant to this or any other contract, such information shall be reported in confidence by the Provider directly to SCDHHS.

L. Integration

This contract shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved pursuant to Section W of this Article.

M. Governing Law

It is mutually understood and agreed that this contract shall be governed by the laws of the State of South Carolina both as to interpretation and performance.

N. Conflict of Laws

In the event of a conflict in the requirements of Title XVIII and Title XIX, the provisions of Title XIX shall apply. In the event of conflict in the requirements of this contract and Title XVIII requirements, principles and policies, the provisions of this contract shall apply. In the event of a conflict in the requirements of a SCDHHS Policy Manual and the State Plan, the State Plan shall apply.

O. Severability

Any provision of this contract prohibited by the laws of the State of South Carolina shall be ineffective to the extent of such prohibition without invalidating the remaining provisions of this contract.

P. Non-Waiver of Breach

The failure of SCDHHS at any time to require performance by the Provider of any provision of this contract or the continued payment of the Provider by SCDHHS shall in no way affect the right of SCDHHS to enforce any provision of this contract; nor shall the waiver by SCDHHS of any breach of any provision hereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself.

Q. Non-Waiver of Rights

SCDHHS and the Provider hereby agree that the execution and any performance pursuant to this contract does not constitute a waiver, each to the other, of any claims, rights, or obligations which shall or have arisen by virtue of any previous agreement between the parties. Any such claims, rights, or obligations are hereby preserved, protected, and reserved.

R. Automatic Assignment of Contract

Pursuant to 42 CFR 442.14, (2004, as amended) when there is a change of ownership in this nursing facility, the SCDHHS will automatically assign this contract to the new owner upon execution of a consent to assignment by both parties.

S. Legal Services (Does not apply to state agencies)

No attorney-at-law shall be engaged through use of any funds provided by SCDHHS pursuant to the terms of this contract. Further, with the exception of attorney's fees awarded in accordance with S.C. Code Ann. §15-77-300 (1976, as amended), SCDHHS shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the Provider. This covenant and condition shall apply to any and all suits, legal actions, and judicial appeals of whatever kind or nature to which the Provider is a party.

T. Venue of Actions

Any and all suits or actions for the enforcement of the obligations of this contract and for any and every breach thereof, or for the review of a SCDHHS final agency decision with respect to this contract or audit disallowances, and any judicial review sought thereon and brought pursuant to the S.C. Code Ann. §1-23-380 (1976, as amended) shall be instituted and maintained in any court of competent jurisdiction in the County of Richland, State of South Carolina.

U. Place of Suit

Any action at law, suit in equity, or judicial proceeding for the enforcement of this contract or any provision thereof shall be instituted only in the courts of the State of South Carolina.

V. Attorney's Fees (Does not apply to state agencies.)

In the event that SCDHHS shall bring suit or action to compel performance of or to recover for any breach of any stipulation, covenant, or condition of this contract, the Provider shall and will pay to SCDHHS such attorney's fees as the court may adjudge reasonable in addition to the amount of judgement and costs.

W. Amendment

No amendment or modification of this contract shall be valid unless it shall be in writing and signed by both parties hereto.

X. Amendment Due to the Unavailability of Funds

SCDHHS shall have the right to amend the total dollar amount reimbursed under this contract without the consent of the Provider, when the amendment is due to the unavailability of funds and SCDHHS is responsible for providing the matching funds. SCDHHS shall have the sole authority to determine the percentage of any reduction in the dollar amount of this contract. The amendment shall become effective thirty (30) days from the date of written notification from SCDHHS informing the Provider of the reduction/amendment or upon the signature of both parties thereto, whichever is earlier. SCDHHS shall have the sole authority for determining lack of availability of such funds.

Y. Extension

At the end of the term of this contract, SCDHHS shall have the option to extend or renew this contract upon the same terms and conditions as contained herein for a period not to exceed one year, provided, however, that any rate adjustment(s) shall be negotiated and set forth in writing and signed by both parties pursuant to Section W of this Article.

Z. Subcontracts

Unless otherwise expressly authorized in writing, all services to be provided hereunder shall be provided by the Provider directly and no subcontract for the provision of such services shall be entered into by the Provider without the written approval of SCDHHS.

AA. Staff Leasing Services Companies (Does not apply to state agencies.)

The Provider shall not engage the services of any Staff Leasing Services Company pursuant to S.C. Code Ann. Section 40-68-10 (1976) et seq. to perform any services required under the terms and conditions of this contract without the express written consent of SCDHHS. Unauthorized use of a Staff Leasing Services Company by the Provider to fulfill the terms and conditions of this contract may result in termination of the contract.

BB. Copyrights

If any copyrightable material is developed in the course of or under this contract, SCDHHS shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for SCDHHS purposes.

CC. Safety Precautions

SCDHHS and USDHHS assume no responsibility with respect to accidents, illnesses, or claims arising out of any activity performed under this contract. The Provider shall take necessary steps to insure or protect its recipients, itself, and its personnel. The Provider agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

DD. Procurement Code

When applicable, the Provider must comply with the terms and conditions of the South Carolina Consolidated Procurement Code in the acquisition of equipment and supplies and in all subcontracts.

EE. Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

FF. Equipment (if applicable)

Equipment is defined as an article of tangible property that has a useful life of more than one year and an acquisition cost of five thousand dollars (\$5,000) or more. Title to all equipment purchased with funds provided under this contract shall rest with the Provider as long as the equipment is used for the program for which it was purchased. SCDHHS shall be notified and instructions will be issued by SCDHHS pertaining to the disposition of the property.

GG. Single State Agency Responsible for Medicaid

SCDHHS is the single state agency responsible for the administration in South Carolina of a program of Medical Assistance under Title XIX of the Social Security Act (42 USC, Chapter 7, as amended). All final decisions and determinations regarding the administration of the Medicaid program shall be made by SCDHHS.

HH. National Provider Identifier

The HIPAA Standard Unique Health Identifier regulations (45 CFR 165 Subparts A & D) require that all covered entities (health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

Pursuant to the HIPAA Standard Unique Health Identifier regulations (42 CFR 165 Subparts A & D), and if the provider is a covered health care provider as defined in 42 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.

IN WITNESS WHEREOF, SCDHHS and the Provider, by their authorized agents, have executed this contract as of the first day of October 2006.

SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

"SCDHHS"

RIDGEVIEW OF THE MIDLANDS
DBA RIDGEVIEW MANOR
NURSING FACILITY
"PROVIDER"

BY:

Robert M. Kerr
Robert M. Kerr
Director

BY:

Rhonda Starkie
Authorized Signature

Rhonda Starkie
Print Name

WITNESSES:

Jean Y. Mance
Sharon Kluender

WITNESSES:

Stacy Buchanan
Donald Jensen

SURETY BOND

I certify that the necessary Surety bond is in effect to cover all personal needs funds in accordance with Article VI of this contract.

F. M. Cord
Signature

CONTRACT

BETWEEN

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

THE SOUTH CAROLINA STATE AUDITOR'S OFFICE

FOR THE PURCHASE AND PROVISION OF

AGREED-UPON PROCEDURE ACTIVITIES RELATED TO MEDICAID
INSTITUTIONAL PROVIDERS

DATED AS OF

JULY 1, 2011

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TESTIMONIUM

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APPENDIX A.

CONTRACT
BETWEEN
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
SOUTH CAROLINA STATE AUDITOR'S OFFICE

FOR THE PURCHASE AND PROVISION OF AGREED-UPON PROCEDURES
ACTIVITIES RELATED TO MEDICAID INSTITUTIONAL PROVIDERS.

This Contract entered into as of the first day of July 2011, by and between the South Carolina Department of Health and Human Services, 1801 Main Street, Post Office Box 8206, Columbia, South Carolina, 29202-8206, hereinafter referred to as "SCDHHS" and the South Carolina State Auditor's Office, 1401 Main Street, Suite 1200, Columbia, South Carolina, 29201, hereinafter referred to as "SAO".

RECITALS

WHEREAS, SCDHHS is the single state agency responsible for the administration in South Carolina of the Medical Assistance Program under Title XIX of the Social Security Act and makes all final decisions and determinations regarding the administration of the Medicaid Program;

WHEREAS, SCDHHS desires, further to comply with 42 CFR 431.10(e) (2010, as amended) and 42 CFR 447.202 (2010, as amended);

WHEREAS, SCDHHS receives state and federal funds to administer the Medicaid Program;

WHEREAS, pursuant to S.C. Code Ann. §11-7-20(A) (1976, as amended) all State agencies and entities supported partially or entirely by public funds are subject to audit by or under the oversight of the State Auditor, except as otherwise specifically provided by law. The State Auditor, to the extent practicable and consistent with his overall responsibility, shall audit or cause to be audited each State agency and entity annually.

WHEREAS, SCDHHS and SAO have a common and concurrent interest in ascertaining that the expenditure of Medicaid funds is in accordance with the Provider contracts and the State Plan;

WHEREAS, SCDHHS and SAO mutually recognize that information/data available to one party may be beneficial to the other party in its general administration and protection of the integrity of the Medicaid Program, thus they agree that coordination and cooperation between them shall serve the best interests of both agencies;

NOW, THEREFORE, the parties to this Contract, in consideration of the mutual promises, covenants, and stipulations set forth herein, agree as follows:

ARTICLE I

CONTRACT PERIOD

This Contract shall take effect as of July 1, 2011, and shall unless sooner terminated in accordance with Article VII hereof, continue in full force and effect through June 30, 2012.

ARTICLE II

DEFINITION OF TERMS AND ACRONYMS

As used in this Contract, the following terms shall have the following defined meanings:

Agreed-Upon Procedures: Procedures performed by an independent auditor(s) in accordance with attestation standards established by the American Institute of Certified Public Accountants; to determine if the rate or amount of reimbursement to a Provider complies with:

- A. The South Carolina State Plan for Medical Assistance.
- B. The applicable contract between SCDHHS and the Medicaid Provider.
- C. All applicable state and federal laws and regulations.

An understanding of the procedures is agreed to by the audit client (SCDHHS).

CFR: Code of Federal Regulations.

CMS: Centers for Medicare and Medicaid Services.

Federal Financial Participation (FFP): Any funds, either title or grant, from the Federal Government.

GAO: Government Accountability Office.

HIPAA: Health Insurance Portability and Accountability Act of 1996, as amended, along with its attendant regulations.

Medicaid Program: The method of provision of Title XIX services to South Carolina Recipients as provided for in the South Carolina State Plan for Medical Assistance and SCDHHS regulations.

Medicaid Provider: Entity, appropriately certified, if applicable, which contracts or enrolls to provide services under the Title XIX Program.

Policies: The general principles by which SCDHHS is guided in its management of the South Carolina State Plan for Medical Assistance, as further defined by SCDHHS promulgations and by state and federal rules and regulations.

Program: The method of provision of Title XIX services to South Carolina Recipients as provided for in the South Carolina State Plan for Medical Assistance and SCDHHS regulations.

SAO: State Auditor's Office.

Social Security Act: Title 42, United States Code, Chapter 7, as amended.

SCDHHS: South Carolina Department of Health and Human Services.

SCDHHS Appeal Regulations: Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 at S.C. Code Ann. Regs. § 126-150 et seq. and S.C. Code Ann. § 1-23-310 et seq. (1976, as amended).

South Carolina State Plan for Medical Assistance (State Plan): A comprehensive written commitment by SCDHHS, submitted under section 1902(a) of the Social Security Act, to administer or supervise the administration of the Medicaid Program in accordance with federal requirements.

Title XIX (Medicaid): Title 42, United States Code, Chapter 7, Subchapter XIX, as amended. (42 U.S.C. §1396 et seq.)

USDHHS: United States Department of Health and Human Services.

ARTICLE III

SAO RESPONSIBILITIES

- A. The SAO shall provide the SCDHHS Agency Director and the Director of the Office of Internal Audits a consolidated list of recommended engagements of provider contracts engagements and selection criteria in September of each year for the subsequent year contract period. This list should include uncompleted engagements and engagements of the current contract period.
- B. SAO shall be responsible for:
 1. Conducting agreed-upon procedures engagements of Medicaid cost reports for nursing facilities, federally qualified health care centers (FQHC), free-standing residential treatment facilities (RTF), and home health providers as requested by SCDHHS. The agreed-upon procedure engagements shall be conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants.
 2. Determining the materiality limits for the selection of and adjustment to costs or areas tested, or as otherwise directed by SCDHHS.
 3. Conducting all engagements to determine if the reimbursement rate or amount is in accordance with the provisions of the provider contracts, State Plan, and state and federal laws and regulations.
 4. Simultaneously forwarding copies of all "Final" agreed-upon procedures reports to the SCDHHS and the provider.
 5. Referring any questionable practice or fraudulent activity relative to the provision of Medicaid services to the SCDHHS Agency Director and upon request, to the Attorney General, providing further detailed information relative to said matters when requested.
 6. Representing the SCDHHS in appeal proceedings related to provider appeals of adjustments contained in the agreed-upon procedures reports.

Preparation of appeals packages and compilation of all additional documentation required as part of the appeal proceedings will be included as part of this representation.

- C. SAO shall provide the SCDHHS Agency Director and the Director of the Office of Internal Audits in October an annual activity report comparing planned activity of the prior contract year with actual work completed. The activity report should include extent of planned activity accomplished (i.e., draft reports issued, final reports issued, agreed-upon procedure engagements in process on September 30 and other information considered pertinent by the SAO concerning previous year's activity.)
- D. Nursing Facility Agreed-Upon Procedure Requirements:
 - 1. The SAO will perform agreed-upon procedures involving two cost report periods. For non-hospital based/related nursing facilities, the periods will be defined as the cost report period which was used to set the provider's Medicaid rate in effect at the time the field work for the engagement is initiated, plus the preceding cost report period. For hospital based/related nursing facilities, the periods will be defined as the two most recently audited Medicare hospital cost reports. For non-hospital based/related nursing facilities, the SAO will be required to issue the final reports of the two cost report periods no later than three (3) years after the end of the closed rate period that is associated with the preceding cost report period. For hospital based/hospital related nursing facilities, the SAO will be required to issue the final report no later than one (1) year after the receipt of the audited Medicare hospital cost report.
 - 2. Agreed-upon procedure activities must be performed for each nursing facility at least once out of every four (4) consecutive cost reporting periods.
 - 3. Agreed-upon procedure activities should be performed more frequently if previously issued reports identify significant problems.
 - 4. These restrictions do not apply in relation to any procedures initiated subsequent to or in relation to any investigation of fraud.

ARTICLE IV

SCDHHS RESPONSIBILITIES

- A. SCDHHS shall, upon resolution of any concerns, provide SAO a letter of concurrence as to Medicaid providers selected.
- B. SCDHHS shall be responsible for:
 - 1. Conducting desk reviews of Medicaid (Nursing Facility, Federally Qualified Health Care Centers (FQHC), Home Health and free-standing residential treatment facility (RTF)) provider cost reports, if applicable.
 - 2. Deriving appropriate settlements resulting from desk audits.

3. Informing the SAO of any unusual or questionable issues arising from desk audits.
 4. Establishing interim rates for reimbursement of the aforementioned Medicaid providers.
 5. Forwarding promptly to the SAO copies of all executed contracts, desk audit adjustments, rate revisions, Medicaid Bulletins, settlement agreements, State Plan amendments, notice of contract terminations, and related documents necessary for agreed-upon procedure engagement purposes of the aforementioned providers.
 6. Reviewing all "Draft" reports received from the SAO and submitting any written comments within the required ten (10) day period.
 7. Determining appropriate action resulting from agreed-upon procedure activities conducted or subcontracted through the SAO.
 8. Adjusting any account receivable which must be changed as a result of an agreed-upon procedures engagement and Appeals decision and advising the SAO in a timely manner of all such adjustments.
 9. Providing staff to address specific, technical appeal questions related to the rate setting methodology and other reimbursement issues as requested by the SAO.
 10. Referring any special requests for Medicaid agreed-upon procedure engagements to the SAO.
- C. After receipt and approval of the monthly reimbursement invoice, SCDHHS shall comply with the 2011-2012 State Appropriations Act.

ARTICLE V

CONDITIONS FOR REIMBURSEMENT BY SCDHHS

A. Method of Reimbursement

SAO shall submit a monthly reimbursement invoice to SCDHHS in accordance with the 2011-2012 State Appropriations Act as it relates to the SAO. Bills shall be submitted to:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

All June billing must be submitted July 5th for fiscal month 13 processing either as actual expenditures or best estimate. All final billings must be received within ninety (90) days of the end of the contract period. Any invoices received after this period will not be paid without the approval of the SCDHHS Deputy Director for Finance and Administration.

B. Non-Federal Share of Costs

SAO agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable and necessary cost for the provision of administrative services to the Medicaid Program under this Contract prior to submitting invoices for payment under this Contract. Documentation of the non-federal expenditures necessary to support the invoices for reimbursement must be maintained by SAO and are subject to audit by SCDHHS. SCDHHS may withhold and/or recoup reimbursements if Certified Public Expenditures (CPE) are not adequately documented. The required total estimated state appropriated funds and/or funds derived from tax revenue to be expended by SAO as a Certified Public Expenditure (CPE) are Five Hundred Thousand Dollars (\$500,000). As required by 45 CFR Part 201.5 (2010, as amended) all funds expended for the non-federal share of this Contract must be in compliance with 42 CFR Part 433 Subpart B (2010, as amended). Such non-federal funds must be actually expended for the provision of services to be provided under this Contract.

C. Cost Report

In lieu of filing an annual cost report, SAO shall incorporate the following certification statement in each of its monthly reimbursement requests:

I do solemnly swear (or affirm) that I have examined the information contained in this request or report. That all information has been prepared from the books and records of SAO. That the aforesaid information is true and correct to the best of my knowledge and belief; and, that no other request for reimbursement from other federal and/or state funds has been made nor has any other reimbursement been received, applied for, nor will they be applied for, for the services herein described. That SAO has on file the proper documentation to support this request for reimbursement. And, that the costs represented are true costs incurred during the period of this request.

This statement must be signed and dated by a finance person dually authorized by SAO.

D. Public Funds as the State Share of Federal Financial Participation

To be considered as the state's share in claiming FFP, public funds must meet the conditions specified in accordance with Federal Regulation 42 CFR 433.51 (2010, as amended).

E. Donations

SAO agrees to comply with 42 CFR 433 Subpart B, (2010, as amended), regarding any and all donations made by SAO pursuant to this Contract.

ARTICLE VI
RECORDS AND AUDITS

A. Accuracy of Data and Reports

SAO shall certify that all statements, reports and claims, financial and otherwise are true, accurate, and complete. SAO shall not submit for payment any claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this Contract and SCDHHS policy.

1. Maintenance of Records

SAO must maintain an accounting system with supporting fiscal records adequate to assure that claims for funds are in accordance with this Contract and all applicable laws, regulations, and policies. SAO further agrees to retain all financial and programmatic records, supporting documents and statistical records and other records of Recipients under this Contract for a period of five (5) years after the last payment made under this Contract (including any amendments and/or extensions to the Contract). If any audit, litigation, claims, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues. This provision is applicable to any subcontractor. SAO agrees to retain SCDHHS Provider programmatic and/or financial records including all applicable SAO audit working papers related to these documents, for a period of five (5) years after the expiration of the contract period being audited (including any amendments and/or extensions to the Contract). If any audit litigation, claims, or other actions involving SAO records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues.

2. Inspection of Records

At any time during normal business hours and as often as SCDHHS, the State Attorney General's Office, GAO, and USDHHS, and/or any of the designees of the above may deem necessary during the Contract period (including any amendments and/or extensions to the Contract) and for a period of five (5) years after last payment under this Contract, SAO shall make all program and financial records and service delivery sites open to the representatives of SCDHHS, GAO, the State Attorney General's Office, USDHHS, and/or any designees of the above. SCDHHS, the State Attorney General's Office, GAO, USDHHS, and/or their designee(s) shall have the right to audit, review, examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with SAO's recipients and employees, and do on-site reviews of all matters relating to service delivery as specified by this Contract. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. This provision

is applicable to any subcontractor and must be included in all subcontracts.

ARTICLE VII

TERMINATION OF CONTRACT

The parties hereto covenant and agree that their liabilities and responsibilities, one to another shall be contingent upon the availability of state and federal funds and that this Contract shall be subject to renegotiation or termination if such funding ceases to be available.

ARTICLE VIII

APPEALS PROCEDURES

If any dispute shall arise under the terms of this Contract, the sole and exclusive remedy shall be the filing of a Notice of Appeal within thirty (30) days of receipt of written notice of SCDHHS' action or decision which forms the basis of the appeal. Administrative appeals shall be in accordance with SCDHHS' regulations 27 S.C. Code Ann. Regs. §126-150, et seq. (1976, as amended), and in accordance with the Administrative Procedures Act, S.C. Code Ann. §1-23-310, et seq., (1976, as amended). Judicial review of any final SCDHHS administrative decisions shall be in accordance with S.C. Code Ann. §1-23-380, (1976, as amended).

ARTICLE IX

COVENANTS AND CONDITIONS

In addition to all other covenants and conditions contained herein, the parties to this Contract agree to the following covenants and conditions:

A. Applicable Laws and Regulations

The SAO agrees to comply with all applicable federal and state laws and regulations including constitutional provisions regarding due process and equal protection of the laws and including, but not limited to:

1. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970, as amended (42 U.S.C. §7401, et seq.).
2. Title VI of the Civil Rights Act of 1964 as amended (42 U.S.C. §2000d et seq.) and regulations issued pursuant thereto (45 CFR Part 80 (2010, as amended), which provide that the Provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract.
3. Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. § 2000e) in regard to employees or applicants for employment.

4. Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, (45 CFR Part 84 (2010, as amended)).
5. The Age Discrimination Act of 1975, as amended, (42 U.S.C. § 6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.
6. The Omnibus Budget Reconciliation Act of 1981, as amended, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.
7. The Americans with Disabilities Act (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto.
8. The Drug Free Workplace Acts, S.C. Code Ann. §44-107-10 et seq. (Supp. 2000, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 2 CFR Part 182 (2010, as amended).

B. Employees of SAO

No services required to be provided under this Contract shall be provided by anyone other than the SAO or with the prior approval of SCDHHS, SAO's subcontractor.

C. Information on Persons Convicted of Crimes

The SAO agrees to furnish to SCDHHS or to the USDHHS information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII), Medicaid (Title XIX), or the Social Services Block Grant program (Title XX) or the State Children's Health Insurance Program (Title XXI) as set forth in 42 CFR § 455.106 (2010, as amended). Failure to comply with this requirement may lead to termination of this Contract.

D. Safeguarding Information

The SAO shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX services in accordance with 42 CFR Part 431, Subpart F, (2010, as amended), SCDHHS' regulations at 27 S.C. Code Ann. Regs. §126-170, et seq. (1976, as amended), and all other applicable state and federal laws and regulations and shall restrict access to, and use and disclosure of, such information in compliance with said laws and regulations.

E. Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

F. Restrictions on Lobbying

In accordance with 31 U.S.C. § 1352, funds received through this Contract may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. This restriction is also applicable to all subcontractors.

G. Reporting of Fraudulent Activity

If at any time during the term of this Contract, the SAO becomes aware of or has reason to believe by whatever means that, under this or any other program administered by SCDHHS, a recipient of or applicant for services, an employee of the SAO or SCDHHS, and/or subcontractor or its employees, have improperly or fraudulently applied for or received benefits, monies, or services pursuant to this or any other contract, such information shall be reported in confidence by the SAO to SCDHHS.

H. Integration

This Contract shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever, unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved pursuant to Section O of this Article.

I. Governing Law

It is mutually understood and agreed that this Contract shall be governed by the laws of the State of South Carolina and federal laws as they pertain to the performance of services provided under this Contract.

J. Severability

Any provision of this Contract prohibited by the laws of the State of South Carolina shall be ineffective to the extent of such prohibition without invalidating the remaining provisions of this Contract.

K. Non-Waiver of Breach

The failure of SCDHHS at any time to require performance by the SAO of any provision of this Contract or the continued payment of the SAO by SCDHHS shall in no way affect the right of SCDHHS to enforce any provision of this Contract; nor shall SCDHHS' waiver of any breach of any provision hereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself.

L. Non-Waiver of Rights

SCDHHS and the SAO hereby agree that the execution of and any performance pursuant to this Contract does not constitute a waiver, each to the other, of any claims, rights, or obligations which shall or have arisen by virtue of any previous agreement between the parties. Any such claims, rights, or obligations are hereby preserved, protected, and reserved.

M. Non-Assignability

No assignment or transfer of this Contract or of any rights hereunder by the SAO shall be valid without the prior written consent of SCDHHS.

N. Venue of Actions

Any and all suits or actions for the enforcement of the obligations of this Contract and for any and every breach thereof, or for the review of a SCDHHS final agency decision with respect to this Contract or audit disallowances, and any judicial review sought thereon and brought pursuant to the S.C. Code Ann. §1-23-380 (1976, as amended) shall be instituted and maintained in any court of competent jurisdiction in the County of Richland, State of South Carolina.

O. Amendment

No amendment or modification of this Contract shall be valid unless it shall be in writing and signed by both parties hereto.

P. Amendment Due To The Unavailability of Funds

SCDHHS shall have the right to amend the total dollar amount reimbursed under this Contract, without the consent of SAO, when the amendment is due to the unavailability of funds and SCDHHS is responsible for providing the matching funds. SCDHHS shall have the sole authority to determine the percentage of any reduction in the dollar amount of this Contract. The amendment shall become effective thirty (30) days from the date of written notification from SCDHHS informing SAO of the reduction/amendment or upon the signature of both parties thereto, whichever is earlier. SCDHHS shall have the sole authority for determining lack of availability of such funds.

Q. Extension

Prior to the end of the term of this Contract, SCDHHS shall have the option to extend or renew this Contract upon the same terms and conditions as contained herein, so long as the total contract period, including extension, does not exceed five (5) years; provided and shall be set forth in writing and signed by both parties pursuant to Section O of this Article.

R. Subcontracts

Subcontracts under this Contract shall be in writing and shall be subject to the terms and conditions of this Contract. The SAO shall be solely responsible for the performance of any subcontractor.

S. Copyrights

If any copyrightable material is developed in the course of or under this Contract, SCDHHS shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for SCDHHS purposes.

T. Safety Precautions

SCDHHS and USDHHS assume no responsibility with respect to accidents, illnesses, or claims arising out of any activity performed under this Contract. The SAQ shall take necessary steps to insure or protect its recipients, itself, and its personnel. The SAQ agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

U. Procurement Code

When applicable, the SAQ must comply with the terms and conditions of the South Carolina Consolidated Procurement Code in the acquisition of equipment and supplies and in all subcontracts.

V. Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

W. Equipment

Equipment is defined as an article of tangible property that has a useful life of more than one year and an acquisition cost of Five Thousand dollars (\$5,000) or more. Title to all equipment purchased with funds provided under this Contract shall rest with the provider as long as the equipment is no longer required for the program for which it was purchased. SCDHHS shall be notified and instructions will be issued by SCDHHS pertaining to the disposition of the property.

X. HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as agreed upon in Appendix A.

Y. Portable Devices

All Protected Health Information (PHI) stored on portable devices must be encrypted. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPods, and MP3 and MP4 players), and personal organizers.

Z. Debarment/Suspension/Exclusion

The Contractor agrees to comply with all applicable provisions of 2 CFR Part 376 (2010, as amended), pertaining to debarment and/or suspension. As a condition of participation, the Contractor should screen all employees and subcontractors

to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs. To make this determination, the Contractor may search the LEIE website located at <http://www.oig.hhs.gov/fraud/exclusions.asp>. The Contractor should conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search, and any exclusion information discovered should be immediately reported to SCDHHS. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A(a)(6) of the Social Security Act and 42 CFR 1003.102(a)(2).

AA. Provider Responsibility

If under the terms of this Contract SAO makes any decisions, determinations or takes any actions on behalf of SCDHHS, then SAO shall be responsible for evidentiary support of its decisions, determinations or actions in any proceeding or claim asserted against SCDHHS related to such decision, determination or action. If required by SCDHHS, SAO shall be responsible for retaining legal counsel to diligently and capably provide such defense. This responsibility includes, but is not limited to, any appeals before the SCDHHS Division of Appeals and Hearings.

BB. Incorporation of Schedules/Appendices

All schedules/appendices referred to in this Contract are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

IN WITNESS WHEREOF, SCDHHS and SAO by their authorized agents have executed this Contract as of the first day of July 2011.

SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES
"SCDHHS"

SOUTH CAROLINA
STATE AUDITOR'S OFFICE
"SAO"

BY: Anthony E. Keck
Anthony E. Keck
Director

BY: [Signature]
Authorized Signature

RICHARD H. GILBERT JR.
Print Name

WITNESSES:

Antonia M. Busby
Linda Hillman

WITNESSES:

[Signature]
J.P.V.K.

APPENDIX A
HIPAA BUSINESS ASSOCIATE

A. Purpose:

The South Carolina Department of Health and Human Services (Covered Entity) and SAO (Business Associate) agree to the terms of this Appendix for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in performing the functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract between the parties.

B. Definitions (Terms used in this Section, but not otherwise defined, shall have the same meaning as set forth for those terms in HIPAA. A change to HIPAA which modifies any defined HIPAA term, or which alters the regulatory citation for the definition shall be deemed incorporated into this Appendix).

1. Business Associate. "Business Associate" shall mean the SAO. Where the term "business associate" appears without an initial capital letter, it shall have the same meaning as the term "business associate" in 45 CFR § 160.103.
2. Covered Entity. "Covered Entity" shall mean SCDHHS.
3. Data Aggregation. "Data Aggregation" shall have the meaning given to the term in 45 CFR § 164.501.
4. Designated Record Set. "Designated Record Set" shall have the meaning given the term in 45 CFR § 164.501.
5. Electronic Protected Health Information and/or EPHI. "Electronic Protected Health Information" or "EPHI" shall have the meaning given the term in 45 CFR § 160.103, and shall include, without limitation, any EPHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity.
6. HIPAA. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended, and related HIPAA regulations (45 CFR Parts 160-164).
7. HITECH. "HITECH" means the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.
8. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
9. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information, and Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule") that are codified at 45

CFR Parts 160 and Part 164, Subparts A, C, and E and any other applicable provision of HIPAA, and any amendments thereto, including HITECH.

10. Protected Health Information or PHI. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, and shall include, without limitation, any PHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity. Unless otherwise stated in this Agreement, any provision, restriction, or obligation in this Appendix related to the use of PHI shall apply equally to EPHI.
11. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103, and any additional requirements created under HITECH.
12. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
13. Security Incident. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system as provided in 45 C.F.R. § 164.304.
14. Unsecured PHI. "Unsecured PHI" shall have the same definition that the Secretary gives the term in guidance issued pursuant to § 13402 of HITECH.

C. Business Associate Agrees to:

1. Not use or disclose PHI or EPHI other than as permitted or required by the Contract or as Required By Law.
2. Develop, implement, maintain, and use appropriate safeguards to prevent any use or disclosure of the PHI or EPHI other than as provided by this Appendix, and to implement administrative, physical, and technical safeguards as required by sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations and HITECH in order to protect the confidentiality, integrity, and availability of EPHI or PHI that Business Associate creates, receives, maintains, or transmits, to the same extent as if Business Associate were a Covered Entity. See HITECH § 13401.
3. The additional requirements of Title XIII of HITECH that relate to privacy and security and that are made applicable with respect to covered entities shall also be applicable to Business Associate and shall be and by this reference hereby incorporated into this Appendix.
4. Adopt the technology and methodology standards provided in any guidance issued by the Secretary pursuant to HITECH § 13401-13402.
5. Mitigate to the extent practicable, any harmful effect known to Business Associate if Business Associate uses/discloses PHI in violation of the Contract or this

Appendix and to notify Covered Entity of any breach of unsecured PHI, as required under HITECH § 13402.

6. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI or EPHI. Security and/or privacy breaches should be reported to:

South Carolina Department of Health and Human Services
Office of General Counsel
Post Office Box 8206
Columbia, South Carolina 29202-8206
Phone: (803) 898-2795
Fax: (803) 255-8210

The Report shall include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during the breach. If the breach involves the Unsecured PHI of more than 500 residents of South Carolina or residents of a certain region, or is reasonably believed to have been accessed, acquired or disclosed during such incident, the Covered Entity will also notify the prominent media outlets. The media outlets must serve the geographic area affected.

7. Ensure that any agent/subcontractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Appendix. Business Associate must obtain, prior to making any permitted disclosure to any agent/subcontractor, reasonable assurances from such third party that such PHI will be held secure and confidential as provided pursuant to this Appendix and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and that any breaches of confidentiality of the PHI which become known to such third party will be immediately reported to Business Associate. As part of obtaining this reasonable assurance, Business Associate agrees to enter into a Business Associate Agreement with each of its subcontractors pursuant to 45 CFR § 164.308(b)(1) and HITECH § 13401.
8. If the Business Associate has PHI in a Designated Record, provide access at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
9. If the Business Associate has PHI in a Designated Record Set, make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
10. Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

11. Document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
12. Provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with Section C.8 of this Appendix, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
13. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPods, and MP3 and MP4 players), and personal organizers. Portable devices that perform computing, data manipulation or data transmission are called intelligent portable devices.
14. Business Associate understands and agrees that, should SCDHHS be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this Section, Business Associate shall be liable to SCDHHS for any damages, penalties and/or fines assessed against SCDHHS as a result of Business Associate's material breach. SCDHHS is authorized to recoup any and all such damages, penalties and/or fines assessed against SCDHHS by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which SCDHHS may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and SCDHHS, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in this Appendix, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract noted in A, provided that such use would not violate the Privacy Rule if done by Covered Entity or the Covered Entity's minimum necessary policies and procedures. Unless otherwise permitted in this Appendix, in the Contract noted in A, above or as Required by Law, Business Associate may not disclose or re-disclose PHI except to Covered Entity.
2. Except as limited in this Appendix, Business Associate may use or disclose PHI for the proper internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide services to Covered Entity under the above noted Contract.
3. Except as limited in this Appendix, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

4. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

E. Covered Entity Shall:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
2. Notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
4. Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Appendix shall be effective immediately upon award of the Contract noted in A. and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.
2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall:
 - a. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; OR
 - b. Immediately terminate the Contract if Business Associate has breached a material term of this Appendix and cure is not possible; OR
 - c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
3. Effect of Termination.
 - a. Except as provided in paragraph (2) below, upon termination of the Contract, for any reason, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision applies to PHI in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

- b. In the event that Business Associate determines that returning the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Appendix to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

This Section shall be effective on the applicable enforcement date of the Security Standards. Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and subcontractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's security and confidentiality policies, processes, and practices that affect Electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate's security and confidentiality practices, policies, and processes comply with HIPAA, as amended from time to time, and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. Miscellaneous

1. A reference in this Appendix to a section in the Privacy Rule means the section as in effect or as amended.
2. The Parties agree to amend this Appendix as necessary to comply with HIPAA and other applicable law.
3. Any provision related to the use, disclosure, access, or protection of EPHI or PHI or that by its terms should survive termination of this Agreement shall survive termination.
4. Any ambiguity in this Appendix shall be resolved to permit Covered Entity to comply with the Privacy Rule.



December 16, 2011

Mr. Joseph Hunt, Administrator
Countrywood Nursing Center
1645 Ridge Road
Hopkins, SC 29051

Re: ACH 3-RDM-B8, 3-RDM-J8, & 3-RDM-J9 - Countrywood Nursing Center

Dear Mr. Hunt:

Based on the recommendation of the Office of the State Auditor in their audit reports ACH 3-RDM-B8, 3-RDM-J8, & 3-RDM-J9, the Department of Health and Human Services is establishing an accounts receivable of \$546,968, in order to finalize your facility's November 29, 2007 through May 31, 2008, November 29, 2007 through September 30, 2008 and October 1, 2008 through September 30, 2009 cost reports. These cost reports were used to determine your facility's Medicaid reimbursement rate for the following contract periods:

Rate Period	Audited Rate
11/29/07 - 05/31/08	\$129.21
06/01/08 - 09/30/08	\$134.74
10/01/08 - 09/30/09	\$135.11
10/01/09 - 09/30/10	\$135.20
10/01/10 - 04/07/11	\$137.14
04/08/11 - 09/30/11	\$133.03

This results in an overpayment as follows:

Rate Period	Audited Rate	Medicaid Days	Amount Due Provider	Previously Paid Provider	Balance Due Provider/ <DHHS>
11/29/07-05/31/08	\$129.21	2,987	\$ 385,950	<\$ 450,440>	<\$ 64,490>
06/01/08-09/30/08	\$134.74	2,222	\$ 299,392	<\$ 349,565>	<\$ 50,173>
10/01/08-09/30/09	\$135.11	7,866	\$1,062,775	<\$1,240,704>	<\$177,929>
10/01/09-09/30/10	\$135.20	8,913	\$1,205,038	<\$1,371,711>	<\$166,673>
10/01/10-04/07/11	\$137.14	4,204	\$ 576,537	<\$ 621,897>	<\$ 45,360>
04/08/11-09/30/11	\$133.03	4,048	\$ 538,505	<\$ 580,848>	<\$ 42,343>
Total					<\$546,968>

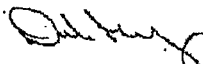
Mr. Joseph Hunt, Administrator
December 16, 2011
Page Two

The amount of \$546,968 is due on or before January 19, 2012. Your check should be made payable to the Department of Health and Human Services and mailed to:

U. S. Post Office	Federal Express or UPS
Bureau of Fiscal Affairs	Bureau of Fiscal Affairs
Department of Health and Human Services	Department of Health and Human Services
Post Office Box 8297	Accounts Receivable, First Floor
Columbia, South Carolina 29202-8355	1801 Main Street
	Columbia, South Carolina 29201

If payment is not received by the due date, reimbursement for services rendered will be withheld until the recoupment is completed. If you have any questions regarding these calculations, please call Brandy Fulman at (803) 898-1016. Should you have questions regarding payment of this receivable, please contact Ms. Lynette Wilson at (803) 898-1085.

Sincerely,



Debra Myers, Director
Division of Long Term Care Reimbursements

DM/bp

Enclosures

cc: Mr. Tree Nielson
State Auditor's Office
Ms. Lynette Wilson

State of South Carolina



Office of the State Auditor

1401 MAIN STREET, SUITE 1200
COLUMBIA, S.C. 29201

RICHARD H. GILBERT, JR., CPA
DEPUTY STATE AUDITOR

(803) 253-4160
FAX (803) 343-0723

November 22, 2011

Mr. Joseph Hunt, Administrator
Countrywood Nursing Center
1645 Ridge Road
Hopkins, South Carolina 29061

Re: AC# 3-RDM-E8 - Countrywood Nursing Center, L.L.C.

Dear Mr. Hunt:

The accompanying report has been prepared by our office based on your Medicaid Financial and Statistical Report submitted to the Department of Health and Human Services for the cost report period November 29, 2007 through May 31, 2008. That report was used to set the rate covering the contract period beginning November 29, 2007.

We are recommending that the Department of Health and Human Services certify an accounts receivable to recover amounts due as a result of the rate change shown on Exhibit A. You will be notified of repayment terms by that Agency.

Yours very truly,

A handwritten signature in dark ink, appearing to read "Richard H. Gilbert, Jr.", written over a horizontal line.

Richard H. Gilbert, Jr., CPA
Deputy State Auditor

RHGjr/sag

cc: Ms. Brenda L. Hyleman
Mr. Jeff Saxon
Ms. Kathleen C. Snider
Mr. Terry K. Schmoyer, Jr.

State of South Carolina



Office of the State Auditor

1401 MAIN STREET, SUITE 1200
COLUMBIA, S.C. 29201

RICHARD H. GILBERT, JR., CPA
DEPUTY STATE AUDITOR

(803) 253-4160
FAX (803) 343-0723

November 22, 2011

Mr. Joseph Hunt, Administrator
Countrywood Nursing Center
1645 Ridge Road
Hopkins, South Carolina 29061

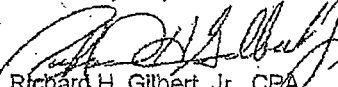
Re: AC# 3-RDM-J8 - Countrywood Nursing Center, L.L.C.

Dear Mr. Hunt:

The accompanying report has been prepared by our office based on your Medicaid Financial and Statistical Report submitted to the Department of Health and Human Services for the cost report period November 29, 2007 through September 30, 2008. That report was used to set the rate covering the contract period beginning October 1, 2009.

We are recommending that the Department of Health and Human Services certify an accounts receivable to recover amounts due as a result of the rate change shown on Exhibit A. You will be notified of repayment terms by that Agency.

Yours very truly,


Richard H. Gilbert, Jr., CPA
Deputy State Auditor

RHGjr/cwc

cc: Ms. Brenda L. Hyleman
Mr. Jeff Saxon
Ms. Kathleen C. Snider
Mr. Terry K. Schmoyer, Jr.

State of South Carolina



Office of the State Auditor

1401 MAIN STREET, SUITE 1203
COLUMBIA, S.C. 29201

RICHARD H. GILBERT, JR., CPA
DEPUTY STATE AUDITOR

(803) 253-4160
FAX (803) 343-0713

November 22, 2011

Mr. Joseph Hunt, Administrator
Countrywood Nursing Center
1645 Ridge Road
Hopkins, South Carolina 29061

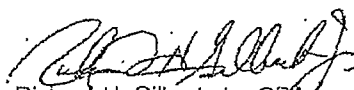
Re: AC# 3-RDM-J9 – Countrywood Nursing Center, L.L.C.

Dear Mr. Hunt:

The accompanying report has been prepared by our office based on your Medicaid Financial and Statistical Report submitted to the Department of Health and Human Services for the cost report period October 1, 2008 through September 30, 2009. That report was used to set the rate covering the contract periods beginning October 1, 2010.

We are recommending that the Department of Health and Human Services certify an accounts receivable to recover amounts due as a result of the rate change shown on Exhibit A. You will be notified of repayment terms by that Agency.

Yours very truly,


Richard H. Gilbert, Jr., CPA
Deputy State Auditor

RHGjr/sag

cc: Ms. Brenda L. Hyleman
Mr. Jeff Saxon
Ms. Kathleen C. Snider
Mr. Terry K. Schroyer, Jr.

Terry Schmoyer

From: Terry Schmoyer
Sent: Tuesday, October 09, 2012 11:14 AM
To: Terry Schmoyer
Subject: FW: Countrywood Nursing Center

From: Larry Warrington [mailto:lwarrington@osa.state.sc.us]
Sent: Friday, July 15, 2011 3:52 PM
To: Terry Schmoyer
Cc: Jay Vonkannel
Subject: Countrywood Nursing Center

Terry,

I was wondering if you could provide us some information. We are in the process of starting up a review of cost reports submitted by Countrywood Nursing Center (formally Ridgeview Manor). We will be reviewing the following cost reports:

- 1) 11/29/07 - 5/31/08
- 2) 11/29/07 - 9/30/08
- 3) 10/01/08 - 9/30/09

We have obtained cost reports, copies of trial balances and other information from DHHS, but we would like to see if you could provide the following information related to the listed cost reports:

- 1) Accountants working trial balance adjustments and copies of related workpapers.
- 2) General Ledgers, if available.

Thank you,
Lawrence Warrington, CPA
Audit Supervisor
Office of the State Auditor
1401 Main Street Suite 1200
Columbia, SC 29201
Phone # 803.832.8258
Fax # 803.343-0723

=====
Confidentiality Notice

This message is intended exclusively for the individual or entity to which it is addressed. This communication may contain information that is proprietary, privileged, confidential or otherwise legally exempt from disclosure.

If you are not the named addressee, you are not authorized to read, print, retain, copy or disseminate this message or any part of it. If you have received this message in error, please notify the sender immediately either by phone (800-237-2000) or reply to this e-mail and delete all copies of this message.

To ensure compliance with the requirements imposed by the IRS, we inform you that any U.S. federal tax advice contained in this communication (including the attachments) is not intended or written to be used, for the purpose of (a) avoiding penalties under the Internal Revenue Code or (b) promoting, marketing or recommending to another party any transaction or tax-related matter[s].

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP
Attorneys and Counselors at Law
1320 Main Street / 17th Floor / Columbia, SC 29201
Tel: 803.799.2000 Fax: 803.255.5506
www.nelsonmullins.com

Alice V. Harris
Tel: 803.255.9487
Fax: 803.255.5506
alice.harris@nelsonmullins.com

December 17, 2012

Hand Delivered

Betsy Schindler, Hearing Officer
South Carolina Department of Health
& Human Services
Division of Appeals and Hearings
Post Office Box 8206
Columbia, SC 29202-8206

RE: AC #3-RDM-J8; AC #12-AUD-010
AC #3-RDM-J9; AC #12-AUD-011
AC #3-RDM-E8; AC #12-AUD-012
Our File No. 39092/09000



Dear Ms. Schindler:

Enclosed for filing in the above-referenced matter are the original and one copy of Petitioner's Reply to DHHS's Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment. Please return a clocked-in copy to us.

By copy of this letter to counsel, we are hereby serving them with a copy of this document.

Very truly yours,

Alice V. Harris

AVH:jmh

Enclosures

cc: Terry K. Schmoyer (via email)
W. Allen Nickles, III, Esq. (via email)
Richard G. Hepfer, Esq. (via email)
Byron Roberts, Esq. (via email)



With offices in the District of Columbia, Florida, Georgia, Massachusetts, North Carolina, South Carolina, Tennessee and West Virginia

COUNTY OF RICHLAND

BEFORE THE DIVISION OF APPEALS
AND HEARINGS OF THE
SOUTH CAROLINA DEPARTMENT
OF HEALTH AND HUMAN SERVICES

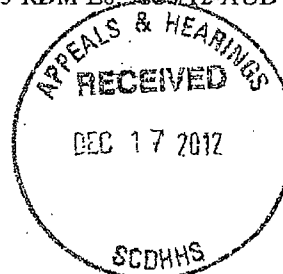
Petitioner,

AC #3-RDM-J8; AC #12-AUD-010
AC #3-RDM-J9; AC #12-AUD-011
AC #3-RDM-E8; AC #12-AUD-012

Y.

South Carolina Department of Health
and Human Services,

Respondent.



**PETITIONER'S REPLY TO DHHS'S MEMORANDUM IN OPPOSITION TO
PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT**

The Petitioner Countrywood Nursing Center, LLC ("Countrywood") hereby submits this Reply to the South Carolina Department of Health and Human Services's ("SCDHHS") Memorandum in Opposition to Petitioners' Motion for Partial Summary Judgment ("Memorandum in Opposition").

I. The State Plan Defines the Term "Rate Period / Rate Cycle" as Time Frame Up to a One Year Period

The crux of SCDHHS's argument is that the cost report "rate period/rate cycle" is somehow a grouping together of "periods" governed by Countrywood's initial six month cost report. See Memorandum in Opposition at 5. This concept results from SCDHHS re-casting the terms "rate period" and "rate cycle" to refer to a multi-year period to be governed by Countrywood's initial six month cost report. See *id.*

Throughout its Memorandum in Opposition, in fact, SCDHHS studiously avoids referring to the six-month and year-long "periods" by the correct terms: rate period, contract period, and rate cycle. This is due to the fact that the South-Carolina Medicaid State Plan

under Title XIX of the Social Security Medical Assistance Program (the "State Plan") defines the "rate period/rate cycle" in three ways, all of which describe a period of less than or equal to one year. Mr. Saxon's affidavit also uses the term "cost report" as a substitute for the terms rate period or rate cycle.

It is also significant that SCDHHS was unable to articulate any language in the State Plan that calls for grouping together multiple rate periods into a "single rate cycle" or that of an "extended period of time." Instead, the State Plan defines rate period in three ways: September 1 through Oct. 30, the first six months of operation when a facility goes through a change of ownership, and the rate period beginning with the seventh month after a change of ownership.

Specifically, Section III.E.2. of Attachment 4.19-D provides that upon any change of ownership through a purchase of fixed assets, nursing homes must submit a cost report for the first six months of operations. *See* State Plan, Attachment 4.19. This cost report establishes "allowable reimbursement of the provider for the initial rate cycle." *See id.* Section III.E.2. provides that "[e]ffective on the first (1st) day of the seventh (7th) month of operation, a new prospective rate, based upon the Uniform Financial and Statistical Report [cost report] will be determined..." *See id.*

Section III.E.3. provides for a change in ownership through a lease of fixed assets, that "effective the seventh month of operation, the new operator will be entitled to a new rate based upon his actual cost." *See id.* This cost report will determine a rate which will be effective retroactive to the new operator's seventh month of operation. *See id.* There is no language in the State Plan that supports Respondent's contention that the six month rate period extends beyond the first six months of operation or is limited to a term called "extended periods." In

fact, the State Plan delineates that beginning with the seventh month, a new rate cycle or rate period begins.

If SCDHHS utilized the term "rate period/rate cycle" as the State Plan defines it, SCDHHS's attempt to group the four rate periods into one multi-year "rate period/rate cycle" is shown to be illogical. In fact, SCDHHS's use of the term "rate cycle" reflects an unsupportable result when the term is applied to a multi-year period. SCDHHS states Countrywood "divides the 'rate cycle' determined by its initial reports into separate periods of 11/29/07 - 5/31/08 (six months); 06/01/08 - 09/30/08 (4 months); and 10/01/08 - 09/30/09 (12 months)." See Memorandum in Opposition at 3. The "initial reports" are the rate cycles - and cannot be "divided up" as SCDHHS asserts.

Finally, SCDHHS attempts to distinguish the *C.A.N. Enterprises* case on the basis that the opinion addresses former contract language. While the contract language in question is different, the case is still applicable. The principles in the *C.A.N. Enterprises* case are clear: the State is not entitled to recoup funds disallowed in an audit report that was not issued in a timely manner. See *C.A.N. Enterprises, Inc. v. S.C. Health and Human Services Finance Commission*, 296 S.C. 373, 373 S.E.2d 584 (1988). In this case, where SCDHHS has failed to issue audit reports in a timely manner, its attempt to recoup funds should be disallowed.

II. SCDHHS Staff's Construction of the Term Rate Period / Rate Cycle Should Not be Afforded Deferential Treatment

SCDHHS argues that because SCDHHS staff has applied the term rate period (rate cycle) in a certain way it should be entitled to rely on this construction of the term. While in general certain agency interpretations are entitled to "the most respectful consideration and should not be overruled without cogent reasons," *Faile v. S.C. Employment Security Comm'n.*, 267 S.C. 536, 540 230 S.E.2d 219, 221-222 (1976), such positions must *not* be applied when

cogent reasons require a different position. *See Stone Mfg. Co. v. South Carolina Employment Sec. Comm'n*, 219 S.C. 239, 249, 64 S.E.2d 644, 648 (1951) *quoting F. W. Woolworth Co. v. United States*, 91 F.2d 973, 976 (2d. Cir. 1937) ("At most, administrative practice is a weight in the scale, to be considered, but not to be inevitably followed. * * * While we are of course bound to weigh seriously such rulings, they are never conclusive.""). Moreover, in *S.C. Coastal Conservation League v. S.C. Dep't of Health and Envtl. Control*, 363 S.C. 67, 610 S.E.2d 482 (2005), the South Carolina Supreme Court found that the positions adopted by an administrative agency's *staff* (as opposed to an agency appellate panel) were *not* entitled to deferential treatment. Mr. Saxon is an employee of SCDHHS, and thus his position concerning the issues presented should not be afforded deferential treatment.

Even assuming, *arguendo*, that the practices of SCDHHS staff should be afforded deference in this matter, cogent reasons exist to deviate from the practice of SCDHHS staff. The State Plan clearly defines rate period / rate cycle to refer to time periods of one year or less. Where agency staff has been construing a term contrary to controlling authority - in this case referring to a grouping of rate periods under the State Plan as one "rate period" - SCDHHS staff is not entitled to deference.

III. The Obligation of Providers to Retain Records does not Override Other Contractual Obligations

SCDHHS argues that the contract provision requiring Countrywood to retain records for the term of the contract and six years after somehow overrides the SCDHHS obligation to issue audit reports in a timely manner. *See Memorandum in Opposition* at 7. The Provider Contract stipulates that final audit reports "shall be issued within three (3) years." *See Countrywood Provider Contract*, Exhibit B to Motion for Partial Summary Judgment at Article

V., Section F. Provisions allowing for basic retention and access to records in the same Article V do not override this specific provision at Section F.

In sum, it appears that SCDHHS is attempting to change its executed contracts with Countrywood to allow for a time period to issue audit reports that would extend throughout the provider contract term and six years after termination of the contract. This result would make the three year requirement in Section F of the provider contract meaningless. "A party to a contract should not be given relief from the requirements of the contract simply because it proved to be less favorable than an alternative provision would have been." *Duke Power Co. v. S.C. Public Service Com'n* 284 S.C. 81, 89, 326 S.E. 2d 395, 400 (1985), citing *Bowaters Carolina Corp. v. Carolina Pipeline Co.*, 259 S.C. 500, 193 S.E.2d 129 (1972).

IV. The SAO is Obligated by Contract to Limit Cost Report Audits to two Cost Report Periods

The contract between SCDHHS and the SAO states the SAO is responsible for conducting "agreed-upon procedures engagements" of Medicaid cost reports for nursing facilities. See contract between SCDHHS and SAO attached as Exhibit C to Motion for Summary Judgment at Article III. A-B. The Section titled "Nursing Facility Agreed-Upon Procedure Requirements" stipulates that "[t]he SAO will perform agreed-upon procedures involving two cost report periods." See *id.* at Article III. D.1 (emphasis added). Additionally, this section stipulates which two reporting periods they are to be. See *id.*

SCDHHS contends that this contractual language sets a minimum obligation on the SAO. However, the succinct clear language of this provision does limit the SAO, and in fact authorizes and instructs the SAO to perform audits for "two cost report periods." If the SAO had the authority to proceed beyond two cost report periods as SCDHHS contends, this contract language limiting the audits to "two cost report periods" would be superfluous.

Also, SCDHHS again refers to the contract provision requiring Countrywood to retain records for the term of the contract plus six years after the contract term in an attempt to override more specific contract language. See Memorandum in Opposition at 6. Provisions allowing for basic retention and access to records in Article V of the provider contract does not override the specific limitation in the contract between SCDHHS and the SAO limiting the SAO audits to two cost report periods. SCDHHS cannot seek relief from the contractual restriction in the contract with the SAO simply because it is now less favorable than an alternative provision might be. See *Duke Power Co. v. S.C. Public Service Com'n* 284 S.C. 81, 89, 326 S.E. 2d 395, 400 (1985), citing *Bowaters Carolina Corp. v. Carolina Pipeline Co.*, 259 S.C. 500, 193 S.E.2d 129 (1972).

V. Countrywood, as a Nursing Facility, is a Direct Beneficiary of the Restriction on the State Auditor's Office's Auditing Procedures

The Section of the contract between SCDHHS and the State Auditors Office ("SAO") titled "Nursing Facility Agreed-Upon Procedure Requirements" stipulates that "[t]he SAO will perform agreed-upon procedures involving two cost report periods." See Contract between SCDHHS and SAO at Article III. D.1, attached as Exhibit C to Countrywood's Motion for Partial Summary Judgment. Article III, Section D of the Contract between SCDHHS and SAO is titled: "Nursing Facility Agreed-Upon Procedure Requirements." It is clear from the title and content of Section D, that this section governs the SAO's procedures for auditing *nursing facilities*. On its face, nursing facilities, such as Countrywood, are the direct and intended beneficiaries of the restriction regarding the number of cost reports that the SAO can audit.

A third-party beneficiary is a party that the contracting parties intend to directly benefit. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 344, 611 S.E.2d 485 (2005). Thus, if a contract is made for the benefit of a third person, that person may enforce the contract if

the contracting parties intended to create a direct, rather than an incidental or consequential, benefit to such third person. *Id.* The contract between SCDHHS and the SAO was intended by the parties to create a direct benefit to Countrywood as a third-party beneficiary.

VI. Countrywood Asserts Injury and Prejudice due to SCDHHS's Failure to Comply with its Contractual Obligations

Countrywood is not asserting an equitable claim in its Motion for Partial Summary Judgment. Instead, Countrywood is asserting its contractual rights. The provider contract is clear: final audit reports "shall be issued within three (3) years." *See* Countrywood Provider Contract, Exhibit B to Motion for Partial Summary Judgment at Article V., Section F. The burden and expense incurred by Countrywood arises from SCDHHS's unauthorized attempts to recoup funds based on audit reports issued in an untimely manner.

Also, as noted previously, SCDHHS cannot now rely on a provision regarding maintenance of records to override the specific auditing time frame of three years. *See* Section III of this memorandum. Furthermore, public interest is not served when a public agency such as SCDHHS seeks to avoid clear contractual obligations. SCDHHS had ample time - three years - in which to issue its audit report. SCDHHS cannot now override its contractual obligations and claim Countrywood must refund monies based on untimely reports.

CONCLUSION

As a matter of law, the SAO did not issue final audit reports for the rate periods in question within the three-year period required by the SAO's contract with the SCDHHS and Countrywood's-Provider Contract. *See* Exhibits B to Motion for Partial Summary Judgment. We therefore hereby request that the hearing officer issue a summary judgment finding that the SAO did not issue final audit reports for the rate periods in question within the required three-year period and dismiss the audit reports for the periods outlined herein.

NELSON MULLINS RILEY & SCARBOROUGH LLP

By: Alice V. Harris
William A. Prince
SC Bar No. 4576
Alice V. Harris
SC Bar No. 66223
1320 Main Street / 17th Floor
Post Office Box 11070 (29211-1070)
Columbia, SC 29201
(803) 799-2000

Attorneys for Petitioner

Columbia, South Carolina

December 17, 2012

CERTIFICATE OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Countrywood Nursing Center, LLC, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified to the following address(es):

Pleadings: **PETITIONER'S REPLY TO DHHS'S MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT**

Counsel Served: W. Allen Nickles, III, Esq.
Nickles Law Firm, LLC
1519 Richland Street
Columbia, SC 29201

Richard G. Hepfer
Deputy General Counsel
South Carolina Department
of Health and Human Services
1801 Main Street, 11th Floor
Post Office Box 8206
Columbia, SC 29202-8206

Byron Roberts, Esq.
South Carolina Department
of Health and Human Services
1801 Main Street, 11th Floor
Post Office Box 8206
Columbia, SC 29202-8206



Jane M. Heinzelman
Jane M. Heinzelman
Administrative Assistant

December 17, 2012



Schmoyer and Company, LLC
CERTIFIED PUBLIC ACCOUNTANTS

March 14, 2013

Mrs. Betsy Schindler, Hearing Officer
Division of Appeals and Hearings
SC Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Re: Countrywood Nursing Center, LLC
Appeal Case # 12 - AUD-010 - A/C # 3 - RDM-E8 - Cost Report YE 05/31/08
Appeal Case # 12 - AUD-011 - A/C # 3 - RDM-J8 - Cost Report YE 09/30/08
Appeal Case # 12 - AUD-012 - A/C # 3 - RDM-J9 - Cost Report YE 09/30/09

Dear Mrs. Schindler:

On behalf of Countrywood Nursing Center, LLC ("Countrywood"), we are submitting a summary of issues resolved and remaining for the above referenced cases, as well as an estimate of time and availability for the hearing.

I. Issues Resolved and Remaining

The parties have resolved and Countrywood withdraws its appeal of the following issues:

1. Cost of Capital - 05/31/08 - E8 (AJE # 1,2,15, & 16); 09/30/08 - J8 - (AJE # 1,2 & 14); 09/30/09 - J9 (AJE # 1, 2, & 12)
2. Administrative Salary Adjustment - 05/31/08 - E8 (AJE # 6); 09/30/08 - J8 (AJE # 6)
3. Stepdown adjustment -- 05/31/08 - E5 (AJE # 13 & 14); 09/30/08 - J8 (AJE # 12 & 13); 09/30/09 - J9 (AJE # 9 & 10) -- The component related to the allocation of the medical supply cost center and the direct allocation of supplies to the assisted living wing.

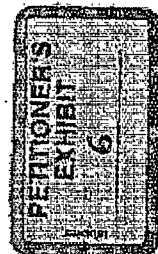
In addition, the parties have been able to reach partial resolution of some the following adjustments, but at this time Countrywood is appealing the following remaining adjustments and issues:

Minor Equipment - 05/31/08 - E8 (AJE # 3); 09/30/08 - J8 (AJE # 3)

Minor equipment purchases in the amount of \$58,833 have been removed from allowable costs. It is Countrywood's position these are allowable costs and should be reimbursable by the Medicaid program.

Inventory - 05/31/08 - E8 (AJE # 4); 09/30/08 - J8 (AJE # 4)

A portion of the initial purchase of facility supplies, for dietary supplements and disposable diapers, in December 2007 have been disallowed. It is Countrywood's position these are allowable costs and should be reimbursable by the Medicaid program.



Software Costs - 05/31/08 - E8 (AJE # 7)

Software costs purchased in the amount of \$1,451 have been removed from allowable costs. It is Countrywood's position these are allowable costs and should be reimbursable by the Medicaid program.

Medical Director - 05/31/08 - E8 (AJE # 8); 09/30/08 - J8 (AJE # 7); 09/30/09 - J9 (AJE # 3)

Medical director consulting fees were only partially allowed for reimbursement. It is Countrywood's position these are allowable costs and should be fully reimbursable by the Medicaid program.

OTC Drugs - 05/31/08 - (AJE # 9); 09/30/08 - J8 (AJE # 8); 09/30/09 - J9 (AJE # 5)

Most of Countrywood's over-the-counter drugs were disallowed based on a sample of invoices reviewed. It is Countrywood's position these are allowable costs and should be fully reimbursable by the Medicaid program.

Health Insurance - 05/31/08 - E8 (AJE # 10); 09/30/08 - J8 (AJE # 9)

Certain health insurance costs have been removed from allowable costs. It is Countrywood's position these are allowable costs and should be fully reimbursable by the Medicaid program.

AL Nurse Salary - 05/31/08 - E8 (AJE # 11); 09/30/08 - J8 (AJE # 10); 09/30/09 - J9 (AJE # 7)

Certain nursing salary costs were disallowed as applicable to the assisted living wing of the facility. It is Countrywood's position that some of this cost should remain in allowable cost and we request the ability to present at the hearing.

AL Nurse Salary Benefits 05/31/08 - E8 (AJE # 10); 09/30/08 - J8 (AJE # 9); 09/30/09 - J9 (AJE # 6)

Countrywood requests the right to appeal the benefit disallowance associated with the above nursing salary adjustment.

Home Office Costs - 05/31/08 - E8 (AJE # 12); 09/30/08 - J8 (AJE # 11); 09/30/09 - J9 (AJE # 8)

Countrywood objects to the disallowance of home office costs as follows:

- A) Certain home office costs were disallowed from the home office cost report, which include administrative contract services and owner salary. It is Countrywood's position these are allowable costs and should be reimbursable by the Medicaid program.
- B) Home office costs were directly allocated to the assisted living wing based on patient days. It is Countrywood's position that home office cost should be allocated to the facility in total and then allowed to be stepped down to the assisted living wing based on accumulated cost, as completed on the as filed cost report.

Stepdown Adjustment - 05/31/08 - E5 (AJE # 13 & 14); 09/30/08 - J8 (AJE # 12 & 13);
09/30/09 - J9 (AJE # 9 & 10)

Countrywood objects to the changes made to the assisted living wing stepdown adjustment, cost before stepdown allocations, as follows:

- A) The facility purchases laundry and housekeeping services from a third-party vendor. This vendor separated the assisted living wing services out on its invoices. Adjustments have been completed to consolidate the costs and then allocated based on square footage. It is Countrywood's position that the allocation of laundry and housekeeping services should be based on the amounts billed by the vendor.
- B) Dietary consultant services were allocated to the assisted living wing. It is Countrywood's position that these registered dietitian services relate to the patients in the SNF only and should not be allocated to the assisted living wing.

Ancillary Services - 09/30/09 - J9 (AJE # 11)

Countrywood objects to the ancillary services adjustment as follows:

- A) Certain Medicaid therapy charges were disallowed which reduced Medicaid therapy reimbursement. It is Countrywood's position that some of these charges should remain and requests the ability to present at the hearing.
- B) Oxygen costs in the amount of \$3,990 were disallowed due to a lack of charges. A majority of the residents served at the facility during this cost report year were Medicaid patients. It is Countrywood's position these are allowable costs and should be reimbursable by the Medicaid program.

Audit Conducted Outside of the SAO/DHHS Contract, Audit Report AC # 3 - RDM - E8

We appeal all disallowances included within the entire May 31, 2008 audit report AC # 3 - RDM - E8 that relate to all Rate Periods 11/29/07 - 09/30/09 because this cost report is outside of the scope of the contract between the SC State Auditor's office and DHHS. It is our understanding that the auditor's office is under a specific contract arrangement that dictates they are allowed to audit a Medicaid cost report that is *currently* paying a rate and the cost report *immediately* prior. Countrywood was contacted in the summer of 2011 to have its September 30, 2009 cost report audited. The audit report immediately prior is September 30, 2008, which was also audited. Accordingly, it is our position that the audit report for the period ended May 31, 2008 is outside the scope of the current DHHS contract. We inquired of the auditor if DHHS requested that the May 31, 2008 report be audited based on alleged improprieties and they said it had not. Our arguments concerning this issue are more fully set forth in Countrywood's previous submissions concerning Plaintiff's Motion for Partial Summary Judgment.

We therefore request that all disallowances for rate period November 29, 2007 through September 30, 2009 be deleted and any accounts receivable related to this rate period be reinstated.

Expired Rate Periods within Audit Report AC # 3 - RDM - E8

We appeal all disallowances included within audit report AC # 3 - RDM - E8 that relate to rate periods 11/29/07 - 09/30/09 because the final audit report for these rate periods was not issued in a timely manner.

Pursuant to Countrywood's contract between the South Carolina Department of Health and Human Services and CountryWood Nursing Center, LLC, a final audit report must be issued within three years of the close of the contract period in question. See Article V, Section F at page eight of Countrywood contract, which defines the timely issuance of an audit report and Article II at page two that defines what the audit contract period is. The final audit report for the rate periods ending September 30, 2008 was not issued until November 22, 2011, which was 52 days too late. The final audit report for the rate periods of November 29, 2007 through September 30, 2008 should have been issued within three years, or no later than September 30, 2011. Our arguments concerning this issue are more fully set forth in Countrywood's previous submissions concerning Plaintiff's Motion for Partial Summary Judgment.

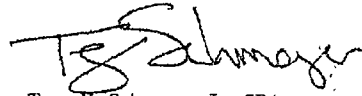
We therefore request that all disallowances for rate period November 29, 2007 through September 30, 2008 be deleted and any accounts receivable related to this rate period be rescinded.

II. Estimate of Time for Hearing and Availability for Hearing

Countrywood estimates the hearing will take one day to hear the appeal of the adjustments and ½ day to hear the appeal of the third audit report and expired rate periods. As the witnesses for the days may be separate, we request two days to complete the hearing. We are available for a hearing any day after June 1, except for the week of June 18, 2013.

Thank you for your consideration of our concerns and objections. Please advise if you require any additional information.

Sincerely,



Terry K. Schmoeyer, Jr., CPA

TKS:enm

cc: Mr. Al Nickles, III, Esquire
Nickles Law Firm, LLC

Mr. Jay Von Kannel, Manager
Office of the State Auditor

Mr. Jerry Hicks, CPA
Hicks and Clark, LLC

Mrs. Alice Harris, Esquire
Nelson Mullins