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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

SC Court of Appeals

Appellate Case No. 2015-001986

Countrywood Nursing, LLC, ... Appellant,

v.

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

RECORD ON APPEAL
VOLUME II
Pages 373-786

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August 22, 2014

Betsy Schindler, Hearing Officer
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Division of Appeals and Hearings
1801 Main Street, 9th Floor
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RECEIVED
AUG 22 2014
SCDHHS APPEALS

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:

I am enclosing herewith Petitioner's Prehearing Brief. By copy of this letter, I am serving opposing counsel with a copy of same.

Very truly yours,


Daniel J. Westbrook

DJW:mybrown

cc: W. Allen Nickles, Esq.



With offices in the District of Columbia, Florida, Georgia, Massachusetts, North Carolina, South Carolina, Tennessee and West Virginia

R0373

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.

PETITIONER'S
PREHEARING BRIEF

Pursuant to the Consent Scheduling Order and Rule 16(c) of the South Carolina Rules of Civil Procedure, Petitioner submits its Prehearing Brief.

I. STATEMENT OF FACTS

A. Introduction

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 ("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. Exs. 1-3. Based on these audit reports, DHHS demands a recoupment of \$546,968. Pet. Ex. 8

B. Limitations on the Number of Cost Reports the SAO Can Audit, Absent Allegations of Fraud

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"). Pet. Ex. 4. "Agreed-upon procedure activities" includes audits and audit reports, such as the 11/22/11 final audit reports SAO issued on Countrywood. See Pet. Ex. 4, p. 2. A former version of the SAO Contract provided that the SAO will perform agreed-upon procedures involving three cost report periods. At some point, however, during 2000-2005 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 over 90 percent of the state's nursing homes. As a result of those discussions the SAO Contract was revised. Article III, Section D(1) of the SAO Contract now provides: "The SAO will perform agreed-upon procedures involving *two* cost report periods." Pet. Ex. 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.

Pet. Ex. 4, p. 4.

SAO initiated the field work for the Countrywood audits on August 10, 2011. Pet. Ex. 5, p.1. See also Ex. 13 (on 7/15/11 SAO is "in the process of starting up a review" of Countrywood cost reports). 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." Pet. Ex. 4, p 4.

C. Time Limits on Issuance of Final Audit Reports

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. 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. 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. . . ." Pet. Ex. 6, p. 8.

The Facility Contract defines "contract period" in three ways, but each definition applies only to a specific section of the contract. Pet. Ex. 6, p. 2. For Article V, Section F, "contract period" means "the rate period as defined by the South Carolina State Plan." Ex. 6,

p. 2. The South Carolina State Plan (the "Plan"), however, does not define "rate period."¹
See Pet. Ex. 7.

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. Pet. Ex. 7, p. 22. 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. Pet. Ex. 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. Pet. Ex. 8. The rate did not change again until October 1, 2008, when DHHS raised it to \$135.11. Pet. Ex. 8.

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. Exs. 9-12. The SAO's final audit reports also identified these three periods as separate rate periods. Pet. Exs. 1-3. On December 16, 2011, Debra Myers, DHHS's Director of the Division of Long Term Care Reimbursements, wrote a letter to Countrywood in which she, also, identifies these same periods as three separate "rate periods." Pet. Ex. 8.

II. FACTS IN CONTROVERSY

Petitioner is unaware of any material facts in controversy.

¹ The Plan describes a "rate cycle" as lasting "from October 1 through September 30 and will be recomputed every twelve (12) months." Ex. 7, p. 12. It is undisputed, however, that "rate cycle" and "rate period" have different meanings.

III. LEGAL ISSUES

A. DHHS Cannot Recoup Funds Based on Audits of Three Cost Report Periods.

1. The SAO Contract Prohibits Audits of More than Two Cost Report Periods, When Fraud is Not an Issue.

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." Pet. Ex. 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 rule as a "restriction," which applies in all cases except those involving allegations of fraud. Pet. Ex. 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." Pet. Ex. 4, p. 4.

As set forth in the Statement 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 August 10, 2011. The cost report period used to set the rate in effect on August 10, 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).

DHHS argues that the SAO routinely audits six-month cost reports. Even if that is true, it is beside the point. The SAO Contract allows the SAO to audit two cost report periods, not three. 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 has the right only to audit the 2nd and 3rd Cost Report Periods, but not the 1st.

2. Countrywood is a Third Party Beneficiary.

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 South Carolina 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 with other state agencies, such as the SAO, "in order to effectuate 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.

2. The Public Importance Exception Confers Standing on Countrywood.

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 arbitrarily and capriciously 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.

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

As discussed in the Statement of Facts, Article V, Section F of the Facility Contract requires that any disallowment pursuant to an on-site audit must be made in a final audit report issued within three years of the close of the contract period. Pet. Ex. 6, p. 8. A "contract period" is the same as a "rate period." Pet. Ex. 6, p. 2.

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. 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 Exs. 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.

C. DHHS Is Not Entitled to Reconcile Funds Based on Final Audit Reports Issued Outside Contractual Deadlines.

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 \$24,080.00, 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 Oakonont 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.

D. Conclusion to Legal Issues

The SAO violated the SAO Contract by auditing three cost report periods, rather than two. 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, the Hearing Officer should grant Countrywood's Petition and requested relief.

IV. PETITIONER'S EXHIBITS AND WITNESSES

A. Exhibits

1. 11/22/11 Final Audit Report AC#3-RDM-E8
2. 11/22/11 Final Audit Report AC#3-RDM-J8
3. 11/22/11 Final Audit Report AC#3-RDM-J9
4. 7/1/11 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 ("SAO Contract")
5. 8/4/11 letter from Jay Von Kannel to Joe Hunt

6. 10/1/06 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 ("Facility Contract")
7. South Carolina State Plan, Attachment 4.19-D.
8. 12/16/11 letter from Debra Myers to Joseph Hunt
9. 4/3/09 Letter from Debra Myers to Lawrence A. Haynes.
10. 4/3/09 cover letter and 4/1/09 desk audit of Countrywood Nursing Center, LLC for rate period 11/29/07-5/31/08
11. 4/1/09 desk audit of Countrywood Nursing Center, LLC for rate period 6/1/08-9/30/08
12. 4/1/09 desk audit of Countrywood Nursing Center, LLC for rate period 10/1/08-9/30/09
13. 7/15/11 email from Larry Warrington to Terry Schmoyer

B. Witnesses

Terry Schmoyer
Schmoyer and Company, LLC
1330 Lady Street, Suite 507
Columbia, SC 29201
(803) 254-2050

V. UNUSUAL PROBLEMS RELATED TO EVIDENCE

Countrywood is not aware of any unusual problems related to evidence to be introduced.

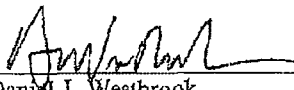
VI. UNUSUAL QUESTIONS OR MATTERS WHICH SHOULD BE BROUGHT TO THE ATTENTION OF THE HEARING OFFICER

Countrywood recently requested from DHHS, but has not yet received, copies of prior versions of the SAO Contract and other documents related to revisions of the SAO Contract. Countrywood is unaware of whether such material exists or its accessibility.

VII. SETTLEMENT STATUS

The parties have engaged in settlement discussions but have been unable to reach an agreement.

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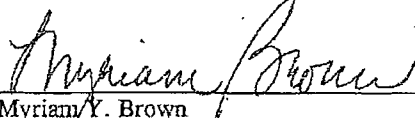
August 21, 2014.

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 emailing a copy of the same to the following address(es):

Pleadings: Petitioner's Prehearing Brief

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


Myriam Y. Brown
Administrative Assistant

August 22, 2014

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
1845 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 black 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.

COUNTRYWOOD NURSING CENTER, L.L.C.

HOPKINS, SOUTH CAROLINA

**CONTRACT PERIODS
BEGINNING NOVEMBER 29, 2007
AC# 3-RDM-ES**

AGREED-UPON PROCEDURES REPORT

ON CONTRACT

FOR

PURCHASE OF NURSING CARE SERVICES

WITH

STATE OF SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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State of South Carolina



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INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

September 21, 2011.

Department of Health and Human Services
State of South Carolina
Columbia, South Carolina

We have performed the procedures enumerated below, which were agreed to by the South Carolina Department of Health and Human Services, solely to compute the rate change and related adjusted reimbursement rate to be used by the Department in determining the reimbursement settlement with Countrywood Nursing Center, L.L.C., for the contract periods beginning November 29, 2007, and for the six month cost report period ended May 31, 2008, as set forth in the accompanying schedules. The management of Countrywood Nursing Center, L.L.C. is responsible for the Financial and Statistical Report for Nursing Homes and supporting accounting and statistical records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the South Carolina Department of Health and Human Services. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

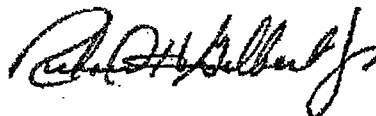
The procedures and the associated findings are as follows:

1. We selected costs or areas based on our analytical procedures applied to the reimbursable Medicaid program costs as shown on the Financial and Statistical Report for Nursing Homes, as filed by Countrywood Nursing Center, L.L.C., to determine if these costs were allowable as defined by the State Plan for Medicaid reimbursement purposes and supported by accounting and statistical records maintained by the Provider. Our findings as a result of these procedures are presented in the Summaries of Costs and Total Patient Days, Adjustment Report, and Cost of Capital Reimbursement Analyses sections of this report.
2. We recomputed the Computation of Reimbursement Rate using the adjusted costs and calculated the rate change in accordance with the provisions of the contract between the South Carolina Department of Health and Human Services and Countrywood Nursing Center, L.L.C. dated as of November 29, 2007, as amended. Our findings as a result of these procedures are presented in the Computation of Rate Change and Computations of Adjusted Reimbursement Rate sections of this report.

Department of Health and Human Services
State of South Carolina
September 21, 2011

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the financial statements or a part thereof. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the South Carolina Department of Health and Human Services and is not intended to be and should not be used by anyone other than the specified party.



Richard H. Gilbert, Jr., CPA
Deputy State Auditor

COUNTRYWOOD NURSING CENTER, L.L.C.
Computation of Rate Change
For the Contract Periods
Beginning November 29, 2007
AC# 3-RDM-ES

	11/29/07- <u>05/31/08</u>	06/01/08- <u>09/30/08</u>	10/01/08- <u>09/30/09</u>
Interim Reimbursement Rate (1)	\$150.80	\$157.32	\$157.73
Adjusted Reimbursement Rate	<u>129.21</u>	<u>134.74</u>	<u>135.11</u>
Decrease in Reimbursement Rate	\$ <u>21.59</u>	\$ <u>22.58</u>	\$ <u>22.62</u>

(1) Interim reimbursement rate from the South Carolina Medicaid Management Information System (MMIS) Provider Rate Listing dated July 15, 2011.

COUNTRYWOOD NURSING CENTER, L.L.C.
Computation of Adjusted Reimbursement Rate
For the Contract Period November 29, 2007 Through May 31, 2008
AC# 3-RDM-E8

	<u>Incentives</u>	<u>Allowable Cost</u>	<u>Cost Standard</u>	<u>Computed Rate</u>
<u>Costs Subject to Standards:</u>				
General Services		\$ 71.88	\$ 79.97	
Dietary		10.83	16.36	
Laundry/Housekeeping/Maintenance		<u>10.02</u>	<u>13.89</u>	
Subtotal	<u>\$7.72</u>	92.73	110.22	\$ 92.73
Administration & Medical Records	<u>\$4.24</u>	<u>17.17</u>	<u>21.41</u>	<u>17.17</u>
Subtotal		109.90	<u>\$131.63</u>	109.90
<u>Costs Not Subject to Standards:</u>				
Utilities		3.24		3.24
Special Services		.45		.45
Medical Supplies & Oxygen		3.70		3.70
Taxes and Insurance		2.92		2.92
Legal Fees		-		-
TOTAL		<u>\$120.21</u>		120.21
Inflation Factor (N/A)				-
Cost of Capital				7.25
Cost of Capital Limitation				-
Profit Incentive (Maximum 3.5% of Allowable Cost)				4.21
Cost Incentive				7.72
Effect of \$1.75 Cap on Cost/Profit Incentives				<u>(10.18)</u>
ADJUSTED REIMBURSEMENT RATE				<u>\$129.21</u>

COUNTRYWOOD NURSING CENTER, L.L.C.
Computation of Adjusted Reimbursement Rate
For the Contract Period June 1, 2008 Through September 30, 2008
AC# 3-RDM-E8

	<u>Incentives</u>	<u>Allowable Cost</u>	<u>Cost Standard</u>	<u>Computed Rate</u>
<u>Costs Subject to Standards:</u>				
General Services		\$ 71.88	\$ 79.97	
Dietary		10.83	16.36	
Laundry/Housekeeping/Maintenance		<u>10.02</u>	<u>13.89</u>	
Subtotal	<u>\$7.72</u>	92.73	110.22	\$ 92.73
Administration & Medical Records	<u>\$4.24</u>	<u>17.17</u>	<u>21.41</u>	<u>17.17</u>
Subtotal		109.90	<u>\$131.63</u>	109.90
<u>Costs Not Subject to Standards:</u>				
Utilities		3.24		3.24
Special Services		.45		.45
Medical Supplies & Oxygen		3.70		3.70
Taxes and Insurance		2.92		2.92
Legal Fees		-		-
TOTAL		<u>\$120.21</u>		120.21
Inflation Factor (4.60%)				5.53
Cost of Capital				7.25
Cost of Capital Limitation				-
Profit Incentive (Maximum 3.5% of Allowable Cost)				4.21
Cost Incentive				7.72
Effect of \$1.75 Cap on Cost/Profit Incentives				<u>(10.18)</u>
ADJUSTED REIMBURSEMENT RATE				<u>\$134.74</u>

COUNTRYWOOD NURSING CENTER, L.L.C.
Computation of Adjusted Reimbursement Rate
For the Contract Period October 1, 2008 Through September 30, 2009
AC# 3-RDM-E8

	<u>Incentives</u>	<u>Allowable Cost</u>	<u>Cost Standard</u>	<u>Computed Rate</u>
<u>Costs Subject to Standards:</u>				
General Services		\$ 71.88	\$ 76.00	
Dietary		10.83	16.33	
Laundry/Housekeeping/Maintenance		<u>10.02</u>	<u>14.74</u>	
Subtotal	<u>\$7.49</u>	92.73	107.07	\$ 92.73
Administration & Medical Records	<u>\$6.02</u>	<u>17.17</u>	<u>23.19</u>	<u>17.17</u>
Subtotal		109.90	<u>\$130.26</u>	109.90
<u>Costs Not Subject to Standards:</u>				
Utilities		3.24		3.24
Special Services		.45		.45
Medical Supplies & Oxygen		3.70		3.70
Taxes and Insurance		2.92		2.92
Legal Fees		-		-
TOTAL		<u>\$120.21</u>		120.21
Inflation Factor (4.80%)				5.77
Cost of Capital				7.38
Cost of Capital Limitation				-
Profit Incentive (Maximum 3.5% of Allowable Cost)				4.21
Cost Incentive				7.49
Effect of \$1.75 Cap on Cost/Profit Incentives				<u>(9.95)</u>
ADJUSTED REIMBURSEMENT RATE				<u>\$135.11</u>

COUNTRYWOOD NURSING CENTER, L.L.C.
Summary of Costs and Total Patient Days
For the Cost Report Period Ended May 31, 2008
For the Contract Periods November 29, 2007 Through September 30, 2008
AC# 3-RDM-E8

<u>Expenses</u>	<u>Totals (From Schedule SC 13) as Adjusted by DH&HS</u>	<u>Adjustments</u>		<u>Adjusted Totals</u>
		<u>Debit</u>	<u>Credit</u>	
General Services	\$559,176	\$ -	\$ 58,633 (3) 4,798 (10) 90 (10) 5,357 (11) 4,966 (14)	\$485,132
Dietary	77,577	47,426 (13)	5,923 (4) 27 (10) 45,977 (14)	73,076
Laundry	13,918	6,861 (13)	8,025 (14)	12,754
Housekeeping	41,967	16,544 (13)	24,053 (14)	34,458
Maintenance	22,020	15,003 (13)	1,976 (5) 118 (10) 142 (12) 14,357 (14)	20,430
Administration & Medical Records	143,524	1,457 (5) 30,010 (13)	2,030 (6) 1,451 (7) 6,000 (8) 390 (10) 19,816 (12) 29,406 (14)	115,898
Utilities	22,408	15,235 (13)	452 (12) 15,321 (14)	21,870
Special Services	3,036	-	-	3,036
Medical Supplies & Oxygen	53,445	-	7,513 (4) 10,470 (9) 10,499 (14)	24,963

COUNTRYWOOD NURSING CENTER, L.L.C.
Summary of Costs and Total Patient Days
For the Cost Report Period Ended May 31, 2008
For the Contract Periods November 29, 2007 Through September 30, 2008
AC# 3-RDM-E8

<u>Expenses</u>	<u>Totals (From Schedule SC 13) as Adjusted by DH&HS</u>	<u>Adjustments</u>		<u>Adjusted Totals</u>
		<u>Debit</u>	<u>Credit</u>	
Taxes and Insurance	20,152	12,913 (13)	450 (12) 12,923 (14)	19,692
Legal Fees	-	-	-	-
Cost of Capital	48,742	384 (1) 3,642 (2) 895 (13)	148 (12) 954 (14) 3,642 (15)	48,919
Subtotal	1,005,965	150,370	296,107	860,228
Ancillary	22,799	10,470 (9)	-	33,269
Nonallowable	140,760	58,833 (3) 13,436 (4) 519 (5) 1,451 (7) 6,000 (8) 5,423 (10) 5,357 (11) 21,008 (12) 166,481 (14) 3,642 (15)	384 (1) 3,642 (2) 144,887 (13)	281,997
CNA Training and Testing	-	-	-	-
Total Operating Expenses	<u>\$1,177,524</u>	<u>\$442,990</u>	<u>\$445,020</u>	<u>\$1,175,494</u>
Total Patient Days	<u>6,749</u>	-	-	<u>6,749</u>
Total Beds	<u>38</u>			

COUNTRYWOOD NURSING CENTER, L.L.C.
Summary of Costs and Total Patient Days
For the Cost Report Period Ended May 31, 2008
For the Contract Period October 1, 2008 Through September 30, 2009
AC# 3-RDM-E8

<u>Expenses</u>	Totals (From Schedule SC 13) as Adjusted by DN&HS	Adjustments Debit	Credit	Adjusted Totals
General Services	\$559,176	\$ -	\$ 58,833 (3) 4,798 (10) 90 (10) 5,357 (11) 4,966 (14)	\$485,132
Dietary	77,577	47,426 (13)	5,923 (4) 27 (10) 45,977 (14)	73,076
Laundry	13,918	6,861 (13)	8,025 (14)	12,754
Housekeeping	41,967	16,544 (13)	24,053 (14)	34,458
Maintenance	22,020	15,003 (13)	1,976 (5) 118 (10) 142 (12) 14,357 (14)	20,430
Administration & Medical Records	143,524	1,457 (5) 30,010 (13)	2,030 (6) 1,451 (7) 6,000 (8) 390 (10) 19,816 (12) 29,406 (14)	115,898
Utilities	22,408	15,235 (13)	452 (12) 15,321 (14)	21,870
Special Services	3,036	-	-	3,036
Medical Supplies & Oxygen	53,445	-	7,513 (4) 10,470 (9) 160,499 (14)	24,963

COUNTRYWOOD NURSING CENTER, L.L.C.
Summary of Costs and Total Patient Days
For the Cost Report Period Ended May 31, 2008
For the Contract Period October 1, 2008 Through September 30, 2009
AC# 3-RDM-E8

<u>Expenses</u>	<u>Totals (From Schedule SC 13) as Adjusted by DH&HS</u>	<u>Adjustments</u>		<u>Adjusted Totals</u>
		<u>Debit</u>	<u>Credit</u>	
Taxes and Insurance	20,152	12,913 (13)	450 (12) 12,923 (14)	19,692
Legal Fees	-	-	-	-
Cost of Capital	49,518	384 (1) 3,642 (2) 895 (13)	148 (12) 954 (14) 3,520 (16)	49,817
Subtotal	1,006,741	150,370	295,985	861,126
Ancillary	22,799	10,470 (9)	-	33,269
Nonallowable	147,984	58,833 (3) 13,436 (4) 519 (5) 1,451 (7) 6,000 (8) 5,423 (10) 5,357 (11) 21,008 (12) 166,481 (14) 3,520 (16)	384 (1) 3,642 (2) 144,887 (13)	281,099
CNA Training and Testing	-	-	-	-
Total Operating Expenses	<u>\$1,177,524</u>	<u>\$442,868</u>	<u>\$444,898</u>	<u>\$1,175,494</u>
Total Patient Days	<u>6,749</u>	-	-	<u>6,749</u>
Total Beds	<u>38</u>			

COUNTRYWOOD NURSING CENTER, LLC
Adjustment Report
Cost Report Period Ended May 31, 2008
AC# 3-RDM-E8

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
1	Fixed Assets	\$243,615	
	Cost of Capital	384	
	Accumulated Depreciation		\$ 96,864
	Other Equity		146,751
	Nonallowable		384
	To adjust fixed assets and related depreciation HIM-15-1, Section 2304 State Plan, Attachment 4.19D		
2	Cost of Capital	3,642	
	Nonallowable		3,642
	To adjust depreciation expense to comply with capital cost policy State Plan, Attachment 4.19D		
3	Nonallowable	58,833	
	Nursing		58,833
	To disallow expense due to lack of adequate documentation HIM-15-1, Sections 1000, 1005 and 2304		
4	Nonallowable	13,436	
	Dietary		5,923
	Medical Supplies		7,513
	To disallow expense due to lack of adequate documentation HIM-15-1, Section 2304		
5	Administration	1,457	
	Nonallowable	519	
	Maintenance		1,976
	To remove duplicate expense posting and reclassify expense to the proper cost center HIM-15-1, Section 2304 DH&HS Expense Crosswalk		

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended May 31, 2008
AC# 3-RDM-E8

ADJUSTMENT NUMBER	ACCOUNT TITLE	DEBIT	CREDIT
6	Retained Earnings Administration	2,030	2,030
	To properly charge expense applicable to the prior period HIM-15-1, Section 2302.1		
7	Nonallowable Administration	1,451	1,451
	To adjust expense to agree to postings per the general ledger HIM-15-1, Section 2304		
8	Nonallowable Medical Records	6,000	6,000
	To disallow expense due to lack of adequate documentation HIM-15-1, Section 2304		
9	Ancillary Medical Supplies	10,470	10,470
	To reclassify expense to the proper cost center DH&HS Expense Crosswalk		
10	Nonallowable Nursing Restorative Dietary Maintenance Administration	5,123	4,798 90 27 118 390
	To adjust fringe benefits and related allocation HIM-15-1, Section 2304 State Plan, Attachment 4.19D		
11	Nonallowable Nursing	5,357	5,357
	To reclassify salaries to the proper cost center DH&HS Expense Crosswalk		

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended May 31, 2008
AC# 3-RDM-EB

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
12	Nonallowable	21,008	
	Maintenance		142
	Administration		19,816
	Utilities		452
	Taxes and Insurance		450
	Cost of Capital		148
	To disallow home office cost allocation due to lack of adequate documentation HIM-15-1, Section 2304		
13	Dietary	47,426	
	Laundry	6,861	
	Housekeeping	16,544	
	Maintenance	15,003	
	Administration	30,010	
	Utilities	15,235	
	Taxes and Insurance	12,913	
	Cost of Capital	895	
	Nonallowable		144,887
	To reverse Provider/DH&HS adjustments to remove cost applicable to a non-reimbursable cost center HIM-15-1, Sections 2102.3 and 2304 State Plan, Attachment 4.19D		
14	Nonallowable	166,481	
	Restorative		4,966
	Dietary		45,977
	Laundry		8,025
	Housekeeping		24,053
	Maintenance		14,357
	Administration		29,406
	Utilities		15,321
	Taxes and Insurance		12,923
	Medical Supplies		10,499
	Cost of Capital		954
	To remove indirect cost applicable to a non-reimbursable cost center HIM-15-1, Section 2102.3 State Plan, Attachment 4.19D		

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended May 31, 2008
AC# 3-RDM-E8.

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
15	Nonallowable Cost of Capital	3,642	3,642
	To adjust capital return State Plan, Attachment 4.19D		
	(This adjustment applies only to the contract periods 11/29/07 - 9/30/08)		
16	Nonallowable Cost of Capital	3,520	3,520
	To adjust capital return State Plan, Attachment 4.19D		
	(This adjustment applies only to the contract period 10/1/08 - 9/30/09)		
	TOTAL ADJUSTMENTS	<u>\$692,155</u>	<u>\$692,155</u>

Due to the nature of compliance reporting,
adjustment descriptions and references
contained in the preceding Adjustment
Report are provided for general guidance
only and are not intended to be all-
inclusive.

COUNTRYWOOD NURSING CENTER, L.L.C.
Cost of Capital Reimbursement Analysis
For the Cost Report Period Ended May 31, 2008
For the Contract Periods November 29, 2007 Through September 30, 2008
AC# 3-RDM-E8

Original Asset Cost (Per Bed)	\$ 15,618
Inflation Adjustment	<u>2.85382</u>
Deemed Asset Value (Per Bed)	44,571
Number of Beds	<u>38</u>
Deemed Asset Value	1,693,698
Improvements Since 1991	16,746
Accumulated Depreciation at 5/31/08	<u>(342,279)</u>
Deemed Depreciated Value	1,368,165
Market Rate of Return	<u>.0489</u>
Total Annual Return	66,903
Number of Days in Period	<u>185/366</u>
Adjusted Annual Return	33,817
Return Applicable to Non-Reimbursable Cost Centers	(1,806)
Allocation of Interest to Non-Reimbursable Cost Centers	<u>-</u>
Allowable Annual Return	32,011
Depreciation Expense	17,862
Amortization Expense	-
Capital Related Income Offsets	-
Allocation of Capital Expenses to Non-Reimbursable Cost Centers	<u>(954)</u>
Allowable Cost of Capital Expense	48,919
Total Patient Days (Minimum 96% Occupancy)	<u>6,749</u>
Cost of Capital Per Diem	\$ <u>7.25</u>

COUNTRYWOOD NURSING CENTER, L.L.C.
Cost of Capital Reimbursement Analysis
For the Cost Report Period Ended May 31, 2008
For the Contract Period October 1, 2008 Through September 30, 2009
AC# 3-RDM-E8

Original Asset Cost (Per Bed)	\$ 15,618
Inflation Adjustment	<u>2.94141</u>
Deemed Asset Value (Per Bed)	45,939
Number of Beds	<u>38</u>
Deemed Asset Value	1,745,682
Improvements Since 1981	16,746
Accumulated Depreciation at 5/31/08	<u>(342,279)</u>
Deemed Depreciated Value	1,420,149
Market Rate of Return	<u>.0483</u>
Total Annual Return	68,593
Number of Days in Period	<u>185/365</u>
Adjusted Annual Return	34,766
Return Applicable to Non-Reimbursable Cost Centers	(1,857)
Allocation of Interest to Non-Reimbursable Cost Centers	<u>-</u>
Allowable Annual Return	32,909
Depreciation Expense	17,862
Amortization Expense	-
Capital Related Income Offsets	-
Allocation of Capital Expenses to Non-Reimbursable Cost Centers	<u>(954)</u>
Allowable Cost of Capital Expense	49,817
Total Patient Days (Minimum 96% Occupancy)	<u>6,749</u>
Cost of Capital Per Diem	\$ <u>7.38</u>

3 copies of this document were published at an estimated printing cost of \$1.55 each, and a total printing cost of \$4.65. Section 1-11-125 of the South Carolina Code of Laws, as amended requires this information on printing costs be added to the document.

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) 253-4140
FAX (803) 243-0923

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,

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/cwc

cc: Ms. Brenda L. Hyleman
Mr. Jeff Saxon
Ms. Kathleen C. Snider
Mr. Terry K. Schmoyer, Jr.

COUNTRYWOOD NURSING CENTER, L.L.C.

HOPKINS, SOUTH CAROLINA

**CONTRACT PERIOD
BEGINNING OCTOBER 1, 2009
AC# 3-RDM-J8**

AGREED-UPON PROCEDURES REPORT

ON CONTRACT

FOR

PURCHASE OF NURSING CARE SERVICES

WITH

STATE OF SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

September 30, 2011

Department of Health and Human Services
State of South Carolina
Columbia, South Carolina

We have performed the procedures enumerated below, which were agreed to by the South Carolina Department of Health and Human Services, solely to compute the rate change and related adjusted reimbursement rate to be used by the Department in determining the reimbursement settlement with Countrywood Nursing Center, L.L.C., for the contract period beginning October 1, 2009, and for the twelve month cost report period ended September 30, 2008, as set forth in the accompanying schedules. The management of Countrywood Nursing Center, L.L.C. is responsible for the Financial and Statistical Report for Nursing Homes and supporting accounting and statistical records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the South Carolina Department of Health and Human Services. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

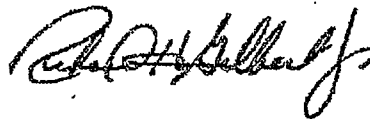
The procedures and the associated findings are as follows:

1. We selected costs or areas based on our analytical procedures applied to the reimbursable Medicaid program costs as shown on the Financial and Statistical Report for Nursing Homes, as filed by Countrywood Nursing Center, L.L.C., to determine if these costs were allowable as defined by the State Plan for Medicaid reimbursement purposes and supported by accounting and statistical records maintained by the Provider. Our findings as a result of these procedures are presented in the Summary of Costs and Total Patient Days, Adjustment Report, and Cost of Capital Reimbursement Analysis sections of this report.
2. We recomputed the Computation of Reimbursement Rate using the adjusted costs and calculated the rate change in accordance with the provisions of the contract between the South Carolina Department of Health and Human Services and Countrywood Nursing Center, L.L.C. dated as of November 29, 2007, as amended. Our findings as a result of these procedures are presented in the Computation of Rate Change and Computation of Adjusted Reimbursement Rate sections of this report.

Department of Health and Human Services
State of South Carolina
September 30, 2011

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the financial statements or a part thereof. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the South Carolina Department of Health and Human Services and is not intended to be and should not be used by anyone other than the specified party.



Richard H. Gilbert, Jr., CPA
Deputy State Auditor

3
Exhibit A

COUNTRYWOOD NURSING CENTER, L.L.C.
Computation of Rate Change
For the Contract Period
Beginning October 1, 2009
AC# 3-RDM-J8

	10/01/09- 09/30/10
Interim Reimbursement Rate (1)	\$153.90
Adjusted Reimbursement Rate	<u>135.20</u>
Decrease in Reimbursement Rate	<u>\$ 18.70</u>

- (1) Interim reimbursement rate from the South Carolina Medicaid Management Information System (MMIS) Provider Rate Listing dated July 15, 2011.

COUNTRYWOOD NURSING CENTER, L.L.C.
Computation of Adjusted Reimbursement Rate
For the Contract Period October 1, 2009 Through September 30, 2010
AC# 3-RDM-J8

	<u>Incentives</u>	<u>Allowable Cost</u>	<u>Cost Standard</u>	<u>Computed Rate</u>
<u>Costs Subject to Standards:</u>				
General Services		\$ 73.03	\$ 87.54	
Dietary		11.14	16.45	
Laundry/Housekeeping/Maintenance		<u>9.83</u>	<u>14.83</u>	
Subtotal	<u>\$ 8.32</u>	94.00	118.82	\$ 94.00
Administration & Medical Records	<u>\$10.25</u>	<u>15.35</u>	<u>25.60</u>	<u>15.35</u>
Subtotal		109.35	<u>\$144.42</u>	109.35
<u>Costs Not Subject to Standards:</u>				
Utilities		3.50		3.50
Special Services		.40		.40
Medical Supplies & Oxygen		4.01		4.01
Taxes and Insurance		3.12		3.12
Legal Fees		-		-
TOTAL		<u>\$120.38</u>		120.38
Inflation Factor (4.70%)				5.66
Cost of Capital				7.41
Cost of Capital Limitation				-
Profit Incentive (Maximum 3.5% of Allowable Cost)				4.21
Cost Incentive				8.32
Effect of \$1.75 Cap on Cost/Profit Incentives				<u>(10.78)</u>
ADJUSTED REIMBURSEMENT RATE				<u>\$135.20</u>

COUNTRYWOOD NURSING CENTER, L.L.C.
Summary of Costs and Total Patient Days
For the Cost Report Period Ended September 30, 2008
AC# 3-RDM-J8

<u>Expenses</u>	<u>Totals (From Schedule SC 13) as Adjusted by DH&RS</u>	<u>Adjustments</u>		<u>Adjusted Totals</u>
		<u>Debit</u>	<u>Credit</u>	
General Services	\$900,815	\$ -	\$58,833 (3) 6,782 (9) 124 (9) 9,019 (10) 8,150 (13)	\$817,899
Dietary	129,884	73,963 (12)	5,923 (4) 40 (9) 73,103 (13)	124,781
Laundry	23,066	11,369 (12)	12,722 (13)	21,713
Housekeeping	70,316	27,899 (12)	40,300 (13)	57,915
Maintenance	32,207	21,854 (12)	1,976 (5) 131 (9) 236 (11) 21,267 (13)	30,451
Administration & Medical Records	214,711	1,457 (5) 46,029 (12)	2,030 (6) 10,200 (7) 469 (9) 33,029 (11) 44,598 (13)	171,874
Utilities	40,050	27,115 (12)	754 (11) 27,261 (13)	39,150
Special Services	4,529	-	-	4,529
Medical Supplies & Oxygen	86,079	-	7,513 (4) 14,642 (8) 19,065 (13)	44,859

COUNTRYWOOD NURSING CENTER, L.L.C.
Summary of Costs and Total Patient Days
For the Cost Report Period Ended September 30, 2008
AC# 3-RDM-J8

<u>Expenses</u>	<u>Totals (From Schedule SC 13) as Adjusted by DH&RS</u>	<u>Adjustments</u>		<u>Adjusted Totals</u>
		<u>Debit</u>	<u>Credit</u>	
Taxes and Insurance	35,719	22,838 (12)	749 (11) 22,856 (13)	34,952
Legal Fees	-	-	-	-
Cost of Capital	94,301	266 (1) 6,156 (2) 1,476 (12)	247 (11) 1,546 (13) 17,434 (14)	82,972
Subtotal	1,631,677	240,422	441,004	1,431,095
Ancillary	34,133	14,642 (8)	-	48,775
Nonallowable	660,235	58,833 (3) 13,436 (4) 519 (5) 10,200 (7) 7,546 (9) 9,019 (10) 35,015 (11) 270,873 (13) 17,434 (14)	266 (1) 6,156 (2) 232,543 (12)	844,145
CNA Training and Testing	-	-	-	-
Total Operating Expenses	<u>\$2,326,045</u>	<u>\$677,939</u>	<u>\$679,969</u>	<u>\$2,324,015</u>
Total Patient Days	<u>11,199</u>	-	-	<u>11,199</u>
Total Beds	<u>38</u>			

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended September 30, 2008
AC# 3-RDM-J8

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
1	Fixed Assets	\$243,615	
	Cost of Capital	266	
	Accumulated Depreciation		\$ 96,747
	Other Equity		146,868
	Nonallowable		266
	To adjust fixed assets and related depreciation		
	HIM-15-1, Section 2304		
	State Plan, Attachment 4.19D		
2	Cost of Capital	6,156	
	Nonallowable		6,156
	To adjust depreciation expense to comply with capital cost policy		
	State Plan, Attachment 4.19D		
3	Nonallowable	58,833	
	Nursing		58,833
	To disallow expense due to lack of adequate documentation		
	HIM-15-1, Sections 1000, 1005 and 2304		
4	Nonallowable	13,436	
	Dietary		5,923
	Medical Supplies		7,513
	To disallow expense due to lack of adequate documentation		
	HIM-15-1, Section 2304		
5	Administration	1,457	
	Nonallowable	519	
	Maintenance		1,976
	To remove duplicate expense posting and reclassify expense to the proper cost center		
	HIM-15-1, Section 2304		
	DH&HS Expense Crosswalk		

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended September 30, 2008
AC# 3-RDM-J8

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
6	Retained Earnings Administration	2,030	2,030
	To properly charge expense applicable to the prior period HIM-15-1, Section 2302.1		
7	Nonallowable Medical Records	10,200	10,200
	To disallow expense due to lack of adequate documentation HIM-15-1, Section 2304		
8	Ancillary Medical Supplies	14,642	14,642
	To reclassify expense to the proper cost center DH&HS Expense Crosswalk		
9	Nonallowable Nursing Restorative Dietary Maintenance Administration	7,546	6,782 124 40 131 469
	To adjust fringe benefits and related allocation HIM-15-1, Section 2304 State Plan, Attachment 4.19D		
10	Nonallowable Nursing	9,019	9,019
	To reclassify salaries to the proper cost center DH&HS Expense Crosswalk		

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended September 30, 2008
AC# 3-RDM-J8

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
11	Nonallowable	35,015	
	Maintenance		236
	Administration		33,029
	Utilities		754
	Taxes and Insurance		749
	Cost of Capital		247
	To disallow home office cost allocation due to lack of adequate documentation HIM-15-1, Section 2304		
12	Dietary	73,963	
	Laundry	11,369	
	Housekeeping	27,899	
	Maintenance	21,854	
	Administration	46,029	
	Utilities	27,115	
	Taxes and Insurance	22,838	
	Cost of Capital	1,476	
	Nonallowable		232,543
	To reverse Provider/DH&HS adjustments to remove cost applicable to a non-reimbursable cost center HIM-15-1, Sections 2102.3 and 2304 State Plan, Attachment 4.19D		
13	Nonallowable	270,873	
	Restorative		8,158
	Dietary		73,103
	Laundry		12,722
	Housekeeping		40,300
	Maintenance		21,267
	Administration		44,595
	Utilities		27,261
	Taxes and Insurance		22,856
	Medical Supplies		19,065
	Cost of Capital		1,546
	To remove indirect cost applicable to a non-reimbursable cost center HIM-15-1, Section 2102.3 State Plan, Attachment 4.19D		

10
Schedule 1
(Continued)

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended September 30, 2008
AC# 3-RDM-J8

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
14	Nonallowable Cost of Capital	17,434	17,434
	To adjust capital return State Plan, Attachment 4.19D		
	TOTAL ADJUSTMENTS	<u>\$923,584</u>	<u>\$923,584</u>

Due to the nature of compliance reporting, adjustment descriptions and references contained in the preceding Adjustment Report are provided for general guidance only and are not intended to be all-inclusive.

COUNTRYWOOD NURSING CENTER, L.L.C.
Cost of Capital Reimbursement Analysis
For the Cost Report Period Ended September 30, 2008
AC# 3-RDM-J8

Original Asset Cost (Per Bed)	\$ 15,618
Inflation Adjustment	<u>3.03131</u>
Deemed Asset Value (Per Bed)	47,343
Number of Beds	<u>38</u>
Deemed Asset Value	1,799,034
Improvements Since 1981	16,746
Accumulated Depreciation at 9/30/08	<u>(354,050)</u>
Deemed Depreciated Value	1,461,730
Market Rate of Return	<u>.0471</u>
Total Annual Return	68,847
Number of Days in Period	<u>307/365</u>
Adjusted Annual Return	57,907
Return Applicable to Non-Reimbursable Cost Centers	(3,021)
Allocation of Interest to Non-Reimbursable Cost Centers	<u>~</u>
Allowable Annual Return	54,886
Depreciation Expense	29,632
Amortization Expense	~
Capital Related Income Offsets	~
Allocation of Capital Expenses to Non-Reimbursable Cost Centers	<u>(1,546)</u>
Allowable Cost of Capital Expense	82,972
Total Patient Days (Minimum 96% Occupancy)	<u>11,199</u>
Cost of Capital Per Diem	\$ <u>7.41</u>

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State of South Carolina



Office of the State Auditor

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RICHARD H. GILBERT, JR., CPA
DEPUTY STATE AUDITOR

(803) 253-4160
FAX (803) 243-0721

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,

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.

COUNTRYWOOD NURSING CENTER, L.L.C.

ROPKINS, SOUTH CAROLINA

CONTRACT PERIODS
BEGINNING OCTOBER 1, 2010
ACH 3-RDM-J9

AGREED-UPON PROCEDURES REPORT

ON CONTRACT

FOR

PURCHASE OF NURSING CARE SERVICES

WITH

STATE OF SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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State of South Carolina



Office of the State Auditor

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INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

October 11, 2011

Department of Health and Human Services
State of South Carolina
Columbia, South Carolina

We have performed the procedures enumerated below, which were agreed to by the South Carolina Department of Health and Human Services, solely to compute the rate change and related adjusted reimbursement rate to be used by the Department in determining the reimbursement settlement with Countrywood Nursing Center, L.L.C., for the contract periods beginning October 1, 2010, and for the twelve month cost report period ended September 30, 2009, as set forth in the accompanying schedules. The management of Countrywood Nursing Center, L.L.C. is responsible for the Financial and Statistical Report for Nursing Homes and supporting accounting and statistical records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the South Carolina Department of Health and Human Services. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

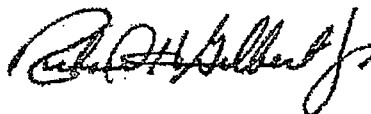
The procedures and the associated findings are as follows:

1. We selected costs or areas based on our analytical procedures applied to the reimbursable Medicaid program costs as shown on the Financial and Statistical Report for Nursing Homes, as filed by Countrywood Nursing Center, L.L.C., to determine if these costs were allowable as defined by the State Plan for Medicaid reimbursement purposes and supported by accounting and statistical records maintained by the Provider. Our findings as a result of these procedures are presented in the Summary of Costs and Total Patient Days, Adjustment Report, and Cost of Capital Reimbursement Analysis sections of this report.
2. We recomputed the Computation of Reimbursement Rate using the adjusted costs and calculated the rate change in accordance with the provisions of the contract between the South Carolina Department of Health and Human Services and Countrywood Nursing Center, L.L.C. dated as of November 29, 2007, as amended. Our findings as a result of these procedures are presented in the Computation of Rate Change and Computations of Adjusted Reimbursement Rate sections of this report.

Department of Health and Human Services
State of South Carolina
October 11, 2011

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the financial statements or a part thereof. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the South Carolina Department of Health and Human Services and is not intended to be and should not be used by anyone other than the specified party.



Richard H. Gilbert, Jr., CPA
Deputy State Auditor

COUNTRYWOOD NURSING CENTER, L.L.C.
Computation of Rate Change
For the Contract Periods
Beginning October 1, 2010
AC# 3-RDM-J9

	<u>10/01/10- 04/07/11</u>	<u>04/08/11- 09/30/11</u>
Interim Reimbursement Rate (1)	\$147.93	\$143.49
Adjusted Reimbursement Rate	<u>137.14</u>	<u>133.03</u>
Decrease in Reimbursement Rate	<u>\$ 10.79</u>	<u>\$ 10.46</u>

(1) Interim reimbursement rate from the South Carolina Medicaid Management Information System (MMIS) Provider Rate Listing dated July 15, 2011.

COUNTRYWOOD NURSING CENTER, L.L.C.
Computation of Adjusted Reimbursement Rate
For the Contract Period October 1, 2010 Through April 7, 2011
AC# 3-RDM-J9

	<u>Incentives</u>	<u>Allowable Cost</u>	<u>Cost Standard</u>	<u>Computed Rate</u>
<u>Costs Subject to Standards:</u>				
General Services		\$ 74.33	\$ 98.22	
Dietary		10.69	16.72	
Laundry/Housekeeping/Maintenance		<u>10.62</u>	<u>15.73</u>	
Subtotal	<u>\$9.15</u>	95.64	130.67	\$ 95.64
Administration & Medical Records	<u>\$5.94</u>	<u>19.94</u>	<u>25.88</u>	<u>19.94</u>
Subtotal		115.58	<u>\$156.55</u>	115.58
<u>Costs Not Subject to Standards:</u>				
Utilities		3.25		3.25
Special Services		-		-
Medical Supplies & Oxygen		3.44		3.44
Taxes and Insurance		3.50		3.50
Legal Fees		-		-
TOTAL		<u>\$125.77</u>		125.77
Inflation Factor (2.00%)				2.52
Cost of Capital				7.10
Cost of Capital Limitation				-
Profit Incentive (Maximum 3.5% of Allowable Cost)				4.40
Cost Incentive				9.15
Effect of \$1.75 Cap on Cost/Profit Incentives				<u>(11.80)</u>
ADJUSTED REIMBURSEMENT RATE				<u>\$137.14</u>

COUNTRYWOOD NURSING CENTER, LLC.
Computation of Adjusted Reimbursement Rate
For the Contract Period April 8, 2011 Through September 30, 2011
AC# 3-RDM-J9

	<u>Incentives</u>	<u>Allowable Cost</u>	<u>Cost Standard</u>	<u>Computed Rate</u>
<u>Costs Subject to Standards:</u>				
General Services		\$ 74.33	\$ 98.22	
Dietary		10.69	16.72	
Laundry/Housekeeping/Maintenance		<u>10.62</u>	<u>15.73</u>	
Subtotal	<u>\$9.15</u>	95.64	130.67	\$ 95.64
Administration & Medical Records	<u>\$5.94</u>	<u>19.94</u>	<u>25.88</u>	<u>19.94</u>
Subtotal		115.58	<u>\$156.55</u>	115.58
<u>Costs Not Subject to Standards:</u>				
Utilities		3.25		3.25
Special Services		-		-
Medical Supplies & Oxygen		3.44		3.44
Taxes and Insurance		3.50		3.50
Legal Fees		-		-
TOTAL		<u>\$125.77</u>		125.77
Inflation Factor (2.00%)				2.52
Cost of Capital				7.10
Cost of Capital Limitation				-
Profit Incentive (Maximum 3.5% of Allowable Cost)				4.40
Cost Incentive				9.15
Effect of \$1.75 Cap on Cost/Profit Incentives				(11.80)
Effect of 3% Rate Reduction				<u>(4.11)</u>
ADJUSTED REIMBURSEMENT RATE				<u>\$133.03</u>

COUNTRYWOOD NURSING CENTER, L.L.C.
Summary of Costs and Total Patient Days
For the Cost Report Period Ended September 30, 2009
AC# 3-RDM-J9

<u>Expenses</u>	<u>Totals (From Schedule SC 13) as Adjusted by DH&HS</u>	<u>Adjustments</u>		<u>Adjusted Totals</u>
		<u>Debit</u>	<u>Credit</u>	
General Services	\$1,003,046	\$11,397 (9)	\$ 1,860 (6) 10,724 (7) 12,185 (10)	\$989,674
Dietary	144,038	92,166 (9)	93,884 (10)	142,320
Laundry	26,693	13,749 (9)	16,074 (10)	24,368
Housekeeping	83,978	33,266 (9)	48,249 (10)	68,995
Maintenance	51,524	37,752 (9)	7,222 (4) 223 (8) 33,828 (10)	48,003
Administration & Medical Records	307,710	68,539 (9)	14,400 (3) 30,656 (8) 65,717 (10)	265,476
Utilities	39,309	7,222 (4) 27,286 (9)	40 (8) 30,451 (10)	43,326
Special Services	30,513	-	30,513 (11)	-
Medical Supplies & Oxygen	84,777	3,000 (9)	9,930 (5) 27,705 (10) 4,345 (11)	45,797
Taxes and Insurance	46,247	31,548 (9)	387 (8) 30,744 (10)	46,664
Legal Fees	628	185 (9)	813 (8)	-

COUNTRYWOOD NURSING CENTER, LLC.
Summary of Costs and Total Patient Days
For the Cost Report Period Ended September 30, 2009
AC# 3-RDM-J9

<u>Expenses</u>	Totals (From Schedule SC 13) as Adjusted by DH&HS	Adjustments		Adjusted Totals
		<u>Debit</u>	<u>Credit</u>	
Cost of Capital	91,568	407 (1) 7,309 (2) 2,787 (9)	175 (8) 1,935 (10) 5,441 (12)	94,520
Subtotal	1,910,031	336,613	477,501	1,769,143
Ancillary	42,792	9,930 (5)	-	52,722
Nonallowable	1,128,752	14,400 (3) 1,860 (6) 10,724 (7) 32,294 (8) 360,772 (10) 34,858 (11) 5,441 (12)	407 (1) 7,309 (2) 321,675 (9)	1,259,710
CNA Training and Testing	-	-	-	-
Total Operating Expenses	<u>\$3,081,575</u>	<u>\$806,892</u>	<u>\$806,892</u>	<u>\$3,081,575</u>
Total Patient Days	<u>13,315</u>	-	-	<u>13,315</u>
Total Beds	<u>38</u>			

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended September 30, 2009
AC# 3-RDM-J9

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
1	Fixed Assets	\$243,615	
	Cost of Capital	407	
	Accumulated Depreciation		\$ 97,371
	Other Equity		146,244
	Nonallowable		407
	To adjust fixed assets and related depreciation HTM-15-1, Section 2304 State Plan, Attachment 4.19D		
2	Cost of Capital	7,309	
	Nonallowable		7,309
	To adjust depreciation expense to comply with capital cost policy State Plan, Attachment 4.19D		
3	Nonallowable	14,400	
	Medical Records		14,400
	To disallow expense due to lack of adequate documentation HIM-15-1, Section 2304		
4	Utilities	7,222	
	Maintenance		7,222
	To reclassify expense to the proper cost center DH&HS Expense Crosswalk		
5	Ancillary	9,930	
	Medical Supplies		9,930
	To reclassify expense to the proper cost center DH&HS Expense Crosswalk		
6	Nonallowable	1,860	
	Nursing		1,860
	To adjust fringe benefits and related allocation HIM-15-1, Section 2304 State Plan, Attachment 4.19D		

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended September 30, 2009
AC# 3-RDM-J9

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
7	Nonallowable Nursing	10,724	10,724
	To reclassify salaries to the proper cost center DH&HS Expense Crosswalk		
8	Nonallowable	32,294	
	Maintenance		223
	Administration		30,656
	Legal		813
	Utilities		40
	Taxes and Insurance		387
	Cost of Capital		175
	To disallow home office cost allocation due to lack of adequate documentation HIM-15-1, Section 2304		
9	Restorative	11,397	
	Dietary	92,166	
	Laundry	13,749	
	Housekeeping	33,256	
	Maintenance	37,752	
	Administration	68,539	
	Legal	185	
	Utilities	27,286	
	Taxes and Insurance	31,548	
	Medical Supplies	3,000	
	Cost of Capital	2,787	
	Nonallowable		321,675
	To reverse Provider/DH&HS adjustments to remove cost applicable to a non-reimbursable cost center and offset unrecorded vending income against related expense HIM-15-1, Sections 2102.3 and 2304 State Plan, Attachment 4.19D		

COUNTRYWOOD NURSING CENTER, L.L.C.
Adjustment Report
Cost Report Period Ended September 30, 2009
AC# 3-RDM-J9

<u>ADJUSTMENT NUMBER</u>	<u>ACCOUNT TITLE</u>	<u>DEBIT</u>	<u>CREDIT</u>
10	Nonallowable	360,772	
	Restorative		12,185
	Dietary		93,884
	Laundry		16,074
	Housekeeping		48,249
	Maintenance		33,828
	Administration		65,717
	Utilities		30,451
	Taxes and Insurance		30,744
	Medical Supplies		27,705
	Cost of Capital		1,935
	To remove indirect cost applicable to a non-reimbursable cost center HIM-15-1, Section 2102.3 State Plan, Attachment 4.19D		
11	Nonallowable	34,858	
	Medical Supplies		4,345
	Special Services		30,513
	To remove special (ancillary) services reimbursed by Medicare State Plan, Attachment 4.19D		
12	Nonallowable	5,441	
	Cost of Capital		5,441
	To adjust capital return State Plan, Attachment 4.19D		
TOTAL ADJUSTMENTS		<u>\$1,050,507</u>	<u>\$1,050,507</u>

Due to the nature of compliance reporting,
adjustment descriptions and references
contained in the preceding Adjustment
Report are provided for general guidance
only and are not intended to be all-
inclusive.

COUNTRYWOOD NURSING CENTER, L.L.C.
Cost of Capital Reimbursement Analysis
For the Cost Report Period Ended September 30, 2009
AC# 3-RDM-J9

Original Asset Cost (Per Bed)	\$ 15,618
Inflation Adjustment	<u>3.10948</u>
Deemed Asset Value (Per Bed)	48,564
Number of Beds	<u>38</u>
Deemed Asset Value	1,845,432
Improvements Since 1981	16,746
Accumulated Depreciation at 9/30/09	<u>(389,362)</u>
Deemed Depreciated Value	1,472,816
Market Rate of Return	<u>.0440</u>
Total Annual Return	64,804
Return Applicable to Non-Reimbursable Cost Centers	(3,561)
Allocation of Interest to Non-Reimbursable Cost Centers	<u>-</u>
Allowable Annual Return	61,243
Depreciation Expense	35,312
Amortization Expense	-
Capital Related Income Offsets	(100)
Allocation of Capital Expense to Non-Reimbursable Cost Centers	<u>(1,935)</u>
Allowable Cost of Capital Expense	94,520
Total Patient Days (Minimum 96% Occupancy)	<u>13,315</u>
Cost of Capital Per Diem	\$ <u>7.10</u>

3 copies of this document were published at an estimated printing cost of \$1.41 each, and a total printing cost of \$4.23. Section 1-11-125 of the South Carolina Code of Laws, as amended requires this information on printing costs be added to the document.

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

A 2 0004 A

R0437

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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, (46 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:

Antoinette M. Busby
Linda Hillman

WITNESSES:

[Signature]
J. 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.

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) 751-4160
FAX (803) 343-0773

August 4, 2011

Mr. Joe Hunt, Administrator
Countrywood Nursing Center
1645 Ridge Road
Hopkins, South Carolina 29061

RE: MEDICAID REVIEW

Dear Mr. Hunt:

This is to confirm the telephone conversation of August 3, 2011, at which time David Kennedy and Larry Warrington discussed with you the beginning of a Medicaid review of Countrywood Nursing Center by our office for the cost report period November 29, 2007 through May 31, 2008, and a review of the cost report periods November 29, 2007 through September 30, 2008 and October 1, 2008 through September 30, 2009 as deemed necessary. The purpose for the review is to determine your reimbursement settlement, if any, with the Department of Health and Human Services.

Larry Warrington, along with two members of our staff, will start the fieldwork portion of our review on August 10, 2011 at 10:00 a.m. We would appreciate very much your making available adequate working space for our staff as well as access to the following records, documents and workpapers for the periods under review:

1. General ledger and trial balance with adjusting entries.
2. Accounting records of original entry (i.e. receipts, disbursements, accounts receivable and payable, standard monthly journal entries, etc.)
3. Original source documents, such as invoices, contracts, insurance policies, tax statements, canceled checks, etc.
4. Lease agreements.
5. Contracts for service (i.e. medical director, pharmacy consultant, etc.).
6. Depreciation schedule and asset ledger.
7. Debt records to include debt instruments, closing statements, debt schedules and amortization schedules.

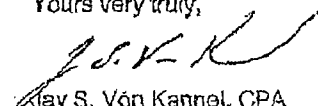
Mr. Joe Hunt, Administrator
August 4, 2011
Page Two

8. Payroll records to include payroll registers, time cards, personnel files, UCE 101 and 941 forms, schedules of year-end accruals, salary allocation worksheets, etc.
9. Patient records, such as charge slips, admission and discharge registers, nurses' census reports and other patient statistical records.
10. A schedule of charge rate changes from November 29, 2007 through present, of both routine and ancillary services.
11. Statistical data to include square footage utilization, meals served, etc.
12. Any other workpapers, schedules (i.e. prepaids, accruals, and allocations), etc. used in the preparation of the cost report.
13. Audited financial statements and minutes of meetings held by the Board of Directors.

Our auditors look forward to working with your staff to accomplish our objectives with a minimum of disruption to your normal operations.

Should you have any questions, please contact David Kennedy at (803) 832-8247 or Larry Warrington at (803) 832-8258.

Yours very truly,


Jay S. Von Kannel, CPA
Audit Manager

JVK/sag

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 13783 N

R0462

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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 USC §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 SENJORS 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 1396 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, or be 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, P.E.N. 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., P.E.N. 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, CAO, 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, CAO, the State Auditor, the State Attorney General's Office, SCDHHS, and/or any designees of the above. SCDHHS, USDHHS, the Comptroller General, CAO, 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 456.104 (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 SCDHHS information related to significant business transactions as set forth in 42 CFR 456.105 (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 5 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 de-licensure. 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 E 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 H, B, E, and/or F of this Article, termination shall be effective upon receipt of such notice. This Section does not apply to Section C 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 426-150, 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 § 1-23-380, 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.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. 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 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 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 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 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
Tharon K. Luondor

WITNESSES:

Stacy Bushamfn
Donald J. Sennett

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.

J. McCord Blair Jr.
Signature

PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF SOUTH CAROLINA

The Medicaid Agency Rate Setting Policies, Procedures and Methods for Nursing Facilities, Facilities for the Mentally Retarded, and Long Term Care Institutions for Mental Diseases

I. Cost Finding and Uniform Cost Reports

- A) Each nursing facility shall complete and file with the Medicaid Agency, Division of Long Term Care Reimbursements, an annual financial and statistical report supplied by the Medicaid Agency. Effective for the cost reporting period ending September 30, 2001, all nursing facilities will be required to submit their financial and statistical report using the new SENIORS (South Carolina Electronic Nursing Home Income/Expense Operating Report System) program software provided by the Medicaid Agency. Nursing facilities must report their operations from October 1 through September 30 on a fiscal year basis. Government owned and ICF/MR facilities may report their operations from July 1 through June 30. Hospital based facilities with fiscal year ends other than September 30 will be allowed effective with the 1990 cost reports to use their fiscal year end due to the reporting difficulties of nonconcurrent Medicare and Medicaid fiscal year ends. However, no additional inflation adjustment will be made.

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

Nursing facilities which incur home office cost/management fees through a related organization are responsible for submitting a hard copy of an annual cost report detailing the cost of the related organization (home office) to the Medicaid Agency. The cost report period should be from October 1 to September 30. However, large chain operations which do business in other states may request a different cost reporting period for their home office cost report; however, no additional inflation adjustment will be made.

- B) All nursing facilities are required to detail their cost for the entire reporting period or for period of participation in the plan, if less than the full cost reporting period. These costs are recorded by the facility on the basis of generally accepted accounting principles and the accrual method of accounting. The cash method of accounting is acceptable for public institutions. Effective October 1, 2006, nursing facilities which have an annual Medicaid utilization of 1,500 days or less will not be required to file an annual financial and statistical report.

SC 06-013

EFFECTIVE DATE: 10/01/06

RO APPROVED: 12/19/06

SUPERSEDES: NA 02-006

C) All nursing facilities are required to list the cost of the various services provided under the plan in accordance with the Medicaid Agency's cost reporting format. However, facilities providing services not covered by the plan will be required to use a step down method of cost finding as described in 42 CFR 413.24(d)(1) to apportion cost between the services covered and the services not covered by the plan before listing the cost of the various services provided under the plan. Services not covered by the plan include, but are not limited to, private pay wings of a facility which participates in the Medicaid (XIX) Program. In regard to stepping down capital related cost and maintenance cost of a private pay wing, the facility must allocate capital related cost (depreciation, interest, etc.) and maintenance cost directly associated with the wing in lieu of using square footage as the statistical base for allocating total capital costs and maintenance costs of the facility.

D All nursing facilities are required to report cost on a Uniform Cost Report form provided by the Medicaid Agency. All Uniform Cost Reports must be filed with the Medicaid Agency no later than January 1. However, a thirty (30) day extension of the due date may be granted for good cause. Effective for the cost reporting period ending September 30, 2001, all nursing facilities will be required to submit their financial and statistical report using the SENIORS software program. Hospital based/related nursing facility cost reports will be due no later than 30 calendar days after the due date of the hospital's Medicare cost report.

The financial and statistical report shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

A new contract will not be executed until all cost reporting requirements are satisfied. Additionally, if such report properly executed has not been submitted by the required date, the Medicaid Agency shall withhold all funds, or any portion thereof to be determined by the Director, due the Provider until such report is properly submitted and a new contract executed.

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

SC 07-007

EFFECTIVE DATE: 10/01/07

RD APPROVED: 01/30/08

SUPERSEDES: SC 06-013

E) All nursing facilities are required to retain all financial and statistical records for each cost reporting period, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least 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.

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

- 1) Allowable costs are determined in accordance with Title XIX of the Social Security Act, 42 CFR USCA 1396, et seq. and Federal Regulations adopted pursuant to the Act; the Medicaid Agency regulations; Title XVIII of the Social Security Act, 42 CFR USCA 1395 et seq., Federal regulations adopted pursuant thereto and HIM-15, except those provisions which implement Medicare, retrospective, as opposed to Medicaid's prospective, reimbursement system or those provisions which concern the relationship between the provider and Medicare intermediary or are modified by this Plan.
- 2) Bad debts, charity and courtesy allowance shall not be included in allowable costs except that bad debts that are attributed to cost sharing amounts as defined in 42 CFR 447.50 and 447.59 shall be allowable.
- 3) Allowable cost shall be categorized as follows: (The application is defined in Section III, Payment Determination)

SC: MA 03-014

EFFECTIVE DATE: 10/01/03

NO APPROVED: 05/26/04

SUPERSEDES: MA 01-006

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.

YC: MA 99-012

EFFECTIVE DATE: 10/01/99

NO 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 2005-2006, this index rose 185.382 percent.

Inflating the base period market value of \$15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2005-2006 is \$44,571 per bed and will be used in the determination of nursing facility rates beginning October 1, 2007.

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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SUPERSEDED: SC 06-013

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	78.55%
Equipment and Other	2,883	18.46%
Total	\$15,618	100.00%

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

4) Determination of the Market Rate of Return

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

In determining that rate of return, the question is, "where can that money be raised and what rate of return will be necessary to raise that kind of money." Part of the funds

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SUPERSEDES: MA 02-006

could be raised by borrowing from the banks. But this would be rather costly for the small investor, who would probably have to pay a rate of interest in excess of the prime rate.

The plan sets the rate of return for a fiscal year at the average of rates for thirty year Treasury bonds (through 2001) and the long-term average of Treasury rates longer than 25 years (effective 2002) for the latest three completed calendar years prior to the fiscal year, as determined by the Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 2007, this rate is 4.89%.

Acknowledging a newly constructed facility's plight of high per bed construction costs and interest rates at 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 FYR 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 upgrades 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 upgrades 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, 1983 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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SUPERSEDES: SC 06-013

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

EFFECTIVE DATE: 10/01/00

NO 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%.

SC: MA 00-015
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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 4.24 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:

SC: MA 99-012

EFFECTIVE DATE: 10/01/99

NO APPROVED: 03/20/00

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

- G) 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.
- H) 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 SCMS.

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, 2006, nursing facilities which do not incur an annual Medicaid utilization in excess of 1,500 patient days will receive a prospective payment rate which will represent the average industry rate at the beginning of each rate cycle. The average industry rate is determined by summing the October 1 rate of each nursing facility and dividing by the total number of nursing facilities. This rate will not be subject to change as a result of any field audit, but will be subject to change based on the lower of cost or charges test to ensure compliance with the state plan.

Minimum occupancy levels of 96% are currently being utilized for Medicaid rate setting purposes. Effective on and after October 1, 2003, Medicaid rates for nursing facilities located in counties where the county occupancy rate is less than 90% based upon the FYE September 30 cost report information will be established using the following policy:

- The SCDHHS will waive the 96% minimum occupancy requirement used for rate setting purposes for those nursing facilities located in counties whose occupancy is less than 90%. However, standards will remain at the 96% minimum occupancy level.
- The SCDHHS will calculate the affected nursing facilities' Medicaid reimbursement rate based upon the greater of the nursing facility's actual occupancy or the average of the county where the nursing facility is located.
- In those counties where there is only one contracting nursing facility in the county, the nursing facility Medicaid reimbursement rate will be based upon the greater of the nursing facility's actual occupancy or 85%.

SC 06-013

EFFECTIVE DATE: 10/01/06

RD APPROVED: 12/19/06

SUPERSEDES: MA 05-008

Transportation Escort Add-On

As a result of the implementation of the South Carolina Medicaid non-emergency transportation broker system, the South Carolina Department of Health and Human Services (SCDHHS) will provide an "escort add-on" to each qualifying nursing facility's Medicaid rate beginning October 1, 2007. This add-on will not be available to state-owned governmental, non-state-owned governmental and private ICF/MRs as well as state owned nursing facilities. This add-on is being provided in order to fund new costs that nursing facilities will incur in order to provide an escort with a Medicaid recipient (including a dual eligible) that is receiving non-emergency transportation to a medical provider or health care professional for a medical service ordered by a physician. It is the intent of the SCDHHS to fund one Certified Nurse Aide (CNA) full time equivalent (FTE) for an eight-hour shift in each nursing facility to cover the cost of the escort. The primary responsibility of this CNA will serve as an escort but this individual can also be used in other direct patient care related activities.

The "escort add-on" that will be included in each qualifying nursing facility's Medicaid rate will be computed using data supplied by each nursing facility via the CNA escort add-on survey and the ratio of fringe benefits to salaries reported on the fiscal year ended (FYE) September 30, 2006 or FYE June 30, 2006 cost report (or the cost report used to establish the nursing facility's October 1, 2007 Medicaid rate). The cost to fund one CNA FTE will be determined by adding the CNA annual salary (i.e. nursing facility specific CNA wage rate supplied on the survey multiplied by 2,080 hours) plus the applicable fringe benefit cost. The CNA FTE cost will then be divided by the total patient days that were used to establish the October 1, 2007 rates (i.e. FYE September 30, 2006, FYE June 30, 2006, or the less than full year actual cost report) to determine the "escort add-on". In the event that the cost report used to establish a nursing facility's October 1, 2007 Medicaid rate is less than a full year, then the CNA FTE cost described above will be adjusted accordingly (e.g. six month cost report equates to fifty percent of annual costs; nine month cost report equates to seventy five percent of annual costs, etc.).

If a nursing facility has extenuating circumstances that require an additional escort (above eight hours per day), the nursing facility may request additional staff to cover this cost. The nursing facility must provide a detailed explanation supporting the need for the additional CNA. This explanation should include, but not be limited to, the following:

- The number of non-emergency transports provided to Medicaid recipients (including dual eligibles) on a weekly basis.

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EFFECTIVE DATE: 10/01/07

NO APPROVED: 01/30/08

SUPERSEDED: SC 06-013

- Document that the nursing facility routinely transports residents to physicians' or other providers that are not located in your immediate community or town.
- Document that the nursing facility serves an unusually high number of patients that, due to their medical condition, warrant more frequent use of non-emergency transportation.

If an additional CNA is approved, the CNA cost computed above will be multiplied by the number of approved CNA FTEs to determine the nursing facility specific "escort add-on" effective October 1, 2007.

In order to satisfy the "escort add-on" spending requirement, the SCDHHS will use the following methodology:

1. The SCDHHS will use the FYE September 30, 2006, the FYE June 30, 2005, or the less than full year actual cost report used to establish the October 1, 2007 rates to set the CNA base year cost for the escort add-on.
2. The CNA base year cost will include CNA salary costs and associated fringe benefits, plus CNA pool costs. CNA pool costs refer to the costs incurred by a nursing facility to obtain the services of a CNA from a temporary/employment agency.
3. If the sum of the facility's allowable costs of General Services, Dietary, and Laundry, Housekeeping, & Maintenance exceeds the sum of the three cost center standards, SCDHHS will compute the percentage of reimbursed allowable CNA cost by dividing the sum of the three cost center standards by the sum of the allowable costs of the three cost centers. This percentage will then be applied to 100% of the CNA costs as defined in (2) above to determine the CNA base year costs.
4. A desk audited CNA per diem cost will be calculated from the FYE 2006 cost reporting periods as identified in (1) above by using the total patient days used to establish the October 1, 2007 Medicaid rate. The desk audited CNA per diem cost will be broken out into the following components - CNA salary and CNA pool costs plus CNA associated fringe benefits.
5. To inflate the FYE 2005 costs as determined in (4) forward to the October 1, 2007 through September 30, 2008 rate period, the desk audited CNA per diem salary, CNA per diem pool costs, and CNA per diem associated fringe benefits cost will be inflated by 4.6%.

SC 07-007

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SUPERSEDES: SC 06-013

6. The nursing facility specific CNA escort add-on will be added to the trended FYE 2006 desk audited CNA per diem cost as determined in (5) above to set the spending requirement, on a per diem basis, for CNA salaries, applicable fringe benefits, CNA pool costs, and non employees paid to provide transportation escort services during the FYE September 30, 2008 or June 30, 2008 cost reporting period.
7. Using the September 30, 2008 or June 30, 2008 cost reporting period, the desk audited CNA escort add-on cost, consisting of CNA salary cost, associated fringe benefits, CNA pool costs, and non employees paid to provide transportation escort services will be calculated using the total patient days used to establish the October 1, 2009 Medicaid rate.
8. SCDHHS will then compare the FYE 2008 CNA escort add-on per diem determined in (7) to the CNA per diem as determined in (6). If the CNA escort add-on per diem as determined in (7) exceeds the CNA per diem as determined in (6), the facility has satisfied the spending requirement and thus no funds are due the SCDHHS. However, if the CNA escort add-on per diem, as determined in (7), is less than the CNA per diem as determined in (6), the SCDHHS will recoup the difference (but not to exceed the facility specific CNA escort add-on amount) paid to the facility during the period October 1, 2007 through September 30, 2008.
9. In the event that a nursing facility is overpaid as a result of a significant occupancy change between the base year (i.e. FYE September 30, 2006, FYE June 30, 2006, or the less than full year actual cost report used to establish the October 1, 2007 rate) and the FYE September 30, 2008 or June 30, 2008 cost report, total CNA costs will be reviewed in lieu of a per diem. A significant occupancy adjustment would be defined as follows: a nursing facility whose total occupancy switches from a minimum occupancy of 95% to a county occupancy between 85% to 90% during the FYE 2006 and FYE 2008 cost reporting periods.

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NO APPROVED: 01/30/08

SUPERSEDES: SC 06-013

ATTACHMENT 4.19-D

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Revised 10/01/07

PROVIDER NAME: 0
 PROVIDER NUMBER: 0
 REPORTING PERIOD: 10/01/05 through 09/30/06 DATE RPT. 10/1/2007

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	4.60%			0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 1.5% OF ALLOWABLE COST)				0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LAUNDRY				0.00
EFFECT OF \$1.75 CAP ON COST/PROFIT INCENTIVES			\$0.00	0.00
TRANSPORTATION ESCORT ADD-ON				0.00
REIMBURSEMENT RATE				0.00

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SUPERSEDES: SC 06-013

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 50 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 95%).
- 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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SUPERSEDED: NA 04-007

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 17) 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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SUPERSEDES: SC 06-013

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 2007 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 2007.
 - 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 2008 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 2008.
 - c. The percent change in the total proxy index during the third quarter of 2007 (as calculated in step a), to the total proxy index in the third quarter of 2008 (as calculated in step b), was 4.6%. Effective October 1, 2007 the inflation factor used was 4.6%.
7. The per patient day cost of capital will be calculated by dividing capital cost as determined under I.(F)(c) of this plan by actual patient days. However, if the facility has less than 95% occupancy, actual days will be adjusted to reflect 95% 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: MA 05-008

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. Effective October 1, 2007 a transportation escort add-on will be included in each qualifying facility's reimbursement rate. This add on is described on pages 14 through 16.
11. For rates effective October 1, 2007, the provider's reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive, profit and transportation-escort add-on.

D. Payment for Hospital-based and Non-profit Facilities

Hospital-based and non-profit facilities will be paid in accordance with Sections III A, B, and C.

E. Payment determination for a new facility, replacement facility, change of ownership through a purchase of fixed assets, change of ownership through a lease of fixed assets, when a facility changes its bed capacity by more than fifty percent (50%), or when temporary management is assigned by the state agency to run a facility.

1. Payment determination for a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

The following methodology shall be utilized to determine the rate to be paid to a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

Based on a six (6) month's projected budget of allowable costs covering the first six months of the Provider's operation under the Medicaid program, the Medicaid agency will set an interim rate to cover the first six (6) months of operation or through the last day of the sixth (6th) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate except that all standards to be used will be one hundred twenty percent (120%) of the standards for the size of facility to adjust for lower initial occupancy. The one hundred twenty percent (120%) adjustment is determined by considering the average eighty percent (80%) occupancy for the first six (6) months of operation of a new facility versus the minimum of ninety-six percent (96%) occupancy required for all facilities that have been in operation for more than six (6) months.

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SUPERSEDES: MA 03-014

Within ninety (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical Report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date.

This report will be used to determine allowable reimbursement of the provider for the initial rate cycle. A new prospective rate, based upon the Uniform Financial and Statistical Report, will be determined using the methodology as previously stated in Section III C of this plan except for the following methodology:

- a) Payment for the first six months will be retrospectively adjusted to actual costs not to exceed 120% of the standards and actual occupancy.
- b) No inflation adjustment will be made to the first six (6) months cost.
- c) Effective on the first (1st) day of the seventh (7th) month of operation through the September 30 rate, the per diem costs effective July 1, 1994 will be adjusted to reflect the higher of:
 1. Actual occupancy of the provider at the last month of the initial cost report, or
 2. 90% occupancy.

Facilities that decertify and recertify nursing facility beds that results in a change in its bed capacity by more than fifty percent (50%) will not be entitled to a new budget.

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NO APPROVED: 01/30/88

SUPERSEDES: MA 04-007

2. Payment Determination for a replacement facility, or a change of ownership through a purchase of fixed assets:

A change in ownership will be defined as a transaction that results in a new operating entity. A purchase of the leased fixed assets by a lessee (owner of operating entity) will not be considered a change of ownership unless allowable Medicaid capital costs will be reduced (i.e., purchase price less than historical costs). Each change of ownership request will be reviewed individually to determine whether a six-month cost report will be required. Effective November 22, 1991, to qualify for a "new facility rate" based upon a six month cost report under a change of ownership, a sale or lease of assets between unrelated parties must occur. A new operator who leases a facility from a related party will not be entitled to a "new facility rate". Also, facilities in the process of obtaining a certificate of need due to a sale or lease between related parties prior to November 22, 1991 will be grandfathered in under the existing system.

The following methodology shall be utilized to determine the rate to be paid to a replacement facility and a new owner, where a change of ownership has occurred through a purchase of fixed assets:

Based on a six (6) month's projected budget of allowable costs covering the first six months of the provider's operation under the Medicaid program, the Medicaid Agency will set an interim rate to cover the first six (6) months of operation through the last day of the sixth (6th) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate as described in Section III C of this plan, with the exception of inflation. No inflation adjustment will be made to the interim rates for the first six (6) months cost.

Within (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical Report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date.

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SUPERSEDED: SC 06-013

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 18, Paragraph B-1 (e) for the time periods) as reflected on the SCDHHS Medicaid 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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SUPERSEDED: MA 02-006

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, 1999. 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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SUPERSEDES: SC 06-013

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 B (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 IM'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 F (A) through F (R) 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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SUPERSEDES: SC 06-013

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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SUPERSEDES: MA 05-008

- 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 §483.360(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/MR) 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 §447.372(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 this rate.
- B) The rate excludes the cost associated with therapy services.
- C) The rate reflects a weighted average rate using the state's prior FY8 June 30 Medicaid pennut days. Effective July 1, 1991, projected Medicaid days were used.

I. Intensive Technical Services Reimbursement

An enhanced rate of \$180 per patient day may be available for nursing facility recipients who require more intensive technical services (i.e., those recipients who have extreme medical conditions which requires total dependence on a life support system).

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FO APPROVED: 01/30/99

SUPERSEDES: MA 05-008

This rate will be adjusted as follows:

Intensive Technical Services Reimbursement Rate	
Effective Date	Reimbursement Rate
10/01/2003	\$188.00
10/01/2004	\$187.00
10/01/2005	\$206.00
10/01/2006	\$215.00
10/01/2007	\$225.00

The initial rate was determined through an analysis of costs of 1) a small rural hospital located in South Carolina who would set up a small ward to provide this level of service and 2) contracting with an out-of-state provider which has established a wing in a nursing facility to deliver this type of service. Future reimbursement rates for this service may be adjusted to account for inflationary trends and/or reviews of participating nursing facilities costs of providing the service. This set per diem rate will represent payment in full and will not be cost settled. Providers receiving payment for intensive technical services patients will be required to stop down cost applicable to this nonreimbursable cost center in accordance with item I(C) of this plan, upon submission of their annual cost report.

J. Payment for Out-of-State Long Term Care Facilities

In order to provide services to the South Carolina Medicaid patients awaiting placement into a nursing facility, the agency will contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The agency will use the out-of-state facility's survey conducted by their survey and certification agency for our survey and certification purposes. Placement of a South Carolina Medicaid recipient into an out-of-state facility will only occur if a bed is unavailable in South Carolina. No year end South Carolina Medicaid long term care cost report will be required from the participating out-of-state facilities.

K. Payment Assistance

The Medicaid Agency will pay each Provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the Provider under the Plan according to the methods and standards set forth in Section IV of this attachment.

L. Upper Limits

1. The Medicaid Agency will not pay more than the provider's customary charge for private-pay patients except governmental facilities that provide services free or at a nominal charge. These facilities will be reimbursed on a reasonable cost related basis.
2. Any limitation on coverage of cost published under 42 CFR 413.30 and 413.35 will be applied to payments for long-term care facility services.

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SUPERSEDES: SC 06-013

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.

M. 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.

N. 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.

O. 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 (Sewing Bed Hospitals are exempted from this provision).

P. 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.

SC 07-007

EFFECTIVE DATE: 10/01/07

NO APPROVED: 01/30/08.

SUPERSEDES: SC 06-013

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.

SC 07-007

EFFECTIVE DATE: 10/01/07

RD APPROVED: 01/30/08

SUPERSEDES: MA 05-008

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.

HC 07-007

EFFECTIVE DATE: 10/01/07

NO APPROVED: 01/30/08

SUPERSEDES: SC 06-013

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	0-50 BEDS MAX ALLOWED ANNUAL SALARY	61-99 BEDS MAX ALLOWED ANNUAL SALARY	100+ BEDS MAX ALLOWED ANNUAL SALARY
DIRECTOR OF NURSING (DON)	\$50,742	\$53,472	\$61,572
RN	\$41,585	\$42,939	\$44,086
LPN	\$31,531	\$31,531	\$32,979
CNA	\$17,694	\$17,832	\$18,980
SOCIAL SERVICES DIRECTOR	\$26,025	\$27,218	\$31,579
SOCIAL SERVICES ASSISTANT	\$18,315	\$23,202	\$24,968
ACTIVITY DIRECTOR	\$21,390	\$22,674	\$24,487
ACTIVITY ASSISTANT	\$17,718	\$17,718	\$17,718
DIETARY SUPERVISOR	\$20,746	\$27,172	\$31,624
DIETARY WORKER	\$15,720	\$16,179	\$16,592
LAUNDRY SUPERVISOR	\$24,097	\$24,097	\$24,097
LAUNDRY WORKER	\$14,022	\$14,596	\$15,329
HOUSEKEEPING SUPERVISOR	\$18,428	\$21,296	\$24,373
HOUSEKEEPING WORKER	\$14,894	\$15,008	\$15,537
MAINTENANCE SUPERVISOR	\$29,903	\$29,903	\$34,081
MAINTENANCE WORKER	\$20,746	\$22,444	\$22,652
ADMINISTRATOR	\$55,170	\$69,307	\$84,959
ASSISTANT ADMINISTRATOR	\$51,568	\$51,568	\$51,568
BOOKKEEPER / BUSINESS MGR	\$27,743	\$29,604	\$35,319
SECRETARY / RECEPTIONIST	\$22,467	\$22,467	\$22,467
MEDICAL RECORDS SECRETARY	\$22,260	\$22,260	\$22,260

SC 07-007
 EFFECTIVE DATE: 10/01/07
 RO APPROVED: 01/30/08
 SUPERSEDES: SC 05-008

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 50 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.

SC 07-007

EFFECTIVE DATE: 10/01/07

NO APPROVED: 01/30/08

SUPERSEDED: SC 06-013

G) ALLOWABLE COMPENSATION RANGERS 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	\$55,170	\$69,307	\$84,959	1304* 100+ Admin. Guidelines \$110,447
ASST CEO					
CONTROLLER					
CORPORATE SECRETARY					
CORPORATE TREASURER					
ATTORNEY	75%	\$41,377	\$51,980	\$63,719	\$82,835
ACCOUNTANT					
BUSINESS MGR					
PURCHASING AGENT					
REGIONAL ADMINISTRATOR					
REGIONAL V-P					
REGIONAL EXECUTIVE	70%	\$38,619	\$48,515	\$59,471	\$77,313
CONSULTANTS:					
SOCIAL ACTIVITY					
DIETARY (RD)					
PHYSICAL THER (RPT)					
MEDICAL RECORDS (HRA)					
NURSING (BSRN)	65%	\$35,860	\$45,049	\$55,223	\$71,190
SECRETARIES	see nh	\$22,467	\$22,467	\$22,467	\$22,467
BOOKKEEPERS	see nh	\$27,745	\$29,604	\$35,319	\$35,319
MEDICAL DIRECTOR	90%	\$49,653	\$62,376	\$76,463	\$99,402

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

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

2. No assistant operating executive will be authorized for a chain with 257 beds or less.

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EFFECTIVE DATE: 10/01/07

NO APPROVED: 01/30/08

SUPERSEDES: MA 05-008

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

II) 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.

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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, PBN 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 SCNHS 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. PBN Therapy), these costs will continue to be treated as allowable costs in the facility's Medicaid reimbursement rate. Therefore, only those costs which are reimbursed outside of the overall routine per diem rate by Medicare will be removed from allowable costs for Medicaid rate setting purposes. The ancillary services costs that will be excluded from allowable costs will consist of direct costs only. No indirect costs associated with the removal of ancillary services will be removed from allowable costs in order to encourage Medicare participation. Effective January 1, 2003, Part B coinsurance payments applicable to dual eligibles will no longer be reimbursed through the per diem rate.

For state operated long term care facilities which are reimbursed retrospectively their total allowable costs, no adjustment to the Medicaid rate will be made to ancillary services (including specialty beds) to adjust for dual reimbursement by both the Medicare and Medicaid Programs. Instead, Medicare Part A and Part B ancillary services cost settlements will be made upon submission of the annual FYS 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.

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SUPERSEDES: New Page,

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) 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 Department of Health and Human Services (SCDHHS) 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

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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 SCDHHS 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 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.
- 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.

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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 2162.1.A., 2162.1, 2160.8). 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-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

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RO APPROVED: 01/30/08

SUPERSEDES: New Page

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 2157.5.

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 SCOHHS 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 SCOHHS and/or the SAC 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. 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.

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RD APPROVED: 01/30/08
SUPERSEDES: New Page

South Carolina Department of
Health & Human Services



Anthony Kirk • Director
Nikki Haley • Governor

December 16, 2011

Mr. Joseph Hunt, Administrator
Countrywood Nursing Center
1645 Ridge Road
Hopkins, SC 29061

Re: AC# 3-RDM-E8, 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 AC# 3-RDM-E8, 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	\$ 385,980	<\$ 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>

P.O. Box 1226 • Columbia, South Carolina 29202-0226
(803) 252-1040 • Fax (803) 252-6225

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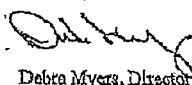
Mr. Joseph Hunt, Administrator
December 16, 2011
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The amount of \$546,968 is due on or before January 19, 2012. Your check should be made payable to the Department of Health and Human Services and mailed to:

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 reimbursement is completed. If you have any questions regarding these calculations, please call Brandy Putnam 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/hp

Enclosures

cc: Mr. Tree Nielson
State Auditor's Office
Ms. Lynette Wilson



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Fortin
Director

April 3, 2009

Mr. Lawrence A. Haynes, Administrator
CountryWood Nursing Center, LLC.
1645 Ridge Road
Hopkins, South Carolina 29061

Re: CountryWood Nursing Center, LLC.
11/29/07-05/31/08 Actual Cost Report

Dear Mr. Haynes:

The above referenced actual cost report has been reviewed. Enclosed are copies of the facility's rate sheet, desk audit adjustments, step down schedule, and cost of capital analysis schedule for the rate period November 29, 2007 through May 31, 2008. Rates effective October 1, 2008 and after are pending approval of the state plan. Please note that all desk audit adjustments are subject to field audit by the Office of the State Auditor.

In accordance with Article VIII of the Nursing Facility contract, you have fifteen (15) days in which to submit objections to these desk audit adjustments. This information must be postmarked by April 20, 2009 and sent to the following address:

Ms. Debra Myers, Director
Division of Long Term Care Reimbursements
Department of Health and Human Services
Post Office Box 8206
1813 Main Street, Suite K-101
Columbia, South Carolina 29202-8206

Bureau of Reimbursement Methodology and Policy
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 698-1040 Fax (803) 255-8228

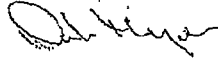
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Mr. Lawrence A. Haynes
April 3, 2009
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Should you have any questions, please call me at (803) 898-1020.

Sincerely,



Debra Myers, Director
Division of Long Term Care Reimbursements

DM/dm
Enclosures

cc: Terry Schmoyer, Schmoyer and Company, LLC
Tree Nelson, Sterling Healthcare, Inc

PROVIDER NAME: COUNTRYWOOD NURSING CENTER, LLC
 PROVIDER NUMBER: 0946NF
 REPORTING PERIOD: 11/29/07
 RATE PERIOD: 11/29/07
 DATE EFF: 11/26/07
 MAXIMUM BED DAYS: 7,030
 PATIENT DAYS USED: 6,749
 PATIENT DAYS INCURRED: 6,506
 TOTAL PROVIDER DEDS: 28
 ACTUAL OCCUPANCY %: 63.83
 % LEVEL A: 0.53
 PATIENT DAYS 15: 0.06
 PATIENT DAYS 15: 6,749

SUMMARY OF ALLOWABLE COST AND PER-PATIENT DAY COST

OPERATING EXPENSES	AS FILED	DEDITS	CREDITS	ADJUSTED	PER DNM
NURSING & RESTORATION	661,649	0	2,345	659,304	22.85
DIETARY	77,576	47,427	47,428	77,575	11.49
LAUNDRY	13,920	21	22	13,919	
HOUSEKEEPING	41,988	2,173	2,114	41,893	
MAINTENANCE	21,328	15,857	15,001	22,082	11.44
ADMIN & MED RECORDS	142,000	32,011	31,583	142,428	21.12
LEGAL COST	0	0	0	0	0.00
UTILITIES	22,841	16,826	16,801	22,846	3.32
TAXES & DISBURSE	20,151	12,814	12,818	20,152	2.99
MEDICAL SUPPLIES & DRUGS	53,445	0	0	53,445	7.82
THERAPY	3,036	0	0	3,036	0.45
COST OF CAPITAL	15,579	36,688	7,405	48,742	7.22
SUBTOTAL	977,581	102,270	124,730	1,004,971	145.91
ADDITIONAL	22,788	0	0	22,788	3.38
NON-ALLOWABLE	177,274	131,577	138,197	140,764	22.19
CNA Training and Testing	0	0	0	0	0.00
TOTAL EXPENSES	\$1,177,624	\$283,947	\$280,947	\$1,177,624	174.47

PROVIDER NAME:	COUNTRYWOOD NURSING CENTER, LLC			
PROVIDER NUMBER:	0912507	Branch:	02/31/08	DATE EFF:
REPORTING PERIOD:	11/28/07			11/28/07

PATIENT DAYS USED:	5749	MAXIMUM BED DAYS:	7030
TOTAL PROVIDER BEDS:	30	PATIENT DAYS INCURRED:	8560
% LEVEL A	0.56	ACTUAL OCCUPANCY %:	81.81
		PATIENT DAYS @	0.90
			5749

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		82.85	73.97	
DIETARY		11.48	10.36	
LAUNDRY/HOUSEKEEPING/MAINT.		11.44	13.83	
SUBTOTAL	4.34	105.77	110.22	105.08
ADMIN & MED REC	0.29	21.12	21.41	21.12
SUBTOTAL	4.63	127.00	131.63	127.00
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		3.32		3.32
SPECIAL SERVICES		0.45		0.45
MEDICAL SUPPLIES AND OXYGEN		7.82		7.82
TAXES AND INSURANCE		2.89		2.89
LEGAL COST		0.00		0.00
SUBTOTAL		14.48		14.58
GRAND TOTAL		141.88		141.65
INFLATION FACTOR 0.00%				
COST OF CAPITAL				
PROFIT INCENTIVE (MAX 0.5% OF ALLOWABLE COST)				
			3.50%	0.28
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				
				4.34
EFFECT OF \$1.75 CAP ON COST/PROFIT INCENTIVES				
			51.75	(2.08)
REIMBURSEMENT RATE				
				150.69

PROVIDER NAME PROVIDER NUMBER REPORTING PERIOD:		COUNTRYWOOD NURSING CENTER, LLC 0946NF 1/25/07		Revolvt	150108	DATE EFF.	1/20/07
PATIENT DAYS USED:	6748	MAXIMUM BED DAYS:				7,030	
TOTAL PROVIDER BEDS:	26	PATIENT DAYS INCURRED:				8,598	
% LEVEL A	6.500	ACTUAL OCCUPANCY %:				93.83	
		PATIENT DAYS @				0.93	0740
COMPUTED RATE		141.88					
PROFIT INCENTIVE		0.29					
COST INCENTIVE		4.34					
EFFECT OF CAP		(2.98)		143.19			
ALLOWABLE COST				141.08			
REIMBURSEMENT OVER (UNDER) ALLOWABLE COST				1.78			

COST OF CAPITAL ANALYSIS

FACILITY NAME		COUNTRYWOOD NURSING CENTER, LLC	
COST REPORT PERIOD		11/29/2007-5/31/2008	
RATE EFFECTIVE		11/29/2007-5/31/2008	
		Actual	
	Old Beds	New Beds	New Beds 2
# OF BEDS	38	0	0
PATIENT DAYS INCURRED	8,898	0	0
Bed Days @ 86 %	6,749	0	0
Original Asset cost	18,618	16,818	15,818
Inflation Adjustment	2,85397	2,85392	2,85392
Deemed Asset Value-Per Bed	44,671	44,671	44,671
Number of Beds	38	-	-
Total Deemed Asset Value	1,695,098	-	-
Improvements Since 1981	18,080	-	-
Accumulated Depreciation 11/20/2007-5/31/2008	(203,150)	-	-
Deemed Depreciation Value	1,609,928	0	0
Market Rate of Return	0.0489	0.0489	0.0489
Return for Facility	73,621	0	0
Amount Applicable to Non-Reimb. Cost Center	(3,265)	0	0
Interest Alloc. From Non-Reimb Cost Center	0	0	0
Return applicable to Nursing Home 185 days	\$ 35,653	\$ -	\$ -
Facility and Home Office Depreciation Expense	13,884	0	0
Facility and Home Office Amortization Expense	0	0	0
Facility and Home Office Income Offsets	0	0	0
Non-allowable C-of-C from Step-down	(885)	0	0
Total Cost of Capital Expense	48,742	0	0
Bed Days @ 86 %	6,749	0	0
Cost of Capital Per Dism-old Beds	\$ 7.22	\$0.00	\$ -
Cap per 603/89 Reimbursement COC+ROE	N/A		
Reimbursable Cost Capital -OLD BEDS	\$7.22		
	48,742		
	EXPENSE	PATIENT DAYS	
OLD BEDS	48,742	6,749	
NEW BEDS	0	0	
NEW BEDS 2	0	0	
TOTAL ALL BEDS	\$ 48,742	6,749	
Total COC Reimbursement Per Dism		\$7.22	
COST OF CAPITAL CALCULATION-USING POLICY PRIOR to 7/1/89			
	Old Beds	New Beds	New Beds 2
Interest Expense	0	0	0
Facility and Home Office Depreciation Expense	13,884	0	0
Facility and Home Office Amortization Expense	0	0	0
Facility and Home Office Income Offsets	0	0	0
Non-allowable C-of-C from Step-down	(885)	0	0
Total Cost of Capital Expense	13,089	0	0
Bed Days @ 86 %	6,749	0	0
Cost of Capital Per Dism-old Beds	\$ 1.94	\$0.00	\$ -
		1.94	

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FACILITY NAME	COUNTRYWOOD NURSING CENTER, LLC
COST REPORT PERIOD	11/29/2007-5/31/2008
RATE EFFECTIVE	11/29/2007-5/31/2008

Actual

# OF BEDS	38
PATIENT DAYS INCURRED	8,596
Bed Days @ 96 %	8,140

FACILITY DEPREC. EXPENSE-OLD BEDS				Accumulated Deprec.	
Facility Deprec. Expense	19,038	19,038		Beginning A/D	(189,320)
Loss on Assets					
Gain on Assets					
Less:					
Cap on Deemed Asset Value					
% of Deprec. Allowable	69.29% SEE DHS % COC WS				
Amount Allowable Deprec.	13,836			Deprec. Expense	(13,836)
Excess Deprec. Expense		8,132		A/D on Disposals	0
Subtotal Deprec. expense to Accumulated		19,836			
Deprec. Expense to C-of-C Analysis	13,836	13,836		Balance to C-of-C	(203,156)

HOME OFFICE DEPREC. EXPENSE ALLOCABLE TO OLD BEDS				Per Provider A/D	203,198
Home Office Deprec. Expense	148	148		DAV Cap	0.6929
Home Office Gain on Assets					203,158
Home Office Loss on Assets				ADoes not trace to prior year ending	
HO Deprec. Expense to C-of-C Analysis	148	148		balances.	

FACILITY AMORT. EXPENSE ALLOCABLE TO OLD BEDS			
Facility Amort. Expense	0	0	
Less:			
Cap on Deemed Asset Value			
% of Amort. Allowable	89.29% SEE DHS % COC WS		
Amount Allowable Amort.	0		
Excess Amort. Expense		0	
Amort. Expense to C-of-C Analysis	0	0	

HOME OFFICE AMORT. EXPENSE ALLOCABLE TO OLD BEDS			
HO Amort. Expense to C-of-C Analysis	0	0	

FACILITY INTEREST EXPENSE ALLOCABLE TO OLD BEDS				INCOME OFFSETS	
Facility Interest Expense	0	0		Interest Income	0
Less:				Rental Income	0
Cap on Deemed Asset Value					
% of Interest Allowable	89.29% SEE DHS % COC WS			Income Offset-C-of-C	0
Amount Allowable Interest	0			% offset to old beds	100.00%
Excess Interest Expense		0		Income Offset-Old beds	\$
Interest Expense to C-of-C Analysis	0	0			

HOME OFFICE INTEREST EXPENSE ALLOCABLE TO OLD BEDS			
HO Interest Expense to C-of-C Analysis	0	0	

IMPROVEMENTS SINCE 1981-OLD BEDS			
Beginning Balance		19,080	
current year asset additions		0	
current year asset disposals		0	
Ending Balance	19,080	19,080	

THIS APPLIES TO OLD-BED ONLY

6/30/89 COC + ROE	\$	
Old COC cap	\$	3.99
Old Beds COC limit	N/A	

STEP-DOWN RATIOS			
Non-allowable C-of-C from Step-down	896	896	
Total C-of-C prior to SD	20,116	20,116	
Non-reimbursable % of C-of-C		4.45%	

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008
November 29, 2007 May 31, 2008

SUMMARY OF DESK AUDIT ADJUSTMENTS

COST CENTER	ADJUSTMENTS	
	DEBITS	CREDIT
NURSING & RESTORATIVE	\$0	\$2,343
DIETARY	\$47,427	\$47,428
LAUNDRY	\$21	\$22
HOUSEKEEPING	\$2,113	\$2,114
MAINTENANCE	\$15,687	\$15,001
ADMINISTRATION & MEDICAL RECORDS	\$32,011	\$31,563
LEGAL	\$0	\$0
UTILITIES	\$15,529	\$15,961
TAXES, INSURANCE & LICENSE	\$12,914	\$12,913
MEDICAL SUPPLIES & OXYGEN	\$0	\$0
THERAPY	\$0	\$0
COST OF CAPITAL	\$36,568	\$7,405
ANCILLARY	\$0	\$0
NONALLOWABLE	\$131,677	\$159,197
CNA TRAINING	\$0	\$0
SUBTOTAL EXPENSES	\$293,947	\$293,947
REVENUES	\$0	\$0
BALANCE SHEET-ASSETS	\$0	\$0
BALANCE SHEET-LIABILITIES	\$0	\$0
GRAND TOTAL	\$293,947	\$293,947

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008

Adjustment Schedule

ADM. No	EXPLANATION & CALCULATIONS	ACCOUNT TITLE	DHHS ACCOUNT NUMBER	AMOUNT	
				DEBIT	CREDIT
15 To reclass expense for medical waste disposal from nursing to maint.					
	Maint Purchased Service		4060206	420	0
	Nursing Purchased Service		4010206	0	420
16 To reclass MDS software from restorative to medical records.					
	Med Rec Minor Equipment		4080221	1,923	0
	Rest Minor Equipment		4020221	0	1,923
17 To reclass expense for pest control from utilities to maintenance.					
	Maint Purchased Service		4060206	727	0
	Utilities Other		4100299	0	727
18 To reverse provider's step-down adj #12.					
	Diet Step Down		4030620	47,427	0
	Laundry Step Down		4040620	21	0
	Hskp Step Down		4050620	2,113	0
	Maint Step Down		4060620	14,539	0
	Adm Step Down		4070620	30,088	0
	Utilities Step Down		4100620	15,528	0
	Taxes, Ins & Lic Step Down		4110620	12,913	0
	Coc Step Down		4250620	915	0
	Nonall Step Down		4270620	0	123,544
19 To disallow unidentified interest expense.					
	Nonall Other		4270299	378	0
	Coc Interest Building		4251010	0	378
20 To adjust allowable depreciation expense to comply with the cost of capital reimbursement policy effective July 1, 1989.					
	Nonall Other		4270299	6,132	0
	Coc Deprec Building		4251020	0	6,132
21 To include calculated cost of capital return in accordance with the cost of capital reimbursement policy effective July 1, 1989.					
	Coc Interest Other		4253299	35,653	0
	Nonall Other		4270299	0	35,653
22 To revise step-down adjustments.					
	Nonall Step Down		4270620	123,381	0
	Diet Step Down		4030620	0	47,427
	Laundry Step Down		4040620	0	22
	Hskp Step Down		4050620	0	2,114
	Maint Step Down		4060620	0	15,001
	Adm Step Down		4070620	0	29,774
	Utilities Step Down		4100620	0	15,234
	Taxes, Ins & Lic Step Down		4110620	0	12,913
	Coc Step Down		4250620	0	895
23 To revise home office allocation based upon SCDHHS desk review					

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008

Adjustment Schedule

ADJ. No	EXPLANATION & CALCULATIONS	ACCOUNT TITLE	DEHS ACCOUNT NUMBER	AMOUNT	
				DEBIT	CREDIT
23 To revise home office allocation based upon SCDHHS desk review					
		Main Home Office Allocation	4060210	1	0
		Utilities Home Office Allocation	4100210	1	0
		Taxes, Ins & Lfe Home Office Allocation	4110210	1	0
		Nonaffl Other	4270299	1,786	0
		Adm Home Office Allocation	4070210	0	1,789
		ADJUSTMENT TOTALS		293,947	293,947

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PROVIDER NAME: COUNTRYWOOD NURSING CENTER, LLC
 PROVIDER NUMBER: 091997
 REPORTING PERIOD: 1/1/2007 through 12/31/08
 DATE PREP: 02/03/09 7:01 AM (initials)
 DATE OF: 02/03/09

PATIENT DAYS USED: 0,749
 TOTAL PROVIDER BEDS: 30
 % LEVEL A: 0.00

MAXIMUM BED DAYS: 7,030
 PATIENT DAYS INCURRED: 6,596
 ACTUAL OCCUPANCY %: 93.83
 PATIENT DAYS @: 0.90

SUMMARY OF ALLOWABLE COST AND PER PATIENT DAY COST

OPERATING EXPENSES	AS FILED	DEBITS	CREDITS	ADJUSTED	PER DIEM
NURSING & RESTORATIVE	661,519	0	2,343	659,176	82.86
DIETARY	77,576	47,427	47,428	77,575	11.49
LAUNDRY	13,820	21	22	13,819	
HOUSEKEEPING	41,088	2,113	2,114	41,987	
MAINTENANCE	27,338	16,687	16,301	22,022	11.54
ADMIN & MED RECORDS	142,060	32,011	31,563	142,508	21.12
LEGAL COST	0	0	0	0	0.00
UTILITIES	72,841	16,829	16,931	22,409	8.32
TAXES & INSURANCE	20,151	12,814	12,919	20,152	2.52
MEDICAL SUPPLIES & OXYG	53,446	0	0	53,446	7.91
THERAPY	3,036	0	0	3,036	0.46
COST OF CAPITAL	19,578	36,608	7,465	48,742	7.22
SUBTOTAL	877,451	162,270	134,760	1,004,971	148.91
AMORTARY	22,789	0	0	22,789	3.28
NON-ALLOWABLE	177,274	131,577	109,187	148,764	22.19
CNA Training and Testing	0	0	0	0	0.00
TOTAL EXPENSES	\$1,177,524	\$293,847	\$293,847	\$1,177,524	174.47

PROVIDER NAME:	COUNTRYWOOD NURSING CENTER, LLC			
PROVIDER NUMBER:	0946HF			
REPORTING PERIOD:	11/29/07	through	06/30/08	DATE RFP: 08/01/08
PATIENT DAYS USED:	8749	MAXIMUM BED DAYS:		7036
TOTAL PROVIDER BEDS:	38	PATIENT DAYS INCURRED:		0598
% LEVEL A	0.84%	ACTUAL OCCUPANCY %:	33.65	
		PATIENT DAYS @	0.06	6746

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SHILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		82.85	78.97	
DIETARY		11.18	10.39	
LAUNDRY/HOUSEKEEPING/MAINT.		11.64	13.67	
SUBTOTAL	4.34	105.68	110.22	108.91
ADMIN & MED REC	0.29	21.12	21.41	21.12
SUBTOTAL	4.63	127.00	131.63	127.03
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		3.32		3.32
SPECIAL SERVICES		0.45		0.45
MEDICAL SUPPLIES AND OXYGEN		7.02		7.92
TAXES AND INSURANCE		2.99		2.99
LEGAL COST		0.00		0.00
SUBTOTAL		14.68		14.68
GRAND TOTAL		141.68		141.63
INFLATION FACTOR	4.80%			8.62
COST OF CAPITAL				7.22
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)			5.50%	0.29
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				4.34
EFFECT OF \$1.75 CAP ON COST/PROFIT INCENTIVES			\$1.75	(2.88)
REIMBURSEMENT RATE				157.17

2/1
1.2
Dakota Health

CDPHHS-DR. 01 LTC Reports

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PROVIDER NAME:	COUNTRYWOOD NURSING CENTER, LLC				
PROVIDER NUMBER:	0946NF				
REPORTING PERIOD:	11/20/07	through	05/31/08	DATE EFF.	06/01/08
PATIENT DAYS USED:	6749		MAXIMUM BED DAYS:		7,030
TOTAL PROVIDED BEDS:	36		PATIENT DAYS INCURRED:		6,598
% LEVEL A	0.833		ACTUAL OCCUPANCY %:	03.83	
			PATIENT DAYS @	6.98	6749
COMPUTED RATE				141.58	
PROFIT INCENTIVE				0.29	
COST INCENTIVE				4.74	
EFFECT OF GAP				(2.68)	143.43
ALLOWABLE COST					141.68
REIMBURSEMENT OVER (UNDER) ALLOWABLE COST					1.76

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COST OF CAPITAL ANALYSIS

FACILITY NAME	COUNTRYWOOD NURSING CENTER, LLC		
COST REPORT PERIOD	11/01/2007-09/30/2008	Actual	7th month
RATE EFFECTIVE	07/1/2008-07/30/2008		

	Old Beds	New Beds	New Beds 2
# OF BEDS	30	0	0
PATIENT DAYS INCURRED	8,896	0	0
Bed Days @ 98 %	8,749	0	0
Original Asset Cost	15,818	18,815	18,818
Inflation Adjustment	2,88382	2,88382	2,88382
Depreciated Asset Value-Per Bed	44,571	44,571	44,571
Number of Beds	58	-	-
Total Depreciated Asset Value	1,363,899	-	-
Improvements Since 1981	18,080	-	-
Accumulated Depreciation 11/20/2007-09/30/2008	(200,156)	-	-
Depreciated Depreciation Value	1,504,822	0	0
Market Rate of Return	0.0468	0.0468	0.0468
Return for Facility	73,821	0	0
Amount Applicable to Non-Reimb. Cost Center	(3,256)	0	0
Interest Allow. From Non-Reimb Cost Center	0	0	0
Return applicable to Nursing Home 180 days	\$ 35,563	\$ -	\$ -
Facility and Home Office Depreciation Expense	18,864	0	0
Facility and Home Office Amortization Expense	0	0	0
Facility and Home Office Income Offsets	0	0	0
Non-deductible C-of-C from Step-down	(899)	0	0
Total Cost of Capital Expense	48,742	0	0
Bed Days @ 98 %	8,749	0	0
Cost of Capital Per Old-old Beds	\$ 7.22	\$0.00	\$ -
Gap per BSO/BS Reimbursement COC+ROE	N/A		
Reimbursable Cost Capital-OLD BEDS	\$7.22		
	48,742		

	EXPENSE	PATIENT DAYS
OLD BEDS	48,742	8,749
NEW BEDS	0	0
NEW BEDS 2	0	0
TOTAL ALL BEDS	\$ 48,742	8,749
Total COC Reimbursement Per Day		\$7.22

COST OF CAPITAL CALCULATION-USING POLICY PRIOR to 7/1/08			
	Old Beds	New Beds	New Beds 2
Interest Expense	0	0	0
Facility and Home Office Depreciation Expense	18,864	0	0
Facility and Home Office Amortization Expense	0	0	0
Facility and Home Office Income Offsets	0	0	0
Non-deductible C-of-C from Step-down	(899)	0	0
Total Cost of Capital Expense	18,080	0	0
Bed Days @ 98 %	8,749	0	0
Cost of Capital Per Old-old Beds	\$ 1.94	\$0.00	\$ -
	1.94		

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SCDHHS- Div of LTC Reimb

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FACILITY NAME	COUNTRYWOOD NURSING CENTER, LLC	
COST REPORT PERIOD	11/29/2007-5/31/2008	Actual 7th month
RATE EFFECTIVE	01/2008-9/30/2008	

# OF BEDS	38
PATIENT DAYS INCURRED	6,696
Bed Days @ 98 %	6,749

FACILITY DEPREC. EXPENSE-OLD BEDS		Accumulated Deprec.	
Facility Deprec. Expense	19,898	19,898	
Loss on Assets		0	Beginning A/D (189,320)
Gain on Assets		0	
Less:			
Cap on Deemed Asset Value			
% of Deprec. Allowable	69.29% SEE DATES % COC WBS		
Amount Allowable Deprec.	13,836		Deprec. Expense (13,836)
Excess Deprec. Expense	DA 20	6,132	A/D on Disposals 0
Subtotal: Deprec. expense to Accumulated		13,836	
Deprec. Expense to C-of-C Analysis	13,836	13,836	Balance to C-of-C (203,156)

HOME OFFICE DEPREC. EXPENSE ALLOCABLE TO OLD BEDS		Per Provider A/D	
Home Office Deprec. Expense	148	148	293,186
Home Office Gain on Assets			DAV Cap 0.0929
Home Office Loss on Assets			203,156
HO Deprec. Expense to C-of-C Analysis	148	148	^a Does not trace to prior year ending balance.

FACILITY AMORT. EXPENSE ALLOCABLE TO OLD BEDS	
Facility Amort. Expense	0
Less:	
Cap on Deemed Asset Value	
% of Amort. Allowable	69.29% SEE DATES % COC WBS
Amount Allowable Amort.	0
Excess Amort. Expense	0
Amort. Expense to C-of-C Analysis	0

HOME OFFICE AMORT. EXPENSE ALLOCABLE TO OLD BEDS	
HO Amort. Expense to C-of-C Analysis	0

FACILITY INTEREST EXPENSE ALLOCABLE TO OLD BEDS		INCOME OFFSETS	
Facility Interest Expense	0	Interest Income	0
Less:		Rental Income	0
Cap on Deemed Asset Value		Income Offset-C-of-C	0
% of Interest Allowable	69.29% SEE DATES % COC WBS	% offset to old beds	100.00%
Amount Allowable Interest	0	Income Offset-Old beds	\$ -
Excess Interest Expense	0		
Interest Expense to C-of-C Analysis	0		

HOME OFFICE INTEREST EXPENSE ALLOCABLE TO OLD BEDS	
HO Interest Expense to C-of-C Analysis	0

IMPROVEMENTS SINCE 1981-OLD BEDS		THIS APPLIES TO OLD BED ONLY	
Beginning Balance	19,880	6/30/88 COC + ROE	\$ -
current year asset additions	0	Old COC cap	\$ 3.89
current year asset disposals	0	Old Beds COC limit	N/A
Ending Balance	19,880		

STEP-DOWN RATIOS	
Non-allowable C-of-C from Step-down	895
Total C-of-C prior to SD	20,116
Non-reimbursable % of C-at-C	4.45%

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008
June 01, 2008 thru September 30, 2008

SUMMARY OF DESK AUDIT ADJUSTMENTS

COST CENTER	ADJUSTMENTS	
	DEBITS	CREDIT
<u>NURSING & RESTORATIVE</u>	<u>\$0</u>	<u>\$2,343</u>
<u>DIETARY</u>	<u>\$47,427</u>	<u>\$47,428</u>
<u>LAUNDRY</u>	<u>\$21</u>	<u>\$22</u>
<u>HOUSEKEEPING</u>	<u>\$2,113</u>	<u>\$2,114</u>
<u>MAINTENANCE</u>	<u>\$15,687</u>	<u>\$15,001</u>
<u>ADMINISTRATION & MEDICAL RECORDS</u>	<u>\$32,011</u>	<u>\$31,563</u>
<u>LEGAL</u>	<u>\$0</u>	<u>\$0</u>
<u>UTILITIES</u>	<u>\$15,529</u>	<u>\$15,961</u>
<u>TAXES, INSURANCE & LICENSE</u>	<u>\$12,914</u>	<u>\$12,913</u>
<u>MEDICAL SUPPLIES & OXYGEN</u>	<u>\$0</u>	<u>\$0</u>
<u>THERAPY</u>	<u>\$0</u>	<u>\$0</u>
<u>COST OF CAPITAL</u>	<u>\$36,568</u>	<u>\$7,405</u>
<u>ANCILLARY</u>	<u>\$0</u>	<u>\$0</u>
<u>NONALLOWABLE</u>	<u>\$131,677</u>	<u>\$159,197</u>
<u>CNA TRAINING</u>	<u>\$0</u>	<u>\$0</u>
<u>SUBTOTAL EXPENSES</u>	<u>\$293,947</u>	<u>\$293,947</u>
<u>REVENUES</u>	<u>\$0</u>	<u>\$0</u>
<u>BALANCE SHEET-ASSETS</u>	<u>\$0</u>	<u>\$0</u>
<u>BALANCE SHEET-LIABILITIES</u>	<u>\$0</u>	<u>\$0</u>
<u>GRAND TOTAL</u>	<u>\$293,947</u>	<u>\$293,947</u>

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008

Adjustment Schedule

ADJ. No	EXPLANATION & CALCULATIONS	ACCOUNT TITLE	DHHS ACCOUNT NUMBER	AMOUNT DEBIT	AMOUNT CREDIT
15 To reclass expense for medical waste disposal from nursing to maint.					
		Maint Purchased Service	4060206	420	0
		Nursing Purchased Service	4010206	0	420
16 To reclass MDS software from restorative to medical records.					
		Med Rec Minor Equipment	4080221	1,923	0
		Rest Minor Equipment	4020221	0	1,923
17 To reclass expense for pest control from utilities to maintenance.					
		Maint Purchased Service	4060206	727	0
		Utilities Other	4100299	0	727
18 To reverse provider's step-down adj #12.					
		Diet Step Down	4030620	47,427	0
		Laundry Step Down	4040620	21	0
		Hksp Step Down	4050620	2,113	0
		Maint Step Down	4060620	14,539	0
		Adm Step Down	4070620	30,088	0
		Utilities Step Down	4100620	15,528	0
		Taxes, Ins & Lic Step Down	4110620	12,913	0
		Coc Step Down	4250620	915	0
		Nonall Step Down	4270620	0	123,544
19 To disallow unidentified interest expense.					
		Nonall Other	4270299	378	0
		Coc Interest Building	4253010	0	378
20 To adjust allowable depreciation expense to comply with the cost of capital reimbursement policy effective July 1989.					
		Nonall Other	4270299	6,132	0
		Coc Deprec Building	4251020	0	6,132
21 To include calculated cost of capital return in accordance with the cost of capital reimbursement policy effective July 1, 1989.					
		Coc Interest Other	4253299	35,653	0
		Nonall Other	4270299	0	35,653
22 To revise step-down adjustment.					
		Nonall Step Down	4270620	123,381	0
		Diet Step Down	4030620	0	47,428
		Laundry Step Down	4040620	0	22
		Hksp Step Down	4050620	0	2,114
		Maint Step Down	4060620	0	15,001
		Adm Step Down	4070620	0	29,774
		Utilities Step Down	4100620	0	15,234
		Taxes, Ins & Lic Step Down	4110620	0	12,913
		Coc Step Down	4250620	0	895
23 To revise home office allocation based upon SCDHHS desk review					

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008

Adjustment Schedule

ADJ. No	EXPLANATION & CALCULATIONS	ACCOUNT TITLE	DHHS ACCOUNT NUMBER	AMOUNT	
				DEBIT	CREDIT
23 To revise home office allocation based upon SCDHHS desk review					
		Maint Home Office Allocation	4060210	1	0
		Utilities Home Office Allocation	4100210	1	0
		Taxes, Ins & Lic Home Office Allocation	4110210	1	0
		Nonall Other	4270299	1,786	0
		Adm Home Office Allocation	4070210	0	1,789
		ADJUSTMENT TOTALS		293,947	293,947

NAME: COUNTRYWOOD NURSING CENTER
 DETERMINATION OF COST BEFORE STEP-DOWN
 CIR PERIOD: 11/7/2007-5/31/2008

FILE NAME: _____
 PFD BY: _____

COST CENTERS	COSTS PER BOOKS	AS #	DEBIT #	AS #	CREDIT #	AS ADJ. BY PROVIDER	SQUARE FOOTAGE
COST OF CAPITAL-Original	19,878	18	815	18	378	20115	
Cost of Capital - Addition	0					0	
TAXES AND INSURANCE	20,161	18 23	12913 1			33066	
ADMINISTRATION	135,616	18	30088	18 23	9748 7789	154188	
LEGAL	0					0	
MAINTENANCE	21,336	18 15 17 23	14530 420 727 1			37023	
UTILITIES	22,841	18 23	15528 1	17	727	37843	
LAUNDRY	13,820	18	21	18	13884	57	
HOUSEKEEPING	41,063	18	2113	18	28864	8227	
DIETARY	77,578	18	47427	18	2196	122807	
MEDICAL RECORDS	6,434	18	1923			8367	
RESTORATIVE	14,576			18	1823	12063	
MEDICAL SUPPLIES	53,445					63445	
SNFIC NURSING, OXYGEN & THERAPY	549,679		72170	15	420	621429	
SUBTOTAL	877,461		198767		- 68917	1108321	0
NON-REIMBURSABLE							
RETIREMENT CENTER	112258					112258	
GIFT SHOP	0					0	
PERSONAL PATIENT LAUNDRY	0					0	
BEAUTY AND BARBER	0					0	
PRIVATE PAY WING	0					0	
OTHER---	0					0	
TOTAL	1089709		298787		68917	1218678	0

* Provider Ancillary Adjustment 11

**100% of Accounting Services, Laundry and Housekeeping Contract Services and Dietary Consultant

COUNTRYWOOD NURSING CENTER, LLC
11252307-0311000

PART 1 - COST ALLOCATION OF COSTS

Cost Center	Net Expenses For Cost Allocation	Cost of Capital - Orig Base	Cost of Capital - Addition	Taxes and Insurance	Salaries	Admin Salaries	Legal	Maintenance	Utilities	Laundry	House- keeping	Dietary	Medical Records	Respiratory	Medical Supplies	Total
Cost of Capital - Original Basis	20,118	20,118														
Cost of Capital - Addition	0	0	0													
Taxes and Insurance	24,058	0	0	24,058												
Salaries	0	0	0	0	1,127	150,644										
Legal	0	0	0	0	0	0	0									
Maintenance	27,123	430	0	430	27,553	5,205	0	43,442								
Utilities	27,643	0	0	0	22,040	2,565	0	0	4,038							
Laundry	0	0	0	0	1,223	276	0	1,276	4,705							
Housekeeping	6,227	285	0	285	5,941	867	0	444	412	0	7,464					
Dietary	122,807	274	0	274	122,533	10,223	0	542	340	0	87	142,370				
Medical Records	9,257	0	0	0	8,267	1,227	0	0	0	0	0	0	9,257			
Respiratory	12,859	0	0	0	12,859	1,911	0	0	0	0	0	0	0	14,864		
Medical Supplies	23,445	0	0	0	23,445	7,264	0	0	0	0	0	0	0	0	31,320	
GRAND TOTAL	621,420	18,625	0	17,777	436,181	166,781	0	24,523	24,450	2,377	1,420	87,763	9,257	14,864	31,320	912,448
Non-Allocable Cost Centers																
Recreation Center	119,259	0	0	11,926	124,251	18,225	0	18,224	15,430	1,810	2,977	58,216	0	0	0	235,644
Chaplain	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical Therapy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Beauty & Hair	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Amphitheater	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total - Non-Allocable	119,259	0	0	11,926	124,251	18,225	0	18,224	15,430	1,810	2,977	58,216	0	0	0	235,644
Total - All	1,218,578	20,118	0	29,003	1,081,035	156,645	0	42,747	43,108	4,705	7,181	142,881	9,257	14,864	31,320	1,148,692
NR - Cost of Capital - Original Basis	0	0	0													
NR - Cost of Capital - Addition	0	0	0													
NR - Taxes and Insurance	0	0	0	11,913												
NR - Administration	141	0	0	140												
NR - Legal	0	0	0	0												
NR - Maintenance	136	0	0	164												
NR - Utilities	0	0	0	0												
NR - Laundry	341	0	0	358												
NR - Housekeeping	113	0	0	119												
NR - Dietary	144	0	0	151												
NR - Medical Records	0	0	0	0												
NR - Respiratory	0	0	0	0												
NR - Medical Supplies	0	0	0	0												
Sum Down of NRs	588	0	0	12,913												
Sum Across To Fund Ducting	0	0	0	0												
Net Amounts To Be Allocated	588	0	0	12,913												
					20,774	0	15,001	13,224	22	2,114	41,418	0	0	0	0	123,081

R0547

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Cost Center	Cost of Capital - Ctry Bds (eq ft)	Cost of Capital - Audience (sq ft)	Taxes and Incidence (eq ft)	Admin Incidence (sq ft)	Legal (sq ft)	Administrative (sq ft)	Medical (sq ft)	Laundry (sq ft)	House- keeping (sq ft)	Security (sq ft)	Medical Records (sq ft)	Alternative (sq ft)	Medical Supplies (sq ft)
Cost of Capital - Capital Bds													
Cost of Capital - Audience													
Taxes and Insurance													
Administration	737		737	0									
Legal				0									
Maintenance	250		250	37,803	37,803								
Utilities				37,845	37,845								
Laundry	635	635		1,889	1,889	635	635						
Housekeeping	174	174		5,511	5,511	174	174						
Dining	228	228		124,573	124,573	228	228		228				
Medical Records				3,287	3,287								
Alternative				12,852	12,852								
Medical Supplies				57,648	57,648								
Security	10,341	10,341		650,161	650,161	10,341	10,341	6,533	10,341	5,625	100	100	100
Non-Allocable Cost Centers:													
Reformed Center		4,963		124,231	124,231	4,963	4,963	4,150	4,963	4,150			
Gleaming				0	0								
Public Financial Liability				0	0								
Barney & Barker				0	0								
Private Pay/Ment				0	0								
Other				0	0								
Archival - Non-Covered				0	0								
Total All	12,259	9	13,254	1,515,525	1,515,525	18,247	18,247	10,758	17,834	10,740	100	100	100
Amount To Be Allocated	20,118	0	20,118	185,644	0	43,648	43,648	4,793	7,054	142,961	9,824	14,864	61,329
Unit Cost Multiplier	1.64578	0.00022	1.51991	0.14732	0.00000	2.21104	2.38223	0.44785	0.41123	13.36559	65.24000	143.64003	613.19229

PARTIAL PROPOSED ADJUSTMENTS: 552.71

Account	Debit	Credit	
Nonresidence	123,341		100% total
Cost of Capital - Original Bonds		855	827-0872
Cost of Capital Addition		0	625-0000
Trust and Investment	22,974	411-0000	
Administration	28,774	407-0000	
Legal		0	609-6430
Administrative	19,801	401-0000	
Utilities	15,204	410-0000	
Luxury		22	404-2000
Home-heating		2,114	408-0000
Security	47,478	409-0000	
Medical Reports		0	400-0000
Referrals		0	400-0000
Medical Supplies		0	410-0000
Total Adjustment	123,341	123,341	

To remove industrial units applicable to non-renewable coal contracts
WRA-134, Section 21.02.2
State Plan Amendment 4, 1997

R0548

DIR: NH Desk Reviews 08
 SUB-DIRECTORY: Home Office
 FILE NAME: Putnam Council
 TAB NAME: alloc
 PREPARED BY: DM

Putnam Council, Inc.
 HOME OFFICE ALLOCATION SCHEDULE
 FYE 6/30/08

01-Apr-09

A	B	C	D	E	F	G	H	I	J	K	L			
FACILITY NAMES	PATIENT DAYS	Nursing	Dietary	Laundry	Housekeeping	Maintenance	Administration	Legal	Utilities	TIL	COO-dept	Non-Allowable	COO-int exp	TOTAL
COUNTRYWOOD	12,864	0	0	0	0	142	18,584	0	452	450	148	0	0	19,778
OTHER FACILITIES	437,269	0	0	0	0	4,763	527,796	0	15,273	15,189	5,009	0	0	658,027
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0
rounding		0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	450,133	0	0	0	0	4,905	646,380	0	15,725	15,639	5,157	0	0	687,823
		0	0	0	0	4,925	646,380	0	15,725	15,639	5,157	0	0	687,823

2.8751%

FACILITY NAME	COUNTRYWOOD	REVISED	AS FILED	VARIANCE
Nursing		0	0	0
Dietary		0	0	0
Laundry		0	0	0
Housekeeping		0	0	0
Maintenance		142	141	1
Administration		18,584	20,373	(1,789)
Legal		0	0	0
Utilities		452	451	1
TIL		450	449	1
COO-Dept		148	148	0
Non-Allowable		0	0	0
COO-Intest Expense		0	0	0
TOTAL		19,778	21,562	(1,784)

FACILITY COUNTRYWOOD

DA# 10

PROVIDER'S A/E# 23

R0549

PROVIDER NAME: COUNTRYWOOD NURSING CENTER, LLC
 PROVIDER NUMBER: 0948NF
 REPORTING PERIOD: 11/29/07 10/01/08
 DATE EFF: 10/01/08
 PATIENT PERIOD: 10/01/08 09/30/09

PATIENT DAYS USED: 6,749
 TOTAL PROVIDER BEDS: 30
 % LEVEL A: 0.494

MAXIMUM BED DAYS: 7,030
 PATIENT DAYS INCURRED: 6,590
 ACTUAL OCCUPANCY %: 93.83
 PATIENT DAYS @: 0.66 6,749

SUMMARY OF ALL OWABLE COST AND PER PATIENT DAY COST

OPERATING EXPENSES	AS FILED	DEBITS	CREDITS	ADJUSTED	PER QTR
NURSING & RESTORATIVE	601,519	0	2,343	599,176	82.85
DIETARY	77,576	47,427	47,428	77,576	11.48
LAUNDRY	15,820	21	22	15,819	
HOUSEKEEPING	41,588	2,119	2,114	41,087	
MAINTENANCE	21,338	15,657	15,001	22,022	11.64
ADMIN & MED RECORDS	142,060	92,611	31,663	142,629	21.12
LEGAL COST	0	0	0	0	0.00
UTILITIES	22,041	15,629	15,851	22,409	3.32
TAXES & INSURANCE	20,181	14,814	12,912	20,152	2.99
MEDICAL SUPPLIES & OUTGO	53,446	0	0	53,446	7.82
THERAPY	3,036	0	0	3,036	0.45
COST OF CAPITAL	19,879	37,344	7,405	49,518	7.34
SUBTOTAL	977,451	183,045	184,760	1,055,747	149.82
ANCILLARY	22,799	0	0	22,799	3.38
NONALLOWABLE	177,274	181,977	189,873	145,078	22.07
CNA Training and Learning	0	0	0	0	0.00
TOTAL EXPENSES	\$1,177,524	\$204,723	\$224,723	\$1,177,524	174.67

PROVIDER NAME: COUNTRYWOOD NURSING CENTER, LLC
 PROVIDER NUMBER: 0348NF
 REPORTING PERIOD: 11/26/07 Through 05/31/08 DATE REPT: 10/1/08

PATIENT DAYS USED:	6749	MAXIMUM BED DAYS:	7030
TOTAL PROVIDER BEDS:	36	PATIENT DAYS INCURRED:	6658
% LEVEL A	0.003	ACTUAL OCCUPANCY %:	95.83
		PATIENT DAYS @	0.86
			6749

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT WHEATWHE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		82.85	78.00	
DIETARY		11.49	10.33	
LAUNDRY/HOUSEKEEPING/MAINT.		11.84	14.74	
SUBTOTAL	1.19	105.28	107.07	106.89
ADMIN & MED REQ	2.07	21.12	28.19	21.12
SUBTOTAL	3.26	127.00	130.26	127.09
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		3.32		3.32
SPECIAL SERVICES		0.45		0.45
MEDICAL SUPPLIES AND OXYGEN		7.52		7.52
TAXES AND INSURANCE		2.99		2.99
LEGAL COST		0.00		0.00
SUBTOTAL		14.28		14.28
GRAND TOTAL		141.58		141.68
INFLATION FACTOR	4.80%			5.90
COST OF CAPITAL				7.34
PROFIT INCENTIVE (MAX 3.6% OF ALLOWABLE COST)			3.60%	2.07
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				1.10
EFFECT OF \$1.75 CAP ON COST/PROFIT INCENTIVES			81.78	(1.84)
REIMBURSEMENT RATE				167.67

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SPRINGFIELD, IL LTC Refid.

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PROVIDER NAME:	COUNTRYWOOD NURSING CENTER, LLC				
PROVIDER NUMBER:	00401F				
REPORTING PERIOD:	11/23/07	through	05/31/08	DATE BY:	10/1/08
PATIENT DAYS USED:	8740		MAXIMUM BED DAYS:		7,030
TOTAL PROVIDER BEDS:	35		PATIENT DAYS INCURRED:		6,520
% LEVEL A	0.00		ACTUAL OCCUPANCY %:	93.03	
			PATIENT DAYS @	0.96	8740
COMPUTED RATE				141.08	
PROFIT INCENTIVE				2.07	
COST INCENTIVE				1.19	
EFFECT OF CAP				(1.61)	143.45
ALLOWABLE COST					141.08
REIMBURSEMENT OVER (UNDER) ALLOWABLE COST					1.76

COST OF CAPITAL ANALYSIS

FACILITY NAME		COUNTRYWOOD NURSING CENTER, LLC	
COST REPORT PERIOD		11/20/2007-5/31/2008	
RATE EFFECTIVE		10/1/2008-03/31/2009	
		Actual	
		Old Beds	New Beds
\$ OF BEDS	38	0	0
PATIENT DAYS INCURRED	8,668	0	0
Bed Days @ 86 %	8,749	0	0
Original Asset cost	16,818	16,818	16,818
Inflation Adjustment	2,94141	2,94141	2,94141
Deemed Asset Value-Per Bed	46,888	45,889	47,839
Number of Beds	38		
Total Deemed Asset Value	1,748,882		
Improvements Since 1981	18,080		
Accumulated Depreciation 11/20/2007-5/31/2008	(203,125)		
Deemed Depreciation Value	1,681,905	0	0
Market Rate of Return	0.0483	0.0483	0.0483
Return for Facility	70,428	0	0
Amount Applicable to Non-Reimb. Cost Center	(3,356)	0	0
Interest Alloc. From Non-Reimb Cost Center	0	0	0
Return applicable to Nursing Home 1st days	\$ 38,438	\$ -	\$ -
Facility and Home Office Depreciation Expense	(3,884)	0	0
Facility and Home Office Amortization Expense	0	0	0
Facility and Home Office Income Offsets	0	0	0
Non-allowable G-of-C from Step-down	(385)	0	0
Total Cost of Capital Expense	48,618	0	0
Bed Days @ 86 %	8,749	0	0
Cost of Capital Per Dism-Old Beds	\$ 7.34	\$ 0.00	\$ -
Cap per 8/30/09 Reimbursement COC/ROE	N/A		
Reimbursement Cost Capital -OLD BEDS	\$7.34		
	48,618		

	EXPENSE	PATIENT DAYS
OLD BEDS	48,618	8,749
NEW BEDS	0	0
NEW BEDS 2	0	0
TOTAL ALL BEDS	\$ 48,618	8,749
Total COG Reimbursement Per Day		\$7.34

COST OF CAPITAL CALCULATION USING POLICY PRIOR to 7/1/89			
	Old Beds	New Beds	New Beds 2
Interest Expense	0	0	0
Facility and Home Office Depreciation Expense	13,084	0	0
Facility and Home Office Amortization Expense	0	0	0
Facility and Home Office Income Offsets	0	0	0
Non-allowable G-of-C from Step-down	(385)	0	0
Total Cost of Capital Expense	13,089	0	0
Bed Days @ 86 %	8,749	0	0
Cost of Capital Per Dism-Old Beds	\$ 1.54	\$ 0.00	\$ -
		1.54	

FACILITY NAME	COUNTRYWOOD NURSING CENTER, LLC
COST REPORT PERIOD	11/29/2007-5/31/2008
RATE EFFECTIVE	10/1/2008-9/30/2009
Actual	
# OF BEDS	38
PATIENT DAYS INCURRED	6,698
Bed Days @ 98 %	6,719

FACILITY DEPREC. EXPENSE-OLD BEDS		Accumulated Deprec.	
Facility Deprec. Expense	10,868	10,956	
Loss on Assets		0	Beginning A/D (189,320)
Gain on Assets		0	
Less:			
Cap on Deemed Asset Value			
% of Deprec. Allowable	60.29% SEE DPHS % COC WTS		
Amount Allowable Deprec.	13,836		Deprec. Expense (13,836)
Excess Deprec. Expense	DA 20	8,132	A/D on Disposals 0
Subtotal: Deprec. expense to Accumulated		13,836	
Deprec. Expense to C-of-C Analysis	13,836	13,836	Balance to C-of-C (203,156)

HOME OFFICE DEPREC. EXPENSES ALLOCABLE TO OLD BEDS		Per Provider A/D	
Home Office Deprec. Expense	148	148	293,196
Home Office Gain on Assets			DAV Cap 0.6229
Home Office Loss on Assets			203,168
HO Deprec. Expense to C-of-C Analysis	148	148	*Does not trace to prior year ending balance.

FACILITY AMORT. EXPENSE ALLOCABLE TO OLD BEDS	
Facility Amort. Expense	0
Less:	
Cap on Deemed Asset Value	
% of Amort. Allowable	60.29% SEE DPHS % COC WTS
Amount Allowable Amort.	0
Excess Amort. Expense	0
Amort. Expense to C-of-C Analysis	0

HOME OFFICE AMORT. EXPENSE ALLOCABLE TO OLD BEDS	
HO Amort. Expense to C-of-C Analysis	0

FACILITY INTEREST EXPENSE ALLOCABLE TO OLD BEDS		INCOME OFFSETS	
Facility Interest Expense	0	Interest Income	0
Less:		Rental Income	0
Cap on Deemed Asset Value			0
% of Interest Allowable	60.29% SEE DPHS % COC WTS	Income Offset-C-of-C	0
Amount Allowable Interest	0	% offset to old beds	100.00%
Excess Interest Expense	0	Income Offset-Old beds	\$ -
Interest Expense to C-of-C Analysis	0		

HOME OFFICE INTEREST EXPENSE ALLOCABLE TO OLD BEDS	
HO Interest Expense to C-of-C Analysis	0

IMPROVEMENTS SINCE 1981-OLD BEDS		THIS APPLIES TO OLD BED ONLY	
Beginning Balance	19,080	8/30/89 COC + ROE	\$ -
current year asset additions	0	Old COC cap	\$ 3.99
current year asset disposals	0	Old Beds COC Unit	N/A
Ending Balance	19,080		

STEP-DOWN RATIOS	
Non-allowable C-of-C from Step-down	895
Total C-of-C prior to SD	20,116
Non-reimbursable % of C-of-C	4.45%

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008
October 01, 2008 thru September 30, 2009

SUMMARY OF DESK AUDIT ADJUSTMENTS

COST CENTER	ADJUSTMENTS	
	DEBITS	CREDITS
NURSING & RESTORATIVE	\$0	\$2,343
DIETARY	\$47,427	\$47,428
LAUNDRY	\$21	\$22
HOUSEKEEPING	\$2,113	\$2,114
MAINTENANCE	\$15,687	\$15,001
ADMINISTRATION & MEDICAL RECORDS	\$32,011	\$31,563
LEGAL	\$0	\$0
UTILITIES	\$15,529	\$15,961
TAXES, INSURANCE & LICENSE	\$12,914	\$12,913
MEDICAL SUPPLIES & OXYGEN	\$0	\$0
THERAPY	\$0	\$0
COST OF CAPITAL	\$37,344	\$7,405
ANCILLARY	\$0	\$0
NONALLOWABLE	\$131,677	\$159,973
CNA TRAINING	\$0	\$0
SUBTOTAL EXPENSES	\$294,723	\$294,723
REVENUES	\$0	\$0
BALANCE SHEET-ASSETS	\$0	\$0
BALANCE SHEET-LIABILITIES	\$0	\$0
GRAND TOTAL	\$294,723	\$294,723

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008

Adjustment Schedule

ADJ. No	EXPLANATION & CALCULATIONS	ACCOUNT TITLE	DUHS ACCOUNT NUMBER	AMOUNT DEBIT	AMOUNT CREDIT
15	To reclass expense for medical waste disposal from nursing to nursing.				
		Maint Purchased Service	4060206	420	0
		Nursing Purchased Service	4010206	0	420
16	To reclass MDS software from restorative to medical records.				
		Med Rec Minor Equipment	4080221	1,923	0
		Rest Minor Equipment	4020221	0	1,923
17	To reclass expense for pest control from utilities to maintenance.				
		Maint Purchased Service	4060206	727	0
		Utilities Other	4100299	0	727
18	To reverse provider's step-down adj #12.				
		Diet Step Down	4030620	47,427	0
		Laundry Step Down	4040620	21	0
		Hksp Step Down	4050620	2,113	0
		Maint Step Down	4060620	14,539	0
		Adm Step Down	4070620	30,088	0
		Utilities Step Down	4100620	15,528	0
		Taxes, Ins & Lic Step Down	4110620	12,913	0
		Coc Step Down	4250620	915	0
		Nonall Step Down	4270620	0	123,544
19	To disallow unidentified interest expense.				
		Nonall Other	4270299	378	0
		Coc Interest Building	4253010	0	378
20	To adjust allowable depreciation expense to comply with the cost of capital reimbursement policy effective July 1, 1989.				
		Nonall Other	4270299	6,132	0
		Coc Deprec Building	4251020	0	6,132
21	To include calculated cost of capital return in accordance with the cost of capital reimbursement policy effective July 1, 1989.				
		Coc Interest Other	4253299	36,429	0
		Nonall Other	4270299	0	36,429
22	To revise step-down adjustment.				
		Nonall Step Down	4270620	123,381	0
		Diet Step Down	4030620	0	47,428
		Laundry Step Down	4040620	0	22
		Hksp Step Down	4050620	0	2,114
		Maint Step Down	4060620	0	15,001
		Adm Step Down	4070620	0	29,774
		Utilities Step Down	4100620	0	15,234
		Taxes, Ins & Lic Step Down	4110620	0	12,913
		Coc Step Down	4250620	0	895
23	To revise home office allocation based upon SCDHHS desk review				

COUNTRYWOOD NURSING CENTER, LLC

November 29, 2007 thru May 31, 2008

Adjustment Schedule

ADJ. No	EXPLANATION & CALCULATIONS	ACCOUNT TITLE	DHHS ACCOUNT NUMBER	AMOUNT	
				DEBIT	CREDIT
23 To revise home office allocation based upon SCDHHS desk review					
		Maint Home Office Allocation	4060210	1	0
		Utilities Home Office Allocation	4100210	1	0
		Taxes, Ins & Lic Home Office Allocation	4110210	1	0
		Nonall Other	4270299	1,786	0
		Adm Home Office Allocation	4070210	0	1,789
ADJUSTMENT TOTALS				294,723	294,723

R0557

Terry Schmoyer

From: Terry Schmoyer
Sent: Tuesday, October 03, 2012 11:14 AM
To: Terry Schmoyer
Subject: FW: Countrywood Nursing Center

From: Larry Warrington [mailto:l.warrington@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 (formerly Ridgeview Manor). We will be reviewing the following cost reports:

- 1) 11/29/07 - 6/31/08
- 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

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1 STATE OF SOUTH CAROLINA

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

2
3 COUNTY OF RICHLAND

4

5 COUNTRYWOOD NURSING, LLC,

6 Petitioner,

7 vs.

Appeal Case Nos.
12-AUD-010,
12-AUD-011, and
12-AUD-012

8
9
10 SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

11 Respondent.

12 D E P O S I T I O N

13 WITNESS: JEFFERY ALLAN SAXON

14 DATE: Friday, August 8, 2014

15 TIME: 9:04 a.m.

16 LOCATION: Nelson Mullins Riley & Scarborough LLP
17 Meridian
18 17th Floor
1320 Main Street
Columbia, South Carolina

19 TAKEN BY: Attorneys for the Petitioner

20 REPORTED BY: NISHA GORDON
Court Reporter

21

22 -----
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APPEARANCES:

ATTORNEYS FOR THE PETITIONER
COUNTRYWOOD NURSING, LLC:

NELSON MULLINS RILEY & SCARBOROUGH LLP
BY: DANIEL WESTBROOK, ESQUIRE
-and-
BY: ALICE V. HARRIS, ESQUIRE
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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN
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ALSO PRESENT:

JAY VON KANNEL, State Auditor's Office

TERRY KENNETH SCHMOYER, JR., Schmoyer and
Company, LLC

(INDEX AT REAR OF TRANSCRIPT)

1 (The deponent waives the right to read and
2 sign the deposition transcript.)

3 JEFFERY ALLAN SAXON, being first duly
4 sworn, testified as follows:

5 EXAMINATION

6 BY MR. WESTBROOK:

7 Q. Mr. Saxon, good morning.

8 A. Good morning.

9 Q. I'm Dan Westbrook, and I'm here on behalf
10 of Countrywood Nursing Home to ask you some questions
11 about this appeal.

12 Have you given your deposition before?

13 A. I sure have.

14 Q. Quite a few times?

15 A. When I've seen you, yes.

16 Q. All righty. Good.

17 Well, then, I'm not going to spend much
18 time going over the ground rules. I'm sure you
19 understand them. Obviously, if I ask a question that
20 you don't understand, ask me for clarification, and I'll
21 try to do that.

22 A. Yes, sir.

23 Q. Mr. Nickels may have some objections to
24 some of my questions, and if he does, that's fine. Let
25 him get his objection on the record, and then you can go

4

1 ahead and answer unless he instructs you not to. Okay?

2 A. Yes, sir.

3 Q. And finally, I don't think this is going to
4 be a terribly long deposition, but if you need to take a
5 break at any time or just want to take a break, let me
6 know.

7 A. I'm fine. Good to go.

8 Q. All right. What degrees do you hold?
9 What's --

10 A. Oh, gosh. I have to think about this. I
11 just got a master of science in -- at the University of
12 South Carolina and a BS in business administration with
13 a major in accounting.

14 Q. When was that?

15 A. I graduated in 1977.

16 Q. Anything else?

17 A. Uh-uh.

18 Q. Have you ever held any professional
19 certifications or licenses?

20 A. No.

21 Q. How long have you been with HHS?

22 A. Well, the entity was created in '84, but
23 prior to that, I was at -- I've been -- Medicaid was
24 with DSS, so I've basically been with Medicaid since
25 1979.

- 1 Q. 1979?
- 2 A. Yes, sir.
- 3 Q. And what did you start out as?
- 4 A. An auditor 1.
- 5 Q. I'm sorry?
- 6 A. An auditor 1.
- 7 Q. Okay. And what's your position there?
- 8 A. Program manager 2.
- 9 Q. And what are your job duties as program
- 10 manager 2?
- 11 A. Oversee the rate, seeing activities of all
- 12 Medicaid contracting, and I wrote providers in the
- 13 state.
- 14 Q. How long have you been doing that, that
- 15 particular job presently, program manager 2?
- 16 A. Probably since 1995.
- 17 Q. What are your duties with respect -- or do
- 18 you have any duties with respect to the State Plan?
- 19 A. I oversee the submission of those bylaws,
- 20 and I also write the language for those bylaws or State
- 21 Plans.
- 22 Q. All right. You write the language
- 23 yourself?
- 24 A. Correct. I mean, the nursing facilities,
- 25 the hospitals, and the noninstitutional providers.

6

1 We're -- the institution was, I particularly write the
2 language for it and the noninstitutional, and they get
3 the assistance from the program staff, but for the most
4 part, we write the reimbursement language for all the
5 State Medicaid Programs.

6 MR. WESTBROOK: Okay. All right.

7 Let me start by asking you to take a look
8 at a contract that I'm going to mark -- I'm going to ask
9 the court reporter to mark as Exhibit 1 to this
10 deposition.

11 (Petitioner's Exhibit Number 1, Contract
12 Between South Carolina Department of Health and Human
13 Services and the South Carolina State Auditor's Office
14 for the Purchase and Provision of Agree-Upon Procedure
15 Activities Related to Medicaid Institutional Providers,
16 Dated as of July 1, 2011, was marked for
17 identification.)

18 BY MR. WESTBROOK:

19 Q. This is the SAO contract here, and if
20 anybody --

21 Jay would you like a copy?

22 Anybody want -- I've got an extra copy if
23 anyone wants it.

24 MR. VON KANNEL: (Shaking head.)

25

1 BY MR. WESTBROOK:

2 Q. This is the July 1st, 2011 contract, it
3 says on the first page, between HHS and the State
4 Auditor's Office, which I'm going to refer to as SAO, if
5 that's okay.

6 Do you recognize that?

7 A. Yes, sir.

8 Q. Okay. Turn over to page 4, if you would,
9 please.

10 A. Okay. I'm already there.

11 Q. Good.

12 I want to ask you to look at D1.

13 A. (Complying.)

14 Q. And I believe the III is not here, but I
15 believe this is Section -- probably about III, D1, there
16 on page 4.

17 A. Okay.

18 Q. Are you familiar with this section of this
19 contract, generally?

20 A. I sure am.

21 Q. I figured you would be.

22 Let me ask you to read just for the record,
23 if you don't mind, that first sentence, please, sir.

24 A. The SAO will perform agreed-upon procedures
25 involving two cost report periods.

8

1 Q. I'm sorry and -- that's the first sentence,
2 as I asked. Why don't you go ahead and read the next
3 sentence as well.

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

10 Q. Okay. Thank you.

11 Now, the term agreed-upon procedures in
12 there, I know that's a defined term, and we can turn to
13 the definition if we need to, but does that include
14 audits and audit reports?

15 A. Yes.

16 Q. And there's a reference in there to
17 non-hospital based nursing facilities.

18 Countrywood would fit into that
19 prescription, would it not?

20 A. Yes, sir.

21 Q. What does engagement mean?

22 The word engagement is used in there. I'm
23 not aware of that term being defined. Are you?

24 Do you see where it says --

25 A. It says, At the time the field work for the

1 engagement.

2 I mean, I can tell you what my -- I.

3 think --

4 Q. Tell me what --

5 A. -- my understanding is.

6 Q. Yes. Tell me what your understanding is,
7 please.

8 A. Is when the field work -- I mean, when the
9 audit of the -- when the audit starts, is when they're
10 there.

11 Q. When you say they're there, are you
12 meaning --

13 A. When the auditors go off-site and begin the
14 audit.

15 Q. Okay. And the auditors for the SAO?

16 A. That's correct.

17 Q. All right. And so engagement would involve
18 audits then. It would be the start or the commencement
19 of -- of the audit process; is that --

20 A. Well, let me just re --

21 MR. NICKELS: I'm going to object to the
22 form. And if you don't mind, let me explain the reason.

23 MR. WESTBROOK: Go ahead.

24 MR. NICKELS: If you mean the term audit to
25 include agreed-upon procedures for review, then we could

10

1 agree that that is what you're going be referencing to
2 throughout your questioning. That's fine,

3 If you mean a specific audit, meaning
4 something that is not in an audit fashion resulting in
5 the report, I think we need more clarification.

6 MR. WESTBROOK: Well, let me ask him for
7 some more clarification about that.

8 MR. NICKELS: All right.

9 MR. WESTBROOK: Because I -- I really would
10 like Mrs. Saxon's understanding of what the word
11 engagement means in that, you know, sentence, in there.

12 THE WITNESS: All right. So let me just
13 read one more time.

14 BY MR. WESTBROOK:

15 Q. Sure. Take your time.

16 A. I mean, yes, it's when the audit activity
17 begins, to me.

18 Q. All right.

19 A. Agreed-upon activity -- procedures activity
20 begins.

21 Q. When the agreed-upon procedures activity
22 begins?

23 A. Right. I mean, again, it's -- I'm trying
24 to correct the -- I'm trying to correct the -- because I
25 was even going to say something about that too. It's

1 not in the audit precisely agreed-upon procedures.

2 Q. Okay. All right.

3 A. Because we know, I mean -- but...

4 Q. So just -- and yes, that's fine. That's
5 fine. I just want to make sure.

6 So if I understand, it's when the
7 agreed-upon procedures activity begins; is that what you
8 said?

9 A. Yes, sir.

10 Q. Okay. Now, for this engagement that we're
11 involved in here today involving Countrywood, do you
12 remember or do you know when the field work for this
13 engagement initiated?

14 A. No, sir.

15 MR. WESTBROOK: Let me ask you to look at
16 another document, and see if that is relevant to that
17 question.

18 I'm going to ask the court reporter to mark
19 this as Exhibit 2, please.

20 If anybody wants a copy of any of these as
21 we go, just let me know. Otherwise, I'll put them back
22 in here.

23 (Petitioner's Exhibit Number 2,
24 October 9th, 2012 E-mail from Larry Warrington to Terry
25 Schmoyer, was marked for identification.)

Jeffery Saxon 8/8/2014

12

1 BY MR. WESTBROOK:

2 Q. All right. Now, what I'd like you to focus
3 on, if you will, Mr. Saxon, is the e-mail dated
4 July 15th, 2011, from Larry Warrington --

5 A. Uh-huh.

6 Q. -- to Terry Schmoyer with Mr. Von Kannel
7 copied on that.

8 First of all, who is Larry Warrington?

9 A. He's an employee of the State Auditor's
10 Office.

11 Q. Okay. And the date of this e-mail is
12 July 15th, 2011, right?

13 A. That's what it says.

14 Q. And I'm going -- just going to, for the
15 sake of efficiency, read the first sentence or two into
16 the record.

17 It says, Terry, I was wondering if you
18 could provide us some information. We are in the
19 process of starting up a review of cost reports
20 submitted by Countrywood Nursing Center, formerly
21 Ridgeview Manor.

22 And then it tells you what cost reports
23 they're reviewing.

24 Does that -- and that's dated, does it say,
25 in July of 2011? Does that indicate to you that the

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1 engagement -- the field work for the engagement was
2 initiated in 2011 -- or July 2011?

3 A. Well, when was the original engagement
4 started?

5 Q. I'm -- that's what I'm -- I really don't
6 know. I'm asking you.

7 A. See, that's why I don't -- I don't know.

8 Q. Okay.

9 A. Again, they're out of their audit period.
10 There are other cost report periods that are being
11 audited.

12 Q. Well, for these three cost report periods,
13 does -- would -- just focusing on these three cost
14 report periods, would this indicate that the
15 engagement -- or the field work was initiated in July?

16 A. I mean, again, I would have assumed that
17 there would have been some earlier work, but I don't
18 know when they started. No, I really don't.

19 Q. Okay.

20 A. I can't tell from this whether the other
21 audits were done prior to or after this. I would assume
22 they were done prior to, but I don't know that.

23 Q. All right. And I'm not trying to badger
24 with you. I'm just trying to understand.

25 The other audits would be -- would they

14

1 be -- would this thing be part of all one engagement, or
2 would it be --

3 A. That's what I would have assumed, that it
4 would have been all one engagement. In other words, you
5 got there, and you're auditing cost reports at a
6 provider's site, the engagement, to me, starts then.

7 Q. All right. And you don't know when that
8 happened in this case?

9 A. No, sir.

10 Q. All right. Well, I want you to assume
11 something then, and I understand that you just said you
12 don't know, and I appreciate that.

13 If -- what cost report period would have
14 been in effect for Countrywood in July of 2011? Would
15 it have been the October 1st, 2008, through
16 September 30th, 2009?

17 A. I've got to think about this a minute, I
18 guess, sir.

19 Q. Sure. Take your time.

20 A. Can I write?

21 Q. Yes.

22 A. Can I have a piece of paper --

23 Q. Sure.

24 A. -- just to write something on --

25 Q. Sure.

1 A. -- so I get down my dates right.

2 Q. Absolutely.

3 A. You say, July 11th, rate period.

4 Q. Yes. In July 2011, what cost report period
5 would have been in effect for Countrywood? That would
6 be my question.

7 A. The -- October of '8 through 2009.

8 Q. October 1st, 2008 --

9 A. Yeah.

10 Q. -- through September 30th of 2009?

11 A. 2009, yeah.

12 Q. Okay. All right.

13 And the cost report period that preceded
14 that October '08 to September '09 -- the cost report
15 period that preceded that for Countrywood would have
16 been 11/29/07 through 9/30/08?

17 A. Well, it would -- I know 9/30/08 would have
18 been the ending period. I don't know exactly what the
19 beginning period would have been.

20 Q. All right.

21 A. But I'm assuming -- let me get back to
22 it -- the 11/29/07 in this e-mail is their date of
23 operation. Yes. That would have been the period.

24 Q. Okay. Thank you.

25 Let me -- I'm going to ask you a couple of

16

1 questions about our affidavit that was submitted
2 earlier.

3 A. Okay.

4 Q. And first of all, I'm going to get that
5 marked as an exhibit.

6 A. Do I give this to her?

7 Q. You can give it to her, or hold on to it,
8 either way, whichever you do.

9 A. Oh. All right.

10 Q. Eventually, it's going back to her, though.

11 A. Okay. I don't know if I need it anymore.

12 Q. Well, you might. I doubt it.

13 A. Okay.

14 MR. WESTBROOK: And if you could mark this,
15 please, as Exhibit 3.

16 (Petitioner's Exhibit Number 3, Jeff Saxon
17 Affidavit, November 7, 2012, was marked for
18 identification.)

19 BY MR. WESTBROOK:

20 Q. Okay. And Mr. Saxon, you recognize this as
21 your affidavit that was --

22 A. Yes, I do.

23 Q. -- submitted earlier, right?

24 A. Yes, I do.

25 Q. Okay. Let's take a look, if you will, over

1 to the second page of the affidavit, paragraph 4.

2 A. Okay.

3 Q. Do you see the phrase "at a minimum" there
4 about -- on the fourth line?

5 A. One, two, three, four. Yeah, I do.

6 Q. Okay. I'm just going to read part of that
7 sentence into the record.

8 At a minimum, the Office of the State
9 Auditor performs agreed-upon procedures involving two
10 cost report periods.

11 And I'm just going to stop right there.

12 And by the phrase -- by use of the phrase
13 "at a minimum," I'm -- I assume that means that you
14 believe that SAO can audit more than two cost report
15 periods; is that correct?

16 A. That's correct.

17 Q. And is there a maximum, or a limit, on the
18 number of cost report periods they can audit?

19 A. Is there a maximum on the number? What I
20 would say is that depending upon what was found in the
21 audits, if there was fraud or something like that, they
22 could go back for a number of years. I don't -- but
23 I've never known. I couldn't say you can go back five
24 years, eight years, ten years.

25 Q. All right.

18

1 A. But it could go back for several years.

2 Q. Absent fraud -- absent some finding or
3 allegation of fraud, can they go back more than two cost
4 report periods?

5 A. If they see problems with cost reports,
6 they can.

7 Q. And aside from this appeal, this
8 Countrywood appeal, can you recall the last time that
9 SAO audited more than two cost reports when there was no
10 fraud allegation involved?

11 A. I can't recall off the top of my head
12 anybody, but for new providers that come into the
13 Medicaid Program, their first cost report is always
14 audited.

15 Q. And I understand that; but has it been your
16 experience -- let's say, in the last five years or so,
17 can you recall any nursing home where, absent fraud --
18 that had more than two cost report periods --

19 A. I -- I just can't remember. I mean, I
20 just -- I do not recall if I saw any or how many I've
21 seen, to be honest with you. I don't necessarily see
22 all the audit reports anymore. My staff do.

23 Q. Okay. Who in your staff? Well, who is
24 your staff?

25 How many staff folks do you have?

1 A. I have -- I'm going to say 15.

2 Q. Okay.

3 A. But they work in various, you know --

4 Q. All right. Who would, of the 15 staff
5 people -- would all 15 or just a portion of those be
6 charged at the times with reviewing audits like this?

7 A. Well, a portion of them would be. I'd say,
8 maybe there's two people involved. One would be the
9 division director, and then the one -- one has the
10 actions of receiving it.

11 Q. Who's the division director?

12 A. Well, right now it's Melissa Simmons.

13 Q. And how long has Melissa Simmons been
14 working in that job?

15 A. She came -- oh, gosh. Well, she used to
16 work there, you know, in earlier years, and then she
17 left, and then she came back. She's been there a little
18 over, I'll say, 14 or 15 months. I'll just say that.

19 Q. All right. Who had her job before she --

20 A. Debra Myers.

21 Q. Okay.

22 A. But then, you know, she left, went to DMH,
23 and now she has returned, but she's not in that capacity
24 anymore. She's in a different capacity.

25 Q. Right,

20

1 A. Different role.

2 Q. But at some time before -- if I understand
3 it, before Melissa came back, she -- Ms. Myers had that
4 role?

5 A. She would, yeah. She would have been
6 probably the one that would have seen those reports and
7 stuff.

8 Q. And you said there were two of your staff
9 people that did that.

10 A. Well, I mean --

11 Q. Who was the other one?

12 A. -- when I say two, there's one that set up
13 the receivables. That's who pulls, you know, the days,
14 you know --

15 Q. All right.

16 A. -- determines the overpayments and stuff.

17 Q. Who was that?

18 A. That has been Brandy Gilbert.

19 Q. Is she -- she's there now?

20 A. Yeah, yeah.

21 Q. And how long has Ms. Gilbert been there?

22 A. Gosh, four or five years. I'm just

23 guessing.

24 Q. All right. Have you ever in -- been
25 involved in any negotiations with the -- or discussions

1 with the -- any representatives of the Health Care
2 Association about the number of cost report periods for
3 a routine audit that can be -- or excuse me, for a --
4 yeah, for a routine audit that can be reviewed?

5 A. There were -- there had been discussion in
6 the past about how many cost report periods can be
7 reviewed.

8 Q. When were those discussions?

9 A. Several years ago. I can't remember
10 exactly what year it was.

11 Q. Well, and I understand that, if you can't
12 remember exactly. I wouldn't ask you exactly.

13 But approximately, what are we talking
14 about?

15 A. Shoot. Probably back in the, maybe, early
16 2000s, I'm guessing. I don't know.

17 Q. Before 2005?

18 A. I can't recall if it was that far back, to
19 be honest with you.

20 Q. Okay. But --

21 A. Well, there were discussions. I've
22 admitted that.

23 Q. Okay. Well -- well, and I'm going to ask
24 you about these discussions. Just one more question,
25 just to understand a little bit more about the time

22

1 frame. And, again, I'm not trying to --

2 A. I know.

3 Q. -- pin you down on exactly when it is. I
4 couldn't remember myself from something going on that
5 long.

6 But are we talking in the two thousand --
7 you said maybe the early 2000s.

8 A. Yeah.

9 Q. Are you talking about from 2000 to 2005?

10 A. Yes.

11 Q. Sometime in that time frame?

12 A. Yes.

13 Q. Okay. Who were the discussions with? Who
14 did you discuss --

15 A. Well, I'm sure it would have been with the
16 agency director and the -- or my deputy director and
17 the -- Randy Lee.

18 Q. Okay. And the agency director was who back
19 then?

20 A. Gosh, in 2000?

21 Q. In that time frame, 2000, 2005, who was the
22 agency director then?

23 A. Gosh, we've had several of them during that
24 time frame. Bill Prince was there. Griswold was there.
25 I can't remember if -- Dr. Laurent left in the late

1 '90s, and then there was -- and Robbie was there, but I
2 think this was all done before Robbie was there.

3 Q. Before Robbie Kerr?

4 A. Yeah.

5 Q. All right. So this would have been, you
6 think, either Bill Prince or --

7 A. Or maybe even Laurent. I just can't
8 remember. It's -- because if it was Laurent, it would
9 have been actually in the late '90s. But...

10 Q. Who would have the deputy -- so the -- who
11 would have been the deputy director during this --

12 A. Well, again, depending on who the director
13 was, it could have been Benny Clark or Jenny Butler
14 or -- like I said, I know it wasn't Robbie. It had to
15 have been William. I'm trying to think.

16 When Griswold was there, it was Gary Bell,
17 and then there was -- I can't remember the other person
18 off the top of my head.

19 Q. All right. But you believe the
20 discussions -- whoever the deputy director was at the
21 time and whoever the director was at the time and Randy
22 Lee, those would be the principal people involved in
23 these discussions and yourself?

24 A. Uh-huh.

25 Q. Okay.

24

1 A. Yes, sir.

2 Q. And nobody else from the Health Care
3 Association besides Mr. Lee that you recall?

4 A. I mean, it could have been John Barber, but
5 I can't exactly remember. But it seemed like it was
6 more of an issue that Randy may have been involved in.

7 Q. All right. How many times -- I mean, were
8 these telephone calls or face-to-face meetings, or do
9 you recall?

10 A. It was probably both, if I had to guess.

11 Q. And, I mean, how long a period of time?
12 Was this a matter of a few days or weeks or months or
13 what?

14 A. I'd say weeks to a few months. It's -- it
15 seemed like there was some work -- I mean, there was
16 some going back into it about defining what period
17 should be looked at and stuff like that.

18 Q. And what was the -- what was it Mr. Lee was
19 asking for?

20 A. I think the issue that they had was that --
21 and, you know, like I say, I'm trying to remember
22 exactly all these things from several years ago, but I
23 don't know if it was -- there was a backlog of audits
24 that needed to be getting out, or they didn't know --

25 Q. I just didn't understand you. I'm sorry?

1 A backlog of what?

2 A. A backlog of audits that needed to be --

3 Q. Audits. All right.

4 A. Or if it was relating to basically how many
5 audit periods would be reviewed, you know, depending
6 upon, like, you know, I guess -- I guess they were just
7 trying to get some feel as to how many audit -- how many
8 years would be reviewed.

9 Q. What was the resolution for that?

10 A. We revised the contract.

11 Q. And this was the contract -- the SAO
12 contract?

13 A. Yes, it was.

14 Q. Between SAO and HHS?

15 A. That's correct.

16 Q. Would that have been the predecessor of the
17 contract that's -- we marked it?

18 A. There was contract before that, and this is
19 the most recent.

20 Q. And what I'm referring -- we were referring
21 to Exhibit -- what was marked as Exhibit 1 a minute ago,
22 right?

23 A. Yes, sir.

24 Q. Okay. So the predecessor to this contract
25 was revised; is that what you're telling me?

26

1 A. I mean the language relating to all of the
2 activity was revised.

3 Q. How was it revised; do you recall?

4 A. It was revised to the language that we
5 wrote, that we just read.

6 Q. That you just read.

7 Okay. Before, did it say two cost report
8 periods?

9 A. I don't remember what it said exactly.

10 Q. But it was -- how -- well, again, I
11 wouldn't expect you to know exactly --

12 A. I think -- I don't remember if it -- I
13 don't know -- I cannot -- I think I know what it said --

14 Q. Okay.

15 A. -- but I can't exactly say that is what it
16 says.

17 Q. Well, let me just clarify, Mr. Saxon. Let
18 me just -- let me just clarify.

19 I certainly do not expect you to remember
20 exactly the -- you know, the words that you had. That
21 would be a superhuman feat.

22 But can you remember the gist of what it
23 said and the gist of --

24 A. In the old contract?

25 Q. Yes.

1 A. The former contract? I would guess it
2 would say three years, maybe.

3 Q. All right. And so you think it was -- the
4 gist of it was revised from three years to two years?

5 A. Well, there's three years in this that
6 impacts the current rate period you're looking at --
7 well, no. That's right. They're auditing the current
8 rate period and then the prior rate period. Never mind.

9 Q. Let me ask you to take a look, again, at
10 that contract, if you don't mind.

11 That's -- again, I think that's what we
12 called Exhibit 1 to this agreement, and we were looking
13 at page 4, I think, weren't we?

14 A. That's correct.

15 Q. And that's Section III, D1. And that first
16 sentence says, SAO will perform agreed-upon procedures
17 involving two cost report periods..

18 Did the old contract say the SAO will
19 perform -- or did the gist of the old contract say --
20 again, not verbatim. I'm not asking for that.

21 But was the gist of it that the SAO will
22 perform agreed-upon procedures involving three cost
23 report periods?

24 A. I can't exactly remember, but I'm thinking
25 that's what it may have said.

28

1 Q. All right. And since that revision, do you
2 recall -- can you name or recall any nursing home since
3 that revision where more than three cost report periods
4 were audited when there was no allegation of fraud?

5 MR. NICKELS: Object to the form.

6 BY MR. WESTBROOK:

7 Q. You can answer it. I can repeat the
8 question.

9 A. Where more than three were audited?

10 Q. Where more than two were audited.

11 A. Okay. You said three just a minute ago.

12 Q. I'm sorry. Well, I appreciate --

13 A. I'm just trying to make sure I wasn't
14 talking about the old stuff versus this stuff.

15 Q. No. Let me repeat that question, and I'll
16 try to be clearer this time.

17 Since those revisions to the contract you
18 were talking about, can you recall any nursing home
19 where, absent any allegations of fraud, more than two
20 cost report periods were audited?

21 A. Now, I know we just got through with a
22 large consent order on one thing. I can't remember how
23 many audit reports were in there. It seemed like there
24 were numerous, or it could have been more than two, but
25 I just can't recall exactly.

1 Q. Who was that? What facility is that?

2 THE WITNESS: Was it those --

3 MR. NICKELS: I can't help you. You'll
4 just have answer to the best of your recollection.

5 THE WITNESS: I'm sorry. I'm trying.

6 Okay.

7 BY MR. WESTBROOK:

8 Q. That's okay. That's okay. That's a
9 natural instinct. I look to Mr. Nickels for help too
10 sometimes.

11 A. I'm trying to think of the -- the group
12 too. Was it Palmetto Facilities?

13 MR. NICKELS: Just to the best of your
14 recollection.

15 BY MR. WESTBROOK:

16 Q. To the best -- that's right.

17 To the best of your recollection,
18 Mr. Saxon, if you can remember it. I don't want you to
19 speculate, but if you can remember it, let me know.

20 A. I just -- no. I can't exactly remember,
21 but I'm thinking that's --

22 Q. So you think it might have been Palmetto?

23 A. I mean -- I mean, there may have -- could
24 have been others, but I just can't -- it just seemed
25 like that's the most recent one, and I just --

30

1 Q. All right. Well --

2 A. That consent order. And there were
3 numerous --

4 Q. Well, let me go back. And, first of all,
5 let me just --

6 A. -- reports.

7 Q. -- tell you something -- just clarify
8 something. I suspect Mr. Nickels -- well, I won't --
9 never mind.

10 I'm not -- if you can't remember, if you
11 don't know, that's fine.

12 A. Okay.

13 Q. That -- you know, I don't want you to --

14 A. But I'm trying to represent the agency the
15 best --

16 Q. I appreciate that.

17 A. -- I can, and I'm trying to remember
18 exactly what I can.

19 Q. I understand, and I appreciate your effort,
20 and I want you to try to remember, but if you can't, you
21 can't.

22 But here's my question.

23 A. Okay.

24 Q. Do you recall, to the best of your
25 ability -- can you -- do you recall any nursing home

1 other than Countrywood since that contract was revised
2 where more than two cost report periods were audited and
3 there were no allegations of fraud?

4 A. I can't say with certainty I can remember
5 of any.

6 Q. All right.

7 A. How is that?

8 Q. That's --

9 A. I mean, I -- I can't --

10 Q. If that's your answer, that's your answer.

11 A. I just -- again, I just can't recall off
12 the top of my head.

13 Q. All right. Now -- bear with me just a
14 second, please, sir.

15 A. Okay.

16 Q. Let me go back to your affidavit. I think
17 that's Exhibit 3.

18 A. (Complying.)

19 Q. And let's look over on the first page, if
20 you don't mind.

21 There's a -- paragraph 3 --

22 A. Yes, sir.

23 Q. -- and there's a number of bullet points
24 underneath that.

25 I wanted to ask you about the second bullet

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1 point. It says, The State Plan addresses two separate
2 and distinct forms of cost reports.

3 And the first one is a 12-month cost report
4 from October 1st to September 30th; is that correct?

5 A. Yes, sir.

6 Q. And then the second form of cost report, it
7 says -- and if you'll go down to the third bullet
8 point -- is a six-month cost report; is that right?

9 A. That's correct.

10 Q. And then it goes on to -- in the paragraph,
11 it goes on to say when the six-month cost report
12 applies.

13 Are there ever cost reports that are less
14 than six months?

15 A. No, sir.

16 Q. So the only kind of cost reports are either
17 a 12-month or a 6-month; is that right?

18 A. Well, there could actually be between six
19 and twelve months.

20 Q. When would that happen?

21 A. It -- I mean, say if a change of ownership
22 occurred in January, they filed January through June and
23 then file a January through September.

24 Q. Okay.

25 A. And then they get back on the normal

1 October-through-September reporting cycle.

2 Q. Does the Plan specifically address that
3 sort of interim cost report -- I -- and that's my word
4 and not yours -- those kind of cost reports that would
5 fall between six and twelve months?

6 A. Well, what it does is, we -- another
7 plan -- again, most people file our annual, and then we
8 ask for a 930.

9 Q. You do?

10 A. So if there's been a change of ownership
11 and they have a cost report period that's -- that they
12 report costs on up through 930 and, you know, the change
13 of ownership occurred anywhere, I guess, between October
14 the 2nd through -- you know, in that 930, they would
15 have -- they would have filed six months when the -- or
16 six -- well, actually, they file almost at seven months,
17 originally, and then they would have filed that
18 following 930 year-end report.

19 So they would be required to submit a 930
20 in that example.

21 Q. And does the Plan --

22 A. This can be less than a year.

23 Q. Does this plan directly address that kind
24 of example you just gave?

25 A. I know on the leases and sales -- I mean,

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1 on the leases, I believe that it does.

2 Q. All right. On leases and sales only,
3 though?

4 A. Well, that's the only -- well, you know,
5 again, we -- our standard reporting period is 930.

6 Q. Right.

7 A. Whether it's 12 months or less.

8 Q. Okay.

9 A. Okay? So once you've -- change of
10 ownership and you meet certain criteria, you file six
11 months, and then you catch up to a 930, and then you get
12 on the annual cycle. It's -- it's there.

13 Q. All right. Okay.

14 Thanks. Thanks for that clarification.

15 Let me go back and ask you about the SAO
16 contract. Again -- that was, again, Exhibit 1, and
17 we've talked about that. That's that section there on
18 page 4 that we were looking at.

19 A. Yes, sir.

20 Q. If you could just look at that again,
21 please, sir.

22 A. (Complying.)

23 Q. Now, in your affidavit, you -- you just
24 said that the two contracts -- the two cost report
25 periods were, in your opinion, minimal; is that right?

1 A. Yes.

2 Q. Is there -- can you tell me what the basis
3 of that opinion is? Is there contractual language or
4 plan language, or has that just been the practice, or --
5 or what's the basis of that opinion that you just
6 offered, that that's a minimum number?

7 A. I mean, the basis is this. If you --
8 nobody knows what they're going to find in an audit. If
9 a provider goes and sees -- if they look at the two cost
10 reports and there are significant issues, reimburse --
11 or allowable cost issues, then we -- I would think we
12 could go in and pull that information and look at it.

13 Q. Okay.

14 A. Now, on guys who change ownership who are
15 on the six-month cost report, those cost reports are
16 audited. That is their baseline cost when they enter
17 the Medicaid Program.

18 Q. All right.

19 A. And if all -- and if you want to get
20 providers on target for proper reporting and useful life
21 determinations that complies with allowable cost
22 definitions, you have to get to that one. That is the
23 basis.

24 Q. All right. But, again, is there any -- and
25 I understand what you just said.

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1 Is there any -- anything in writing that
2 you're relying on, any provision in a contract or the
3 Plan or anywhere else that you're relying on for your
4 opinion that more than two cost report periods can be
5 audited?

6 A. Not off the top of my head.

7 Q. Let me ask you --

8 MR. NICKELS: Is the question beyond what's
9 identified in the affidavit?

10 MR. WESTBROOK: It's -- no. The question
11 is, generally, is there anything?

12 MR. NICKELS: Okay.

13 MR. WESTBROOK: Is there anything?

14 MR. NICKELS: Okay.

15 BY MR. WESTBROOK:

16 Q. Now, is there anything identified in your
17 affidavit that gives you -- why don't you take a minute
18 to look at your affidavit, and look and see what -- if
19 there's anything in there.

20 A. Well, what -- I mean, one thing I guess
21 that -- you know, now that I think about some after
22 looking at the affidavit, is the -- you know, again,
23 we're trying to look at rate periods.

24 In other words, there's -- let me see how
25 to say this. Of course, that's a three-year issue.

1 Never mind. That's not what I was thinking.

2 Q. I'll tell you what. Let me ask you to look
3 back at the SAO contract, Exhibit 1, and turn over to
4 page 3, if you would.

5 A. Okay.

6 Q. Okay. And you see there, it says, Article
7 III, SAO Responsibilities.

8 A. Yes, sir.

9 Q. And then Section B says, SAO shall be
10 responsible for -- and then it lists a number of things.

11 A. That's correct.

12 Q. Look at number 3. Number 3 says, SAO shall
13 be responsible for conducting all engagements to
14 determine if the reimbursement rate or amount is in
15 accordance with the provisions of the provider
16 contracts, State Plan, and state and federal laws and
17 regulations, doesn't it?

18 Correct?

19 A. Correct.

20 Q. Now, that provision gives SAO authority --
21 not only authority, responsibility, to conduct these
22 kind of engagements that's described there, right?

23 A. Yes.

24 Q. And, in fact, SAO has exclusive
25 responsibility and authority to conduct those kind of

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1 engagements; is that correct?

2 A. That's right. The provider requires us to
3 contract with them.

4 Q. Okay. And does this language that I read,
5 B3, relate in any way to the number of audits that SAO
6 can conduct of nursing facilities?

7 A. Could you ask that question again?

8 Q. Sure.

9 Does this section I just read, which is
10 Article 3 -- B3, relate in any way to the number of
11 audits that SAO can conduct of nursing facilities? Do
12 you see a connection or not?

13 A. Yes.

14 Q. What is the connection that you see?

15 A. I mean, because the provider contract talks
16 about when audit enforcement has to be issued. We have
17 an administrative contract with them that tells them,
18 you know --

19 Q. Okay,

20 A. -- all of the actives and the purchasing.

21 Q. Yes, sir, I understand.

22 Does this address the number of audits,
23 though, that can be conducted? Is this relative to that
24 issue?

25 A. This doesn't say exactly how many they can

1 do, if that's what you're asking.

2 Q. That's what I'm -- that's partly what I am
3 asking, yes.

4 Does this give any indication of how many
5 they can conduct?

6 A. It doesn't say that -- it doesn't instruct
7 them to say, You do two, five, twelve, or whatever.

8 Q. Right.

9 Okay. Thank you.

10 Let me go to a new document, please. I'm
11 going I'm to refer to this as the facility contract.
12 It's going to be Exhibit 4, I believe,

13 A. Four.

14 MR. WESTBROOK: And here you go, Al.

15 (Petitioner's Exhibit Number 4, Contract
16 Between the South Carolina Department of Health and
17 Human Services and Ridgeview of the Midlands DBA
18 Ridgeview Manor Nursing Facility for the Purchase and
19 Provision of Nursing Care, Dates as of October 1, 2006,
20 was marked for identification.)

21 BY MR. WESTBROOK:

22 Q. And take a look at that, Mr. Saxon, which
23 I'm going to ask you a couple of questions about that.

24 A. Okay.

25 Q. This -- on the title page -- I'm just going

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1 the read it for the record -- it says, The Contract
2 Between the South Carolina Department of Health and
3 Human Services and Ridgeview of the Midlands DBA
4 Ridgeview Manor Nursing Facility.

5 And is it your understanding that there's
6 an assignment from Ridgeview to Countrywood?

7 A. Well, yeah. I knew there was a change of
8 ownership, yes, sir.

9 Q. Yes. So there was a change of ownership.
10 So this would be the Countrywood contract,
11 would it not?

12 A. Yes, sir.

13 Q. Is that right?

14 A. Yes, because they do get assigned.

15 Q. Okay. All right.

16 And, again, just for the shorthand, I'm
17 going to refer to this as the facility contract.

18 If you could turn over to -- look at it, if
19 you need to, but where I'm -- I'm going to ask you --
20 what I'm going to ask you about is on page 9. So
21 anytime you get ready, if you can turn over to page 9.

22 A. Okay.

23 Q. All right. And this -- actually, if you'll
24 look at the bottom of page 8 for a moment, it says,
25 Subsection G, Accuracy of Data and Reports, and then

1 that spills over to the next page.

2 And then there are two subsections.
3 Number 1, Maintenance of Records, and number 2,
4 inspection of records, right?

5 A. Yes, sir.

6 Q. So what I'm going to be asking you about
7 are Subsections G1 and 2. And I'm just going to
8 represent to you that this is part of a larger section,
9 V, of this contract, but it's on page 9.

10 All right. Why don't you take a look for a
11 minute, just --

12 A. Read just 1 and 2, or the --

13 Q. Just --

14 A. -- entire --

15 Q. Why don't you -- I think for the purposes
16 of my question, if you'll just browse through 1 and 2
17 silently and just refamiliarize yourself with those, and
18 then I'm going to ask you a couple of questions about
19 it.

20 A. (Complying.)

21 Okay.

22 Q. All right. These two sections require --
23 taken together, require a facility, in this case,
24 Countrywood, to maintain records for a six-year period
25 and give SAO the right to inspect those records for a

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1 six-year period; is that right?

2 A. Well, yes. Well, a six -- yeah. You have
3 to do it for six years after the last payment made under
4 the contract.

5 MR. WESTBROOK: Okay. Did you hear that?

6 THE COURT REPORTER: You have to do it for
7 six years after the last --

8 THE WITNESS: Payment made --

9 THE COURT REPORTER: -- under --

10 THE WITNESS: -- under the contract.

11 There are multiple-year contracts.

12 BY MR. WESTBROOK:

13 Q. So this is -- it requires them to keep
14 records for that period of time, and then gives SAO the
15 right to inspect those records, correct?

16 A. Them or these other folks who want to look
17 at it.

18 Q. Yes, that's right. It's not just SAO.
19 It's the other folks listed there as well,
20 correct?

21 A. That's correct.

22 Q. All right. And what's the purpose of --
23 or -- I don't want to ask you a legal question, so I'm
24 simply asking you your understanding of the purpose of
25 this -- these two provisions, the six-year provision.

1 A. I'm -- my initial reaction would be that,
2 if there was fraud involved, and, you know, I guess
3 there's even some -- well, let's see. Let's see.

4 Or for any reason, you know, any of these
5 other governmental entities -- if there was a
6 reimbursement issue that they thought was an issue
7 throughout the country, that they may want to go ahead
8 and look into it. I mean it's -- it's -- it happens all
9 the time.

10 Q. Sure.

11 This -- I notice that this contract, by the
12 way, is signed by Robbie Kerr --

13 A. Uh-huh.

14 Q. -- on behalf of the agency.

15 A. Uh-huh.

16 Q. Contracts like this, are you involved in
17 facility contracts? Are you involved in negotiating or
18 reading or drafting or overseeing these contracts in any
19 way?

20 A. Most of the contract language is -- I mean,
21 it's mostly boilerplate contracts. The things that we
22 may focus in on are the things relating to, you know,
23 the reimbursement costs or the requirements funding
24 issues, things such as that.

25 Q. Uh-huh.

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1 A. Most of this, again, is boilerplate, and
2 our legal department would be the ones developing that.

3 Q. I see.

4 And I understand that, of course, with a
5 lot -- so many facilities, you would have to have, as
6 you say, boilerplate language; otherwise, just -- you
7 don't want to reinvent the wheel every time.

8 A. There's no -- yeah. There's no
9 negotiation, really. I mean, it's a matter of, you
10 know, if the rates calculate correct methodology. The
11 rate doesn't even show up in the contract. It's just in
12 reference to it and where it comes from.

13 Q. Would you have copies of all the facility
14 contracts in your office?

15 A. Myself?

16 Q. Yes, sir.

17 Or your staff?

18 A. No.

19 Q. Okay.

20 A. They would be in the agency but not with my
21 staff.

22 Q. All right. And then there's a section --
23 let me ask you to look at the bottom of that page 9 that
24 we were talking about. It's part of the Section 2, G2.

25 A. Uh-huh.

1 Q. Actually, the next to the last sentence
2 involves -- it's the sentence that beings, If any
3 litigation. And let me -- I'll just read that into the
4 record.

5 If any litigation, claim, or other action
6 involving the records has been initiated prior to the
7 expiration of the six-year period, the records shall be
8 retained until completion of the action and resolution
9 of all the issues which arise from it or until the end
10 of the six-year period, whichever is later.

11 So just for clarification, in some cases,
12 in the cases of litigation, actually, those records have
13 to be maintain for even longer --

14 A. Even longer.

15 Q. Is that right?

16 A. That's -- yes, sir. That's what it looks
17 like.

18 MR. WESTBROOK: Okay. We are -- I'm about
19 halfway through, Al.

20 MR. NICKELS: All right.

21 MR. WESTBROOK: I'd like to take a
22 five-minute break.

23 MR. NICKELS: Okay.

24 MR. WESTBROOK: And -- but it won't be
25 long, and I think we'll go from there. Okay?

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1 MR. NICKELS: Sure.

2 MR. WESTBROOK: Thank you.

3 (A recess transpired.)

4 BY MR. WESTBROOK:

5 Q. All right, Mr. Saxon. We are back from our
6 little break.

7 The -- I understood you to say, but correct
8 me if I'm wrong -- I understood you to say that the
9 six-month cost report is always audited; was that right?

10 A. It should be, yes, sir.

11 Q. Do you know whether, in fact, that's the
12 case?

13 A. Again, I haven't gone and tried to check
14 every one before I came, but that is how -- it's always
15 been my understanding that that one would be audited.

16 Q. So are you aware of any six-month audit --
17 and let's -- I'll tell you what. Let's narrow the scope
18 a little bit.

19 All right. For change of ownership,
20 because that's what's at issue here --

21 A. Right. Whether it's the lease or sale, or
22 whatever.

23 Q. Right.

24 Are you aware of any six-month audit --
25 six-month cost reports for change of ownership or lease

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1 of sale that had not been audited?

2 A. I'm not aware of any.

3 Q. Okay. Your understanding that they -- that
4 six-month cost reports should always be audited is based
5 on -- again, is there anything in writing that mandates
6 that, or is that just your understanding of the
7 practice?

8 A. Again, that's the provider's inception into
9 the Medicaid Program under this payment methodology and
10 it's -- to me, it's standard practice. It's a
11 no-brainer.

12 Q. But it's standard practice?

13 A. That's -- that's how I would look at it,
14 yes, sir.

15 Q. Is it -- but, again -- and I'm not trying
16 to beat a dead horse, but I just didn't understand your
17 response.

18 Is there anything in writing that requires
19 that, either in law or a contract or the State Plan or
20 anywhere else?

21 A. I can't recall it specifically, but, to me,
22 it's if -- to me, a new owner would welcome the
23 opportunity and want to be audited on this report to
24 make sure he's operating in, of course, with the rules
25 and regulations in the State because all the states'

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1 Medicaid Programs are different.

2 Q. I understand that, and that may well be the
3 case. I'm not disputing that.

4 But if I understand you correctly, you're
5 not aware, at least at the moment. You can't put your
6 finger on --

7 A. I can't recall.

8 Q. -- anything in writing.

9 A. Yes, sir, I cannot recall.

10 Q. Okay. Thank you.

11 Now, with -- I was asking you some
12 questions about that section -- or those sections, G1
13 and G2, in the facility contract about the six-year
14 period?

15 A. Yes, sir.

16 Q. Remember we were talking about that?

17 A. Yes, sir.

18 Q. And I was asking you about that, and I
19 think you said that -- again, I may be -- I don't want
20 to misquote you, so you correct me if I'm misstating
21 what you said -- that various agencies could inspect
22 those records for a period of time under certain
23 circumstances, and you used the phrase "it happens all
24 the time." And I was just wanting to follow up on that.

25 My first question --

1 A. Well --

2 Q. I'm sorry. Go ahead.

3 A. I'm sorry. I was getting ready to answer.

4 Q. Well, go ahead. Go ahead and answer. I
5 hadn't -- I was really trying to stumble into a question
6 here, but I hadn't done a very good job.

7 A. Well --

8 Q. Why don't you go ahead and answer, if you
9 can.

10 A. -- I mean, for example, OIG.

11 Q. Okay.

12 A. They've come, and they've looked at, not
13 necessarily nursing homes, but ICF. Well, they're
14 intermediate care facilities for the -- well, they used
15 to call them mentally retarded, but I think it's
16 intellectually disabled facilities now. But they've
17 come back looking at years back in 2006 and '7 for some
18 allowable costs.

19 Q. Were these -- was this for -- based on
20 fraud allegations?

21 A. No.

22 Q. What were they based on?

23 A. They were just based on -- I think they
24 were just based on -- CMS had probably gotten -- CMS may
25 have been a concern in this particular regard, that

50 .

1 there were waiver services being provided by the State
2 Agency for Disabilities -- for People with
3 Disabilities --

4 Q. Okay.

5 A. -- that some State Medicaid Programs may
6 have been including room and board costs in those rates.

7 Q. Okay.

8 A. When they're home- and community-based
9 waivers, they're supposed to keep -- to carve that stuff
10 out. So they will go back and look at stuff like that.

11 Q. Okay.

12 A. I mean...

13 Q. Can you think of any other agencies besides
14 OIG who have done that?

15 A. Those seem to be all, as they come off the
16 top of my head right now.

17 Q. Okay. Good.

18 I may have asked you this question already,
19 and if I have, I apologize.

20 Your opinion that two years -- or two cost
21 reports is a minimum number of cost reports that can be
22 audited -- that opinion -- are there any other bases for
23 that opinion that you hold that we haven't discussed?

24 A. Not that I can recall; but, you know, when
25 you went back to ask me the question about have I ever

1 looked at one or seen any that has been longer than two
2 years --

3 Q. Uh-huh.

4 A. -- there's always got to be a first one.

5 Q. Which means?

6 A. I mean, I'm just saying. I mean, there's
7 always got to be a first one.

8 Q. All right. Was Countrywood the first one
9 in this case?

10 A. I don't know, but I'm just --

11 Q. All right.

12 A. I just made a statement.

13 Q. Okay.

14 A. If it was not, that's why I --

15 Q. All right. Okay.

16 A. That I assumed --

17 Q. But you think we've discussed your
18 opinions? You've set forth your opinions and the basis
19 for your opinions --

20 A. I think so.

21 Q. -- related to this issue?

22 A. I think so.

23 Q. Okay.

24 A. Yes, sir.

25 Q. All right. I appreciate that.

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1 All right. Let's go to the facility
2 contract, and that -- I can't remember what exhibit
3 number that is.

4 A. It's --

5 Q. That would be 4?

6 A. -- 4.

7 Q. Turn to page 8, if you don't mind, please.

8 A. Okay.

9 Q. Okay. On page 8, do you see that Section F
10 down there?

11 A. I figured that's what you was honing in on.

12 Q. Well, honing in is probably too strong of a
13 word --

14 A. Okay.

15 Q. -- but I'm certainly going to ask you about
16 that.

17 A. Okay.

18 Q. And this is from Article V of that
19 contract, V, F. It says, Time Limit for Issuance of the
20 Final Audit Report.

21 A. Yes, sir.

22 Q. That first sentence reads any disallowance
23 made pursuant to an on-site audit shall be made in the
24 final audit report, which shall be issued within three
25 years of the close of the contract period; however --

1 provided, however, if an audit was commenced prior to
2 the expiration of the three-year period, but a final
3 audit report was not issued within three years of the
4 close of the contract period due to any fault of or
5 interference by the provider -- then it goes on to say
6 some other stuff.

7 My first question for you. In this case,
8 was there any fault or interference by the provider that
9 affected the timing of these audits?

10 A. I can't answer that question. I didn't
11 perform the audit.

12 Q. Okay. Are you aware of anything, or have
13 you heard of anything?

14 A. I'm not aware of anything.

15 Q. Okay. In this case, there was a
16 disallowance made pursuant to an on-site audit; is that
17 correct?

18 A. Yes, sir.

19 Q. And that disallowance was made in the final
20 audit report, was it not?

21 A. In the -- yeah. At least three, I think.

22 Q. Three --

23 A. Yes, I think so.

24 Q. Three final audit reports?

25 A. Yes.

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1 Q. And, in fact, if -- just for the sake of
2 the record, let me ask you to look at something.

3 I'm just going to give you -- ask you to
4 look at the cover letters here.

5 Can we mark this, I guess, Exhibit 5,
6 please.

7 (Petitioner's Exhibit Number 5,
8 November 22, 2011 Letter to Joseph Hunt from Richard H.
9 Gilbert, Jr., Regarding AC# 3-RDM-E8 - Countrywood
10 Nursing Center, LLC, AC# 3-RDM-J8 - Countrywood Nursing
11 Center, LLC, AC# 3-RDM-J9 - Countrywood Nursing Center,
12 LLC, was marked for identification.)

13 BY MR. WESTBROOK:

14 Q. And this is a letter dated November 22,
15 2011, from Richmond Gilbert --

16 A. Yes, sir.

17 Q. -- at SAO to Countrywood. And this looks
18 like the cover letter to one of -- to one of the final
19 audit reports; is that correct? Is that what it --

20 A. Yes, sir. That's what it appears to be,
21 yes, sir.

22 Q. Yes. And it's November 22nd, 2011, right?

23 A. Yes, sir.

24 Q. And let me ask you to go back to the
25 facility contract, Exhibit 4.

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1 A. (Complying.)

2 Q. And this time I'm going to ask you to jump
3 over to page 2, please.

4 A. Okay.

5 Q. And that definition of contract period up
6 there towards the top of the page, it's actually got,
7 looks like, three definitions, right?

8 A. That's correct.

9 Q. And the last sentence says, For the
10 purposes of Article V, Section F only, the contract
11 period will be the rate period as defined by the South
12 Carolina State Plan, correct?

13 A. That's correct.

14 Q. And we were just talking about -- and why
15 don't we just turn back over on page 8, which is Article
16 V, Section F, the time limit.

17 So would it be your understanding, then,
18 when in this Section, V, F, when it uses the term
19 contract period, that means the rate period, as defined
20 in the State Plan?

21 A. Yes.

22 Q. Okay. Now, is rate -- is the term rate
23 period actually defined in the Plan?

24 A. There's a reference. I mean, most nursing
25 homes file annual reports, and our annual rate cycle is

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1 October through September of every year.

2 Now, when providers under certain
3 circumstances qualify for six-month cost reports, those
4 cost reports are used to set rates for an extended
5 period of time, and you cannot list every possible rate
6 period that those -- that those cost reports can set a
7 rate for. Providers in the past have utilized this to
8 gain excess revenue through the manipulations or through
9 the purchasing of certain items since they know that
10 this cost report is used set a rate for as long as close
11 to two years, in some instances.

12 So, again, we cannot go in and state that
13 if you file an annual cost report, your rate is this.
14 If you file a six-month cost report, your rate period is
15 that.

16 Q. So is there any definition in the Plan of
17 the term rate period?

18 A. Again, the only reference to -- the State
19 Plan is effective every October, and rates are updated
20 every October.

21 MR. WESTBROOK: Okay. Let me ask you --
22 let's look at the Plan for a minute. I'm going to --
23 this will be Exhibit 6, I think.

24 (Petitioner's Exhibit Number 6, Plan Under
25 Title XIX of the Social Security Act, State of South

1 Carolina, Revised 10/01/10, was marked for
2 identification.)

3 BY MR. WESTBROOK:

4 Q. What I'm going to hand you is a 2010 Plan.

5 A. Okay.

6 MR. WESTBROOK: You can look at those if
7 you need to, but let's start with that paper, Al.

8 Exhibit 6, correct?

9 THE COURT REPORTER: Yes.

10 MR. WESTBROOK: Thanks.

11 THE COURT REPORTER: You're welcome.

12 BY MR. WESTBROOK:

13 Q. What I want to ask you about first is over
14 on page 12.

15 A. I'm already there.

16 Q. You're anticipating my --

17 A. Yeah. I am somewhat familiar with this. I
18 can't remember ever little word but...

19 Q. Well, now, on 12, at the bottom of the
20 page, there's a sentence about rate cycle, right?

21 A. Right.

22 Q. And it says, The rate cycle will be
23 October 1st through September 30th --

24 A. That's correct.

25 Q. -- and will be computed every -- excuse

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1 me -- and will be recomputed every 12 months, utilizing
2 cost reports submitted in accordance to Section I, Cost
3 Finding and Uniform --

4 A. Right.

5 Q. -- Cost Reports, of the Plan.

6 Now -- so that says what the rate cycle
7 will be.

8 Is the rate cycle, in your opinion, the
9 same thing as the rate period, or are they different?
10 Do they mean the same thing, or are they -- do they have
11 different meanings?

12 A. Well, here's the difference. Let me try to
13 explain it.

14 Every rate's cycle, as this references to,
15 we update components of the rate's same methodology, and
16 we update standards. We update inflation factually. We
17 update capital policies. We update allowable cost
18 definitions.

19 And these particular things that I just
20 talked about that are updated, run for that period of
21 time.

22 Q. And so they're updated every --

23 A. I --

24 Q. -- October 1st?

25 A. Right.

1 Q. Okay.

2 A. Right.

3 Q. And I'm sorry. I don't mean to interrupt
4 you, but I just want to understand before you go any
5 further there to make sure I understand what you said.

6 A. Okay.

7 Q. So these updates would include -- I'm
8 apologizing, but can you --

9 A. Try and go back over them again?

10 Q. -- kind of summarize those again? What are
11 some of those things that are updated every October?

12 A. It's like the standards. There's inflation
13 that's applied, there's capital components that that are
14 updated annually. There's -- actually, we've been
15 having a budget neutrality factor which actually reduces
16 payment waves. We've implied those things.

17 I mean, there's a list of rules or caps
18 that are recalculated every October, for the most part.

19 Q. Okay.

20 A. Now, there's some years where there's been
21 rate freezes in the past. Like it might be rates
22 running for 15 months instead of 12 months, you know.
23 Maybe --

24 Q. When's the last time that happened, a rate
25 freeze?

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1 A. Actually, I think we froze -- if it was
2 in -- Robbie was then. It was either in -- I can't
3 remember the exact year. Maybe -- let's see.

4 He took that job in 2003. It was somewhere
5 between 2003 and 2007, is the best I can narrow that
6 down to. I think we did it for three months or
7 something, if I remember correctly.

8 But it has happened in the past.

9 Q. But ordinarily?

10 A. But ordinarily, our rate cycle does run a
11 12 month period; however, if you are a -- you know, if
12 you're under a change of ownership or you qualify for
13 those six-month cost reports, your rate period starts
14 changing.

15 In other words, you now are on a different
16 cost reporting period everybody else is on. We apply
17 your new cost to the rules that are in effect during
18 these rate periods.

19 And then the next time the Plan is updating
20 for the next October rate period, and if that same cost
21 report -- that short repeat is used for that, then those
22 set of rules apply to that same cost report.

23 Q. So it sounds like, if I'm
24 understanding what you're saying --

25 A. So we're trying to audit payment to cost

1 reports.

2 Q. Okay. It sounds like that rate cycle and
3 rate period aren't exactly the same thing then, right?
4 They're different concepts.

5 A. You know, they're -- to me, there a little
6 bit different, yes.

7 Q. All right. And we've already talked
8 about -- and they certainly are different than --
9 different concepts on the cost report period, are they
10 not?

11 A. You're right, because I mean, the rate
12 period gives you prospective, and the cost report serves
13 as the basis of a prior year period.

14 Q. Okay. You said a minute ago in one of your
15 answers, and you say this in your affidavit, about --
16 you use the phrase "an extended period of time."

17 Now, what do you mean by that, an extended
18 period of time?

19 A. That --

20 Q. What does that mean?

21 A. -- the rates can run.

22 Q. Right.

23 A. The run for a -- that cost report sets the
24 rate for a longer than 12-month -- for a period longer
25 than 12 months.

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1 Q. All right. And what is -- what's the basis
2 of that statement, that it lasted longer than 12 months?

3 A. Because if you look at the Plan language,
4 it talks about beginning providers for annual cost
5 reports, and the rates just updated in October. And you
6 go back to the sections that qualify -- or the
7 exceptions that qualify for a new cost report, and it
8 talks about that rate sets the rate for the first six
9 months, and then on the seventh month it starts being --
10 I mean, certain other rules start applying like, you
11 know, depending on what happened to that provider. And
12 it can be occupancy factors, inflation trends starts
13 being applied and stuff.

14 And then what happens, again, because of
15 the timing of the cost report and what the cost report
16 period covers, that cost report can be used in the next
17 rate cycle --

18 Q. Okay.

19 A. -- for the following October --

20 Q. Okay.

21 A. -- and apply against those whole new set of
22 rules.

23 Q. Now, look -- let's turn over to -- what
24 page is this -- page 20, please, of the Plan.

25 A. We're still on the Plan?

1 Q. Yes. We're still on the Plan, which is --
2 I think it's Exhibit 6.

3 A. Page 20?

4 Q. Yes.

5 A. Okay.

6 Q. Now, at the top of the page, it says,
7 Effective November 22nd, 1991, to qualify for a new
8 facility rate based upon a six-month cost report under a
9 change of ownership, a sale or lease of assets between
10 unrelated parties must occur.

11 Now, that's just a reference to a six-month
12 cost report that you were talking about the Plan --

13 A. Uh-huh.

14 Q. -- references from time to time; is that
15 right?

16 A. Uh-huh, yes, sir.

17 Q. And then it goes on and talks about -- on
18 the rest of that page, it talks about a six-month cost
19 report --

20 A. Yeah, and how the rates are set.

21 Q. Let's look over at the top of the next
22 page, page 21.

23 A. (Complying.)

24 Q. It says, This report will be used to
25 determine allowable reimbursement of the provider for

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1 the initial rate cycle, and then it goes on down that
2 paragraph.

3 Do you see the sentence at the end with the
4 word effective, effective on the first day?

5 A. Yeah, on the seventh month.

6 Q. On the seventh month of operation, a new
7 prospective rate --

8 A. Uh-huh.

9 Q. -- will be determined.

10 A. Right.

11 Q. Is this what you were saying a moment ago
12 when you were talking about those same --

13 A. Right, because what --

14 Q. -- periods?

15 A. Right, because -- well, yes, sir. Yes,
16 sir. Yeah.

17 Q. All right. So is there any -- besides this
18 language right here on 20 and 21, I just want to
19 understand the basis for your opinion.

20 Is there any other plan language that
21 supports your opinion about extended period of time?

22 A. I mean, there's other exceptions to qualify
23 for the same type of stuff if you keep on going through
24 these other pages, sir.

25 Q. Okay. Can you just take your time and just

1 kind of browse through here and point me to some
2 language, if you don't mind.

3 A. I mean, you can look at the -- Section 3 on
4 the sale of -- I mean, a lease of fixed assets, the same
5 thing happens.

6 Q. Where does it say that that -- that the
7 rate period will be for an extended period of time, more
8 than 12 months? Now, where does it say that or indicate
9 that?

10 A. It doesn't say that specifically, but it --
11 again, it talks about the process that -- I mean,
12 every -- you know, again, providers aren't dumb.
13 Providers understand our cost reporting requirements,
14 and they understand if that they don't file a 930 cost
15 report every year, they get these short cost reports.
16 That's what their rates are based on. That's why they
17 do the things they do sometimes.

18 Q. Okay.

19 A. You cannot write a plan that's going to
20 cover every little thing that happens. You just can't.

21 Q. Sure. I understand that.

22 A. You just can't.

23 Q. I understand that.

24 A. So --

25 Q. But --

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1 A. -- you have to use, I'd say, common sense
2 in this, saying, look, it says you filed 930s, and it
3 sets you up that following up -- you know, that
4 particular October.

5 And then you've got these exceptions, and,
6 you know, depending upon when you -- you know, if you
7 did an April-through-September cost report -- say that's
8 a six-month cost report -- I mean, that cost report can
9 be used to set a rate for a real long period of time.

10 Q. Well, let me go back to the top of 21, the
11 language we were looking on there.

12 That first paragraph, particularly that
13 sentence that begins, Effective on the first day of the
14 seven month --

15 A. Yes.

16 Q. -- do you see that?

17 A. Yes.

18 Q. It says, A new prospective rate is set on
19 the first day of the seventh --

20 A. Well --

21 Q. Isn't that correct?

22 A. Right. That's what it says. And what
23 happens is, the first six months, you have -- it's
24 actually -- it's not really actual cost reimbursement,
25 but there's no inflation involved. The seventh month.

1 you start applying inflation.

2 And then what would happen, if you roll
3 over into another October rate cycle, where all this
4 stuff is updated that I referred to earlier --

5 Q. Okay.

6 A. -- then you have to go back and apply all
7 those rules to the same cost report.

8 Q. Right, those things you were talking about.

9 So you -- the first six months, though,
10 would be whatever it is -- the rate is. On the first
11 day of the seven month, you would apply --

12 A. It's starting to get inflation applied.

13 Q. That's when the inflation --

14 A. Yes, sir.

15 Q. -- is applied for the first time, and that
16 affects the rate.

17 And that's what it says a new rate?

18 A. That's a new rate, yes, sir.

19 Q. And then on October 1st, there would be the
20 various changes that you talked about to the Plan.

21 A. That's right. And then they start over in
22 that rate cycle.

23 Q. Okay. Let me ask you to look back at your
24 affidavit for a minute, and that is exhibit --
25 something.

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1 A. Three.

2 Q. That sounds right. Exhibit 3, yes, sir.

3 A. (Complying.)

4 Q. Exhibit 3, look over in paragraph 5. And

5 the only reason I'm going to ask you about this is

6 because you were saying something a minute ago that I

7 think ties into what you're saying here in paragraph 5.

8 The first sentence of that paragraph says,

9 Because the six-month cost report sets -- set the rate

10 for extended periods, Medicaid providers are able to

11 leverage their costs in an advantageous fashion.

12 That's what you were just talking about

13 right there --

14 A. That's correct, yeah.

15 Q. Right?

16 Okay. And you go on to give examples,

17 general examples, and you give an example of Countrywood

18 in that paragraph, right?

19 A. Yes, sir.

20 Q. Now, I guess my first question is, Is this

21 activity or this practice, what you call leveraging

22 costs at an advantageous fashion -- is this illegal?

23 A. The Plan and -- no. It's not illegal.

24 Q. Is it prohibited by the Plan?

25 A. It doesn't prohibit it.

1 Q. And the Plan is revised every year, isn't
2 it?

3 A. That's correct. In fact, we're trying to
4 stop this.

5 Q. All right. So that's something you're
6 working on now?

7 A. Uh-huh.

8 Q. And has this kind of activity, this
9 leveraging their cost to an advantageous fashion, has --
10 is this something that's new that's only occurred
11 recently, or is this something that's been going for a
12 while?

13 A. It's probably -- I want -- well, what's a
14 while?

15 Q. Well, how long --

16 A. I'll say --

17 Q. How long has it been going on to your
18 knowledge?

19 A. I'll say it's more of an issue with the
20 larger chains, I guess.

21 Q. And how many years have you been aware of
22 this kind of activity?

23 A. About five or six.

24 Q. Okay. Now, with respect to Countrywood, in
25 paragraph 5, you give an example -- by way of example,

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1 the cost of furniture and equipment reported by
2 Countrywood, and it goes on. I won't go through the
3 numbers --

4 A. Sure.

5 Q. -- but you give that example,

6 That furniture and equipment, do you have
7 any knowledge -- any evidence that that furniture and
8 equipment wasn't necessary or wasn't needed by
9 Countrywood?

10 A. No, sir. Again, it's -- the issue is how
11 you plan to make these purchases and when you decide to
12 make these purchases --

13 Q. Okay.

14 A. -- when it takes money from the Medicaid
15 Program to be used for other areas.

16 Q. Okay. Give me just a minute, please, sir.

17 A. And you'd be surprised. I'm surprised the
18 other providers in the organization aren't upset with
19 this as well and allows this stuff to go on.

20 Q. To revise the State Health Plan, I mean,
21 you do that, I think you said, on an annual basis, and
22 that's your office, and your department is --

23 A. Yes.

24 Q. -- in charge of doing that.

25 Is that a -- I'm not familiar with that

1 process. I mean, does that have to go through -- is
2 there any sort of statutory process that that goes
3 through, or is that --

4 A. What happens, actually, we're -- we all
5 have to file legislation downtown -- let the legislature
6 get involved. And what we do is provide -- propose in a
7 filing of public notice -- that will outline our changes,
8 and the methodology, and it gives a 30-day comment
9 period. And --

10 Q. And the 30-day comment period, is that --
11 can anyone comment on it?

12 A. Sure.

13 Q. Okay.

14 A. Sure. And what happens is, again, we take
15 those comments and considerations, and that's a federal
16 requirement for us to have a 30-day comment period. In
17 fact, our agency director, he uses that same process,
18 you know, for even noninstitutional changes in
19 reimbursement. So he's employed to what we do for
20 institutions to every Medicaid Program when we make a
21 change in reimbursement.

22 Q. And that process has to be completed,
23 obviously, by October 1st every year, correct?

24 A. Correct.

25 Q. And so --

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1 A. Prior to the effective date of the change,
2 yep.

3 Q. I'm sorry? Say that again.

4 A. It's prior to the effective date of the
5 change. I mean, you can change a Plan anytime during
6 the year, but you've still got to go through
7 the agency --

8 Q. Right.

9 A. -- that process.

10 Q. Do you -- normally when you do you start
11 that process of making revisions for the Plan? When do
12 you --

13 A. I mean, we -- you know, the -- because the
14 budget provides those, if we get additional funding for
15 rates, we're supposed to submit the SPAs to CMS, but the
16 State -- I'm sorry. The SPA is the State Plan
17 Amendment, is what it is.

18 Q. Wait. When you SPA, what are you -- how do
19 you spell that?

20 A. S -- well --

21 Q. What's the acronym?

22 A. SPA.

23 Q. SPA.

24 A. Yeah.

25 Q. And that stands for State Plan Amendment?

1 A. State Plan Amendment, right.

2 Q. Okay.

3 A. Every time we make a State Plan change, we
4 have to submit the amendment to CMS. They have to
5 approve it and stuff but...

6 Q. How long does that take?

7 A. They have a 90-day window to approve it, or
8 either they'll say take it off the clock with the
9 request for additional information. They can go in
10 there and say, Okay, I don't understand this, or, I need
11 more information on this. So then it takes it off of
12 their clock, so to speak.

13 We respond back for the RAI in response,
14 and that --

15 Q. What's the RAI?

16 A. I'm sorry. Request for additional
17 information.

18 Q. Okay.

19 A. And then what they'll do is, they'll put it
20 back online at that clock. It doesn't start back at
21 like the 60th day, and the --

22 Q. It starts back at day one?

23 A. It starts back at day one, but normally --
24 I mean, we've had some issues with CMS lately. They've
25 incurred a large staff turnover, it seemed like, because

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1 I don't -- everybody I talk to anymore, I don't even
2 know, and they're taking longer to get plans approved.
3 So...

4 Q. Well, it sounds like a --

5 A. But there is a process the State does. I
6 mean, we do seek -- we do seek comments on our changes,
7 you know.

8 And, again, there's nothing to say that the
9 associations that represent the industry can't at any
10 time, you know, come to the agency director saying, you
11 know, We need to talk about this other and another.

12 Q. Sure.

13 And the process of change with respect to
14 this particular division that you're talking about in
15 paragraph 5 of your affidavit, you said you were in the
16 process or you were working on making some changes to
17 the State Health Plan --

18 A. Right. I mean, we've got different
19 options. We were hoping that -- I mean, personally, I
20 was hoping that the association was going to -- I mean,
21 we don't have anything officially yet from them. I know
22 they were at their meeting the other day, their
23 convention, I think. So we didn't hear back from them
24 yet, but we're --

25 Q. So when did you -- when did this -- when

1 did you actually start, you and your staff, actively
2 working on these revisions that address this issue in
3 the State Plan? Would that be something you would have
4 been working on for the last several weeks or months or
5 what?

6 A. It would have been when the proposed
7 program notice was printed. It was probably a week or
8 two, even though we've had discussions offline about it
9 with representatives of the association.

10 Q. But when would that have been, when you
11 said it went public?

12 A. Well, let's see. We just, I think the
13 comment period ended at the end of July. So it would
14 have been the end of June.

15 Q. So you started at the end of June --

16 A. Uh-huh.

17 Q. -- and you've got to get -- whatever
18 changes are going to be done, you've got to get before
19 October 1st, right?

20 A. Right. But, you know, again, we've got to
21 submit the SPA by August 15th, so we've got to --

22 Q. You've got what on August 15th?

23 A. We've got to submit the State Plan
24 Amendment by August 15th.

25 Q. Okay. So you've got to get it done by

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1 August 15th for

2 A. Right.

3 Q. And you're saying you started in -- the end
4 of June.

5 A. That's correct.

6 Q. Okay. All right.

7 Thanks. Bear with me just a minute.

8 A. Okay.

9 Q. All right. Let's look at HHS's memorandum
10 that was filed with the Court. I know you didn't draft
11 this, but I'm going to make the assumption, and you tell
12 me if I'm wrong, that this was -- that you've seen and
13 read this before.

14 This will be Exhibit 7, I guess. I just
15 have one or two questions about this.

16 (Petitioner's Exhibit Number 7,
17 Respondent's Memorandum and Opposition to Petitioner's
18 Motion for Partial Summary Judgment, November 8, 2012,
19 was marked for identification.)

20 BY MR. WESTBROOK:

21 Q. All right. This will be Exhibit 7.

22 And what this says is --

23 MR. NICKELS: It seems to be particularly
24 well-written.

25 MR. WESTBROOK: I was noticing that the

1 language --

2 THE WITNESS: I didn't touch -- I didn't
3 write this.

4 MR. WESTBROOK: The style is beautifully
5 written, yes.

6 Q. Respondent's Memorandum and Opposition to
7 Petitioner's Motion for Partial Summary Judgment.

8 Try to get past the dazzling language, and
9 get down to the substance there, and I'm going to ask
10 you to look at a sentence on page 4:

11 A. Okay.

12 Q. And the second paragraph on page 4, the
13 third sentence says -- I'll just read it slowly into the
14 record -- six-month reports set the rates for extended
15 periods of time, here 11/29/07 through 9/30/09.

16 Now, we've already talked about extended
17 periods of time, and I understand your position on that.

18 And so for this case, in Countrywood, is it
19 your position, then, that the six-month cost report set
20 the rate, a rate period of 11/29/07 through 9/30/09?

21 A. Yes, sir.

22 Q. Okay. Now -- so the rate was initially set
23 on 11/29/07, and I think that rate would have stayed the
24 same, based on what you told me earlier, until June 1st
25 of '08 when inflation was added; is that right?

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1 A. Yep. I had to count. I was using my
2 fingers.

3 Q. That's right. Now I know how State
4 auditors work.

5 So it would -- inflation would have been
6 added on June 1st --

7 A. That's right.

8 Q. Is that right?

9 A. And then every October and after, they
10 would have received updates based upon the changes that
11 we talked about.

12 Q. Based upon the changes you talked about
13 with the Plan.

14 A. Yes, sir.

15 Q. Okay. All right.

16 Okay. Actually, I think that's the only
17 question I'm going to ask you about that. I just wanted
18 to make sure those dates were right.

19 This will be Exhibit 8.

20 (Petitioner's Exhibit Number 8,
21 December 16, 2011 Letter to Joseph Hunt from Debra
22 Myers, was marked for identification.)

23 BY MR. WESTBROOK:

24 Q. What I've just handed you as Exhibit 8,
25 Mr. Saxon, is a letter dated December 16th, 2011, to

1 Countrywood from Deborah Myers at HHS; is that right?

2 A. That's correct.

3 Q. All right. And you mentioned Ms. Myers

4 earlier. At the time she wrote this letter, her

5 position, it looks like, was director of division of

6 long-term care reimbursements; is that right?

7 A. That's correct.

8 Q. Is that her current position?

9 A. No, sir.

10 Q. What's her current position?

11 A. She's a program manager. Basically,

12 she's -- she's basically almost like my right-hand

13 person, so to speak.

14 Q. Okay.

15 A. I've got -- she helps me with SPAs and all

16 these other special projects I've got her working on.

17 Q. All right. Does she report directly to
18 you?

19 A. Yes.

20 Q. And --

21 A. And even under this (indicating), yes. At
22 this time she did, and currently, she does.

23 Q. At that time she did?

24 A. Yeah.

25 Q. Okay. And she currently does?

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1 A. Yep.

2 Q. And cc'd to this letter are -- the SAO is
3 cc'd.

4 Who is Mr. Tree Nielson? Do you see that
5 cc down there?

6 A. You know, I don't know who that is.

7 Q. Okay. Well, I don't either. So --

8 A. I know Lynette Wilson works at the agency
9 in regards to the receivables.

10 Q. She works at HHS?

11 A. Yes, sir.

12 Q. Okay. All right.

13 But you don't know who Mr. Nielson is?

14 A. I don't know him off the top of my head,
15 who I think he is. Sounds like a basketball player.

16 Q. That's right. I remember Tree Rollins used
17 to play for --

18 A. Uh-huh.

19 Q. -- Atlanta.

20 Over on the first page of this letter, it
21 says -- I'm going to read it into the record -- based on
22 the recommendations of the Office of State Auditor and
23 their audit reports -- and it gives the numbers there --
24 the Department of Health and Human Services is
25 establishing an accounts receivable for \$546,968, in

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1 order to finalize your facility's -- and it lists three
2 cost reports there, correct?

3 A. Well -- yes, it does.

4 Q. See that?

5 November 29th --

6 A. Yeah, I've got it. Yeah.

7 Q. Okay.

8 A. I was thinking it was rate period; and it's
9 cost report. So...

10 Q. It says, November 29th, 2007, through
11 May 31st, 2008; November 29th through September 30th,
12 2008; and October 1st, 2008, through September 30th,
13 2009 cost reports.

14 And it goes on to say, These cost reports
15 were used to determine your facility's Medicaid
16 reimbursement rate for the following contract periods,
17 right?

18 A. Yes, sir.

19 Q. And you recall that the definition of
20 contract period is for -- that we looked at earlier for
21 purposes of Section V, F -- do you remember that -- was
22 denied as rate -- it's the same as rate period, as
23 defined by the Plan?

24 A. Yes, sir.

25 Q. Okay. And then it's got two columns there.

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1 The first column is headed rate period; and then the
2 second one is headed audited rate, correct?

3 A. Correct. That's correct.

4 Q. And it's got six different rate periods
5 listed there, right?

6 A. That, it does.

7 Q. And this first one is from 11/29/07 to
8 5/31/08, and it has an audited rate of \$129.21, right?

9 A. Yes, sir.

10 Q. And the second rate period is listed 6/1/08
11 through 9/30/08 with an audited rate of \$134.74; is that
12 right?

13 A. Yes, sir.

14 Q. And the third one is 10/01/08 through to
15 9/30/09 with an audited rate of \$135.11, right?

16 A. Yes, sir.

17 Q. Now, these are identified as three separate
18 rate periods on this letter, are they not?

19 A. That's how they were presented, yes sir.

20 Q. Okay. And with three different audited
21 rates, correct?

22 A. Yes, sir.

23 Q. Is there anything on here that indicates
24 that is those three periods should be combined into one
25 extended rate period?

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1 A. There's only one cost report that set the
2 rate for all of those, and it's the first one that's
3 listed, in that first paragraph.

4 Q. Okay. I understand that; but it doesn't
5 say -- but they're presented by Ms. Myers as three
6 separate rate periods, aren't they?

7 A. They're presented that way based upon what
8 I just explained.

9 Q. Okay.

10 A. With the changes in the inflation the
11 seventh month and then the new updated standards and
12 stuff. I mean, if its provider would have been happy
13 and not been willing to take the increases with it, we
14 would have been happy for them to give it back to us.

15 Q. Sure.

16 So from 11 -- and, again, I think -- if
17 I've already asked you this, I apologize. I know I've
18 asked you something similar to this, but from 11/29/07
19 through 5/31/08, that audited rate, that figure that's
20 listed there, \$129.21 -- and it didn't change during
21 that period, did it? From 11/29/07 through 5/31/08,
22 that did not change?

23 A. That's right. That's correct.

24 Q. And then inflation was added on June 1st.

25 A. Yes, sir.

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1 Q. And through 9/30, that rate was -- once you
2 added inflation, it was \$134.74, and that didn't change
3 until October 1st, right?

4 A. That's correct.

5 Q. And then it changed on October 1st because
6 the plan changed with -- in all the ways that you talked
7 about earlier?

8 A. All those things, yes, sir.

9 Q. Okay. Okay.

10 Bear with me, please, sir.

11 (Off the record.)

12 MR. WESTBROOK: Let me ask you -- or let me
13 ask the court reporter to mark this as Exhibit 9.

14 (Petitioner's Exhibit Number 9, April 3,
15 2009 Letter to Lawrence A. Haynes from Debra Myers, was
16 marked for identification.)

17 BY MR. WESTBROOK:

18 Q. Okay. What I have just handed you is a --
19 it looks like a cover letter.

20 A. Well, there's Tree Nielson. If you want to
21 know where he works, Sterling Healthcare.

22 Q. How about that. I didn't even notice that.
23 Do you know what Sterling Healthcare is?

24 A. I don't, to be honest with you. I guess
25 maybe they're a management firm. I don't know.

1 Q. Okay. All right.

2 This is a letter dated April 3th, 2009,
3 from HHS to Countrywood, right?

4 A. Yes, sir.

5 Q. And, again, it's signed by Debra Myers
6 right?

7 A. Yes, sir.

8 Q. And it's just a cover letter, and it says
9 enclosed are copies of various things, and it says in
10 the first sentence, For the rate period November 29th,
11 2007, through May 31st, 2008, right?

12 A. Yes, sir.

13 Q. And that is consistent with the letter we
14 looked at a moment ago in Exhibit 8, also from
15 Ms. Myers; that identified the first period is -- first
16 rate period is 11/29/07 to 5/31/08; is it not?

17 A. Yes, sir.

18 Q. Okay.

19 MR. WESTBROOK: Okay. Let's make this
20 Exhibit 10, please.

21 (Petitioner's Exhibit Number 10, April 1,
22 2009 SCDHHS - Division of LTC Reimbursement, Cost of
23 Capital Analysis, 11/29/07 to 5/31/08, 2:26 p.m. and
24 1:40 p.m., was marked for identification.)

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1 BY MR. WESTBROOK:

2 Q. And what I've just given you is Exhibit 10.
3 It says at the top -- it says -- references at the top,
4 a desk audit version.

5 What is -- tell me -- this is, I guess, an
6 obvious question, but for a layman like myself, tell me,
7 what's the difference between a desk audit and an
8 on-site audit?

9 A. Well, a desk audit, all we do is review --
10 we review the information on as far as the provider's
11 cost report and subject to allowable cost definitions
12 that are in effect when the report is -- or when the
13 rate is going to be set off of this report. We don't
14 look at invoices. We don't go over the payrolls and
15 stuff like that.

16 Q. Okay.

17 A. So the auditors will actually go out and do
18 an on-site and look at the supporting documentation to
19 support -- to ensure that expenditures claim on
20 allowable Medicaid reimbursement purposes.

21 So our review is very limited.

22 Q. It's a more limited review than an on-site?

23 A. Yes, it is.

24 Q. And it would precede and on-site review,
25 right?

- 1 A. It should.
- 2 Q. Does it ---
- 3 A. It normally does. I mean...
- 4 Q. Exactly. Does it normally --
- 5 A. Yes, sir,
- 6 Q. -- do that?
- 7 A. Yes, sir.
- 8 Q. Okay. And, again, here, if you'll look at
- 9 the top of this page, page 1, it identifies a rate
- 10 period of 11/29/07 through 5/31/08, correct?
- 11 A. That's correct.
- 12 Q. And that's consistent with the last two
- 13 exhibits we've looked at --
- 14 A. That's correct.
- 15 Q. Right?
- 16 A. And, again, you would have this or the
- 17 other ones we talked about too -- you know, from 6/1 to
- 18 9/30.
- 19 Q. Right.
- 20 But it doesn't -- on this, it -- I mean,
- 21 again, it doesn't indicate that this is part of a larger
- 22 extended rate period, does it? It doesn't give you any
- 23 indication to that effect, does it?
- 24 A. What it's saying is that this cost report
- 25 set the rate -- this is a rate for this rate period off

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1 of this cost report. There's going to be another rate
2 sheet just like this that says the same cost report, but
3 this is the rate for that particular cost report.

4 Q. So this is the rate -- okay.

5 But it -- the period that this rate is
6 effective, according to this, is from 11/29/07 through
7 5/31/08, correct?

8 A. That's correct.

9 MR. WESTBROOK: Okay. Let's look at the
10 next -- this will be Exhibit 11; I guess.

11 (Petitioner's Exhibit Number 11, April 1,
12 2009 SCDHHS - Division of LTC Reimbursement, Cost of
13 Capital Analysis, 6/01/08 through 9/30/08, 2:24 p.m. and
14 1:41 p.m., was marked for identification.)

15 BY MR. WESTBROOK:

16 Q. And this would be, I guess, this sort of
17 the --

18 A. Yeah.

19 Q. -- follow-up that you were just talking
20 about.

21 A. Yes, sir.

22 Q. And this identifies -- again, this is part
23 of a desk audit that identifies a second identified rate
24 period of 6/01/08 through 9/30/08, correct?

25 A. That's correct.

1 Q. And after 9/31 -- excuse me. After the
2 9/30/08, it says seven month actual, correct?

3 A. That's correct.

4 Q. And that -- I guess that refers back to the
5 section of the Plan that we were reading, that on the
6 first day of the seventh month --

7 A. Yes. You get a --

8 Q. -- a new rate --

9 A. Right.

10 Q. -- comes because inflation comes in, right?

11 A. Yes, sir.

12 Q. Okay. And, again, there's nothing on here
13 on this document that says this is the same rate period
14 as the -- or part of the same rate period as the
15 previous document we looked at, is there?

16 A. Because, again, the rate would be
17 different.

18 Q. Right.

19 A. You can't -- it can't overlap because --

20 Q. I understand. I understand.

21 So the rate has to be different because of
22 that inflation factor, right?

23 A. Right.

24 Q. Okay.

25 A. But the cost report period is the same no

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1 matter what.

2 Q. So the cost report period would be the
3 same.

4 Right. I got you.

5 And this -- this is 11 or 12?

6 THE COURT REPORTER: Twelve.

7 MR. WESTBROOK: This will be Exhibit 12,
8 please.

9 (Petitioner's Exhibit Number 12, April 1,
10 2009 SCDHHS - Division of LTC Reimbursement, Cost of
11 Capital Analysis, 10/01/08 through 9/30/09, 2:05 p.m.
12 and 2:50 p.m., was marked for identification.)

13 BY MR. WESTBROOK:

14 Q. And, again, this would be -- and Mr. Saxon,
15 as you can imagine, this is the third of these.

16 A. Yeah. The October one, yeah.

17 Q. I knew you could figure -- knew where I was
18 going on this.

19 And, again, this shows a rate period of
20 10/01/08 through 9/30/09, again, reflecting that new
21 rate that came into being when the Plan was changed on
22 -- effective of 10/01/08, correct?

23 A. That's correct; but at the end of the day,
24 the common denominator there in all of this is the cost
25 reporting period.

1 Q. Okay.

2 A. That set the rate from 11/09 -- 29/07 to
3 September 30th, 2009.

4 Q. Okay. Even though the actual rates --

5 A. The rates were different because the
6 methodology -- you know, and, again, like I said, if the
7 provider didn't want them, we could have paid --

8 Q. All right.

9 A. -- at a lesser rate --

10 Q. And one -- once more, I know I asked you
11 this question, and I apologize, but I just want to make
12 sure that I understand your answer.

13 A. Okay.

14 Q. A rate period, that precise term, is not
15 defined anywhere in the Plan with a precise definition;
16 is that correct? There's no place you can turn where
17 like it's a page --

18 A. There's not a definition that says what a
19 rate period is.

20 Q. -- that specifically says a rate period is
21 this or means this. That doesn't say that in the Plan
22 anywhere, does it?

23 A. I -- let me see. What does that reference
24 in the State Plan say? Does that say rate cycle or rate
25 period?

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1 Q. Let's take a look.

2 A. I'm just trying to make sure before...

3 Q. Sure.

4 A. Is that -- that was on page 20, I think.

5 It says rate cycle.

6 MR. WESTBROOK: All right. I'm going to
7 take -- if it's okay, Al, I'd like another five-minute
8 break, and then I'll --

9 MR. NICKELS: Sure.

10 MR. WESTBROOK: I'll be done, essentially.

11 MR. NICKELS: Sure. All right.

12 MR. WESTBROOK: Just a couple of wrap-up
13 questions, and I'll be done.

14 MR. NICKELS: That'll work.

15 (A recess transpired.)

16 BY MR. WESTBROOK:

17 Q. I just -- Mr. Saxon, I appreciate -- I want
18 to tell you I appreciate your time this morning. We
19 spent a couple of hours going over your opinions in this
20 case.

21 Are there any other major opinions,
22 significant opinions that you have that we have -- that
23 you have not had a chance to discuss that I have not
24 asked you about related to this appeal?

25 A. Not that I can think of at this time.

1 MR. WESTBROOK: All right. Good.

2 Well, thank you very much. I don't have
3 any other questions;

4 EXAMINATION

5 BY MR. NICKELS:

6 Q. Mr. Saxon, I have a few other questions for
7 you.

8 If you could look at Exhibit Number 3
9 that's in front of you --

10 A. (Complying.)

11 Q. -- I believe you examined that for counsel
12 for the petitioners on this particular affidavit,

13 A. Yes.

14 Q. You indicated that you had a familiarity
15 with the affidavit, correct?

16 A. That's correct.

17 Q. There are some attachments identified that
18 are incorporated in your affidavit.

19 Do you see those?

20 A. Yes, I do.

21 Q. And at the time that you prepared this
22 affidavit, did you have those attachments available to
23 you for reference?

24 A. Yes, I did.

25 Q. Okay. Mr. Westbrook wrote -- asked you

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1 some questions about your opinions relating to this
2 affidavit.

3 Have you in any way changed your opinions
4 as expressed in this affidavit based upon the
5 attachments identified?

6 A. No.

7 Q. Okay. There is, in paragraph 5 of this
8 affidavit, an example provided that Mr. Westbrook asked
9 you some questions about having to do with furniture
10 costs and equipment reported by this particular
11 facility.

12 Do you see that?

13 A. Yes, I do.

14 Q. What, if any, is the responsibility of a
15 nursing center to document its cost for reimbursement?

16 A. What's the responsibility of the --

17 Q. Yes.

18 A. -- nursing home?

19 I mean, again, they're supposed to have all
20 the financial-supporting documents to show that the
21 purchase was actually made, that it's used for patient
22 care, and it meets all allowable cost definitions; and
23 if it's -- you know, if it's capitalized, it has to be,
24 you know, depreciated, and if it's not capitalized, is
25 the expense the proper cost to them?

1 Q. Sure.

2 And with regard to purchases through
3 related entities or parties, are there any rules that
4 apply in those particular circumstances?

5 A. Yes. They're supposed to record those at
6 cost.

7 Q. Okay. Now, let me ask you, on Exhibit
8 Number 2 that was provided to you --

9 A. I had them all lying out here, I've got
10 them all out of the way now.

11 Q. Take your time.

12 I believe that's it (indicating).

13 A. There it is.

14 Q. Exhibit Number 2 is an e-mail to Terry
15 Schmoyer from Larry Warrington back in July of 2011; is
16 that correct?

17 A. That's correct.

18 Q. Now, counting back six years from
19 July 10th, 2011, would that take us back to July 15th of
20 2005?

21 A. Yes.

22 Q. Okay. And looking at what is --
23 Mr. Schmoyer's being advised here. What -- there is a
24 period of 10/01/08 to 9/30/09.

25 Do you see that?

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1 A. Yes.

2 Q. It's number 3.

3 But number 2 and number 1 both begin at
4 11/29/07, do they not?

5 A. They do.

6 Q. So would the same costs be incurred in
7 11/29/07 to 5/31/08 as those included in 11/29/07 and
8 9/30/08?

9 A. Those same six months would show up in
10 both.

11 Q. All right, sir. If it were discovered in
12 examining the reported costs for the period 11/29/07 to
13 9/30/08 that there were some undocumented-related party
14 purchases, would that be an irregularity that would
15 prompt further review?

16 A. Yes, it would.

17 Q. Okay. In your judgment, would that warrant
18 examination of costs that even preceded that period of
19 time?

20 A. Yes, because that's a prime -- I mean,
21 that's an important reg to meet.

22 Q. I apologize. I didn't --

23 A. That's --

24 Q. -- quite understand what you said.

25 A. That was an important regulation to meet.

1 Q. Before that, did you say a crime?

2 A. No.

3 MR. WESTBROOK: A prime.

4 MR. NICKELS: Oh, a prime.

5 MR. WESTBROOK: P-r-i-m-e.

6 MR. NICKELS: Okay. Thanks.

7 Q. All right. You had indicated, I believe in
8 your testimony earlier, that to the best of your
9 knowledge, it is routine to review initial cost reports
10 when there is a change of ownership; isn't that correct?

11 A. Yes, that's correct.

12 Q. And is there a reason why it is routine to
13 examine those change of ownership initial cost reports?

14 A. Yes. We try on the front end to make sure
15 that what's being reported is allowable for Medicaid
16 reimbursement purposes.

17 Q. Okay. Now, you made reference to, in your
18 affidavit -- identifying certainly provisions of the,
19 you know, South Carolina State Plan under Title XIX.

20 Is it your experience, Mr. Saxon, that most
21 of the providers of Medicaid services are familiar with
22 that plan?

23 A. Yes, they are.

24 Q. In this instance, did any representative of
25 Countrywood express to you a confusion about its

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1 understanding of the State Plan or to reimbursement of
2 its cost?

3 A. No.

4 Q. You also mentioned that there are, from
5 time to time, discussions between members of the Nursing
6 Home Association and your office; is that correct?

7 A. That's correct.

8 Q. Now, unless those discussions are resulting
9 a change of State Plan or something of that nature, are
10 they binding upon the State?

11 A. No, no.

12 Q. Do you have individualized authority by --

13 A. No, no, no.

14 Q. -- the State of South Carolina?

15 A. No, I don't. Some people think I do
16 sometimes, but I don't.

17 Q. All right. Let me ask you to turn to
18 Exhibit Number 4, if you would.

19 A. (Complying.)

20 Q. And you were asked questions of page 9 of
21 the exhibit, Subsection G1 and G2 on Maintenance and
22 Inspection?

23 A. Uh-huh. Yes.

24 Q. And part of the language brought to your
25 attention is in the middle of the -- Section 1:

1 It says, If any litigation, claim, or other
2 action involving the records has been initiated prior to
3 the expiration of the six-year period.

4 Do you see that?

5 A. Yes.

6 Q. Is an engagement an action involving the
7 records?

8 A. Yes.

9 Q. All right. And would that also be
10 applicable to the inspection provisions below in
11 Section 2?

12 Would an engagement be an other action
13 involving the records?

14 A. Yes.

15 Q. Now, you've indicated that your office is
16 not involved in the actual audit or agreed-upon
17 procedures with the individuals from the Office of the
18 State Auditor, go on-site and review records; is that
19 correct?

20 A. That's correct.

21 Q. Okay. Are you aware that from time to time
22 during that process, nursing facilities do request an
23 opportunity to present additional documentation?

24 A. That's correct.

25 Q. Okay. And if that documentation is

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1 accepted beyond the cost reporting period, would that be
2 something that would be favorable to the provider?

3 A. Yes. I mean, gosh, in this case, if it had
4 been -- if the shoe would have been on the other foot
5 and we owed money back to the provider for that year, we
6 wouldn't even be talking about this.

7 Q. Now, let me ask you, in terms of Exhibit
8 Number 1, which is the contract between the HHS and the
9 Auditor's Office, you were asked a series questions
10 about this particular contract; is that correct?

11 A. Yes.

12 Q. All right. And it says among the things
13 are SAO, which are the State Auditor's Office,
14 responsibilities, if you look at page 3 of this
15 document.

16 A. (Complying.)

17 Q. It begins a list, and there's a number 3.
18 Do you see that?

19 A. Yes.

20 Q. Okay. Conducting all engagements to
21 determine if the reimbursement rates or the amounts is
22 in accordance with the provisions of the provider
23 contracts.

24 You've answered, yes, that's true; but
25 also, the State Plan, state and federal regulations.

1 Do you see that?

2 A. Yes.

3 Q. All right. On the next page, page 14, you
4 were asked questions about the SAO will perform
5 agreed-upon procedures involving two cost report
6 periods.

7 Do you see that?

8 A. Yes.

9 Q. Does that language say the SAO is limited
10 to performing agreed-upon procedures?

11 A. No.

12 Q. And I apologize for sending you back and
13 forward, but I would like you to look, if you would, at
14 the contract between the HHS and this facility. I
15 believe it's Exhibit Number 4.

16 A. Okay.

17 Q. If you'll look at page 16 of this document,
18 please --

19 A. Okay.

20 Q. -- and it has provisions about Integration,
21 Governing Law, and Conflict of Law.

22 Do you see all those provisions there?

23 A. Yes, I did do.

24 Q. And with regard to this particular
25 agreement, it says, In the event of a conflict in the

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1 requirements of a SCDHHS Policy and State Plan, State
2 Plan shall apply, correct?

3 MR. WESTBROOK: I'm sorry. I have to
4 interrupt.

5 THE WITNESS: I'm trying to -- yeah.

6 MR. WESTBROOK: Can you -- where are you
7 reading from, Al?

8 MR. NICKELS: Conflict of Laws, the end.

9 THE WITNESS: Oh, okay, the end. Okay.

10 MR. WESTBROOK: Okay.

11 THE WITNESS: Yeah, because I was lost too.

12 BY MR. NICKELS:

13 Q. Okay. It goes through a sequence.

14 A. Yeah, it does, right.

15 Q. Conflicts between requirements of Title
16 XVIII and XIX, Title XIX apply, correct?

17 A. Correct.

18 Q. Conflict in the requirements of contract to
19 and Title XVIII, principles and policies, provisions of
20 the contract apply --

21 A. Yes.

22 Q. Correct?

23 And then DHHS Policy and State Plan, State
24 Plan apply, correct?

25 A. Correct.

1 Q. Okay. And that's a part of this agreement,
2 correct?

3 A. Yes, it is.

4 Q. Okay. And governing law of the State of
5 South Carolina is to be applied to the interpretation
6 and the performance of this contract; is that correct?

7 A. Yes.

8 Q. And that's Section M.

9 Now, it doesn't say just interpretation,
10 does it? It says performance, correct?

11 A. Yes.

12 Q. All right. And is the State Plan a part of
13 the State of South Carolina law?

14 MR. WESTBROOK: Objection, leading.

15 BY MR. NICKELS:

16 Q. Okay. Do you know whether the State Plan
17 is subject to approval by the General Assembly?

18 A. It's not approved by the General Assembly
19 but by CMS.

20 Q. Okay. And what's CMS?

21 A. The Centers for Medicare & Medicaid
22 Services.

23 Q. And that's --

24 A. It's a Federal Medicaid agency.

25 Q. And is DHSS a single State agency

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1 designated by the General Assembly to administer this
2 federal program?

3 A. Yes.

4 Q. Okay. You were asked some questions, I
5 believe, about the State Plan and whether or not a
6 particular term had a designated definition in the Plan.

7 Do you remember that line of questioning?

8 A. Yes.

9 Q. Okay. Looking through this document that's
10 provided as Exhibit Number 6, it says on page 12,
11 attachment 4.19-D -- page 12 --

12 A. Yeah. I'm there.

13 Q. Under Auditing, page -- II, E --

14 A. Yep.

15 Q. -- what does it say about cost reports
16 being subject to audit for desk review?

17 A. It says, All costs reports will be desk
18 reviewed by the Medicaid agency.

19 Q. Does it say anything about any limitation
20 on those being subject to desk review?

21 A. No.

22 Q. What about in F, as to on-site audit? What
23 does it say in regards to cost reports there?

24 A. It says, All cost reports are subject to
25 on-site audit.

1 Q. Any limitation on the number of cost
2 reports there?

3 A. No.

4 Q. Let me ask you some questions about Exhibit
5 Number 8 provided to you. And this is a letter from
6 Ms. Myers to Mr. Hunt, December 16th, 2011.

7 A. There it is.

8 Q. Okay. Now, Mr. Westbrook asked you
9 questions, and, obviously, this document identifies
10 periods by audited rate.

11 Do you see that?

12 A. Yes.

13 Q. Okay. For these periods of time, it says
14 that certain cost reports were reviewed.

15 A. Yes, it does.

16 Q. Okay. Now, in this particular situation,
17 tell me, if you know, whether the initial cost report
18 was setting the rate for more than one period of time.

19 A. Yeah, I knew.

20 Q. Okay. And what is it?

21 A. What rate periods?

22 Q. Yes, sir.

23 A. 11/29/07 through 5/31/08, 6/30/08 through
24 9/30/08, and 10/01/08 to 9/30/09.

25 Q. Okay. So there didn't have to be a

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1 separate cost report prepared by the facility to
2 establish the rates effective therein --

3 MR. WESTBROOK: Object to the form.

4 BY MR. NICKELS:

5 Q. Is that --

6 MR. WESTBROOK: Object to the form.

7 BY MR. NICKELS:

8 Q. Okay.

9 A. No, there wasn't.

10 Q. Was a separate cost report needed to be
11 prepared by a facility to provide information to set
12 those rates?

13 A. No.

14 Q. All right. And let me just ask you to take
15 a look real quickly, if you would, for me at
16 Exhibits 10, 11, and 12. They were handed to you at the
17 end of your questioning by Mr. Westbrook.

18 Here they are.

19 A. {Complying.}

20 Q. Now, this has to do with the desk review;
21 is that correct?

22 A. That's correct.

23 Q. And it identifies who the provider is,
24 Countrywood Nursing Center, LLC; is that correct?

25 A. That's correct.

1 Q. The same -- well, let me ask you this
2 question. I think you may have answered it.

3 The reporting period is identified on each
4 one of these documents.

5 What is that?

6 A. 11/29/07 through 5/31/08.

7 Q. Okay. And just looking at Number 12, if
8 you have that in front of you --

9 A. Yes.

10 Q. -- it has effective date on it 10/01/08.

11 Do you see that?

12 A. Yes.

13 Q. What is the time stamp when this was issued
14 at the very top right-hand corner of the page?

15 A. April 1st of 2009.

16 Q. And what time of day?

17 A. Oh, at 2:05 p.m.

18 Q. Okay. Look at the -- at Number 11, which
19 is for 6/1/08, which would have been, I guess, an
20 earlier period.

21 A. That's correct.

22 Q. What was the time and date that that was
23 issued?

24 A. April 1st, 2009, at 2:24 p.m.

25 Q. Okay. After Number 12?

Jeffery Saxon 8/8/2014

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1 A. Yes.

2 Q. And Number 10, from the earliest date
3 11/29/07, when was that issued?

4 A. 4/1/2009 at 2:26 p.m.

5 Q. That was later still, but they were all
6 within 21 minutes of each other.

7 A. Yes.

8 Q. Based upon your experience, are all these
9 exhibits, 10, 11, and 12 -- they are connect to and
10 arriving from the same information?

11 A. Yes.

12 Q. Now, you were asked questions about the way
13 that audits are performed and reimbursements are
14 requested.

15 Do you have any reason to believe that
16 Countrywood Nursing Center was treated any differently
17 than other facilities who have had their costs reviewed
18 and request for reimbursement presented?

19 A. No.

20 Q. Is there any reason to believe that
21 Countrywood was targeted in any way?

22 A. No.

23 Q. Do you have any reason to believe that any
24 procedures applied to Countrywood that were different
25 from procedures applied in any other instance?

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1 A. I'm not aware of anything.

2 MR. NICKELS: Give me just a minute, if you
3 would. Let's step out for a second.

4 We'll take a short break. We'll be right
5 back.

6 (A recess transpired.)

7 MR. NICKELS: Those are all the questions I
8 have at this time.

9 RE-EXAMINATION

10 BY MR. WESTBROOK:

11 Q. All right. Well, I've just got one or two
12 follow-up questions, Mr. Saxon, based on what
13 Mr. Nickels asked you.

14 If you'll turn to the facility contract,
15 and that is Exhibit 4.

16 A. Yes, 4.

17 Q. All right. Mr. Nickels asked you one
18 question, I believe, about that that I wanted to
19 follow-up on.

20 Over on page 9, please --

21 A. Okay.

22 Q. -- those -- in Subsection 1 and Subsection
23 2, there are sentences about litigation claim or other
24 action.

25 A. Uh-huh.

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1 Q. And do you remember Mr. Nickels asked you a
2 question about that, a question or two about that?

3 A. (Nodding head.)

4 Q. It says, If any litigation, claim, or other
5 action involving the records.

6 Is it your -- and he asked you about that,
7 and I believe he asked you if the term -- if the word
8 engagement or the term engagement was an other action;
9 do you recall that?

10 A. Yes, I do.

11 Q. Now, when I asked you earlier about the
12 term engagement, I believe you acknowledged that that
13 term is not defined in -- specifically in any of these
14 contracts; is that right?

15 A. Yes.

16 Q. And it's not defined in the State Health
17 Plan, is it?

18 A. I don't think it is.

19 Q. And I think you described it, but I don't
20 want to try to remember what you said.

21 Can you describe, again, what you think an
22 engagement is?

23 A. An engagement was -- to me, is when the
24 audit gets started.

25 Q. Okay.

1 A. That the audit itself is an engagement, a
2 project or whatever.

3 Q. It's not a lawsuit, is it?

4 A. No.

5 Q. No.

6 It's not a legal action is it, in the term
7 of a lawsuit?

8 A. No.

9 Q. Okay. All right.

10 The audits in this case -- there were three
11 audits done in this case, correct?

12 A. Yes.

13 Q. Were they started at different times or at
14 the same time; do you know?

15 A. I don't know.

16 MR. WESTBROOK: I don't have any other
17 questions. Thank you.

18 (The deposition concluded at approximately
19 11:32 a.m.)

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1 CERTIFICATE OF REPORTER

2 I, Nisha Gordon, Court Reporter and Notary
3 Public for the State of South Carolina at Large, do
4 hereby certify:

5 That the foregoing deposition was taken before
6 me on the date and at the time and location stated on
7 page 1 of this transcript; that the deponent was duly
8 sworn to testify to the truth, the whole truth, and
9 nothing but the truth; that the testimony of the
10 deponent and all objections made at the time of the
11 examination were recorded stenographically by me and
12 were thereafter transcribed; that the foregoing
13 deposition as typed is a true, accurate, and complete
14 record of the testimony of the deponent and of all
15 objections made at the time of the examination to the
16 best of my ability.

17 I further certify that I am neither related to
18 nor counsel for any party to the case pending or
19 interested in the events thereof.

20 Witness my hand, I have hereunto affixed my
21 official seal this 14th of August, 2014, at Greenville,
22 Greenville County, South Carolina.

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N. Gordon

Nisha Gordon
Notary Public
State of Carolina at Large
My Commission Expires:
June 14, 2022



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I N D E X

Page

EXAMINATION

BY MR. WESTBROOK

3

BY MR. NICKELS

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RE-EXAMINATION

BY MR. WESTBROOK

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Certificate of Reporter

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E X H I B I T S

Deponent's

1 Contract Between South Carolina
Department of Health and Human Services
and the South Carolina State Auditor's
Office for the Purchase and Provision of
Agree-Upon Procedure Activities Related
to Medicaid Institutional Providers,
Dated as of July 1, 2011

6

2 October 9th, 2012 E-mail from Larry
Warrington to Terry Schmoeyer

11

3 Jeff Saxon Affidavit, November 7,
2012

16

4 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, Dates as
of October 1, 2006

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7	AC# 3-RDM-J9 - Countrywood Nursing	
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1 STATE OF SOUTH CAROLINA

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

2
3 COUNTY OF RICHLAND

4

5 COUNTRYWOOD NURSING, LLC,

6 Petitioner,

7 vs.

Appeal Case Nos.
12-AUD-010,
12-AUD-011, and
12-AUD-012

9

10 SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

11 Respondent.

12 D E P O S I T I O N

13 WITNESS: TERRY KENNETH SCHMOYER, JR.

14 DATE: Friday, August 8, 2014

15 TIME: 11:36 p.m.

16 LOCATION: Nielson Mullins Riley & Scarborough LLP
17 Meridian
18 17th Floor
1320 Main Street
Columbia, South Carolina

19 TAKEN BY: Attorneys for the Respondent

20 REPORTED BY: NISHA GORDON
Court Reporter

21

22 -----
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1 (The deponent reserves the right to read
2 and sign the deposition transcript.)

3 TERRY KENNETH SCHMOYER, JR., being
4 first duly sworn, testified as follows:

5 EXAMINATION

6 BY MR. NICKELS:

7 Q. Mr. Schmoyer, good morning.

8 A. Good morning.

9 Q. My name is Al Nickels.

10 We've met on other occasions; is that
11 correct?

12 A. That's correct.

13 Q. Okay. For the purposes of this deposition,
14 I'm going to attempt to ask you questions that are
15 clear. I may occasionally fail to do that. If I do;
16 it's your responsibility to tell me that you do not
17 understand my question, and I'll be happy to attempt to
18 make it understandable.

19 So will you do that for me?

20 A. Yes.

21 Q. Are you aware of any condition or
22 circumstance this morning that would impair your ability
23 to hear, understand, or respond to my questions?

24 A. No.

25 Q. You indicated earlier, in response to

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1 A. South Carolina.

2 Q. Okay. At what point in time did you obtain
3 that?

4 A. I can't recall exactly. I would say 2003,
5 2002, something like that.

6 No. I'm sorry. That's not right. It
7 would be in 1992 or 1993, yeah.

8 Q. Okay. All right.

9 And have you been engaged as a certified
10 public accountant consistently since that period of
11 time?

12 A. Yes.

13 Q. Okay. Tell me what your relationship is
14 with the petitioner in this case, which is -- I guess
15 we're calling it Countrywood?

16 A. Countrywood is an accounting customer of
17 our firm.

18 Q. How long have they been a customer of your
19 firm?

20 A. Since 2007.

21 Q. And is that when they became involved in
22 the South Carolina Medicaid Program?

23 A. Yes.

24 Q. Okay. Did you provide accounting services
25 for the predecessor to Countrywood?

1 report. Then we evaluate related-party transactions.
2 We evaluate ancillary costs. We inquire of management
3 of anything that we need to be aware of that could
4 impact reimbursement that they may know of.

5 We then perform journal entries on the cost
6 reports, which can include allocating employee benefits,
7 adjusting fixed assets to the historical cost, things of
8 that nature, and then we run an estimated Medicaid rate
9 for the provider or the client.

10 Q. Do you present that to anyone other than
11 the client?

12 A. Do I present the cost report?

13 Q. Yes.

14 A. No?

15 Q. Okay. So is a cost report, at least
16 initially, for the exclusive information of your
17 customer?

18 A. Well, I mean we send it to the State of
19 South Carolina and to the customer.

20 Q. Okay. Do you send the same cost report to
21 both the customer and the State of South Carolina?

22 A. Yes, sir.

23 Q. And you were present during Mr. Saxon's
24 deposition earlier today.

25 A. I was.

1 to it.

2 Q. All right. And the dates of these happen
3 to be April 1st, 2009.

4 Does that sound about right to you as to
5 when you had --

6 A. Those aren't --

7 Q. -- received them?

8 A. That's not right.

9 Q. That's not right?

10 A. There's another exhibit in there, which was
11 the cover letter of those three, and that is when those
12 were issued. Those are -- may have been when it was
13 printed but not issued. That's --

14 Q. All right. There's a cover letter that's
15 dated April 3rd, 2009, which would have been two days
16 after these.

17 A. Yes.

18 Q. Okay. So what you're telling me is --

19 A. That's the package.

20 Q. -- the package of Exhibits 9 through 12
21 would have been provided by the State, in this case, to
22 the administrator of Countrywood Nursing Center, LLC?

23 A. Correct.

24 Q. Okay. And can we agree that Countrywood
25 Nursing Center, LLC, is included in -- the petitioner in

1 A. Yes, we do.

2 Q. Do you charge on an hourly base?

3 A. We charge both hourly and on an engaged
4 fee.

5 Q. Okay. In this instance, do you recall what
6 the engaged fee was for Countrywood?

7 A. I do not.

8 Q. Okay. Would that be in your records
9 somewhere?

10 A. It would.

11 Q. Is there an hourly rate you charge
12 Countrywood for your services in addition to an
13 engagement?

14 A. As a clarification, our rates go up every
15 year. So these were done way back when. So the engaged
16 fee for cost preps this year for Medicare and Medicaid
17 are 13,000.

18 Q. For Countrywood?

19 A. No. Just what we charge people.

20 Q. Okay.

21 A. That's where they start.

22 Q. Okay.

23 A. So for Countrywood, it could have been --
24 if you roll that back, it could have been ten. I don't
25 know exactly what the fee was --

1 customers' cost reports?

2 A. I don't understand the question.

3 Q. All right. Do you maintain a record of
4 communications with the Office of the State Auditor when
5 there is an examination cost report you prepared on
6 behalf of the customer?

7 A. What do you mean by record?

8 Q. Do you maintain e-mails, or is there
9 written correspondence?

10 A. Okay.

11 Q. When you send documents to the State
12 Auditor, do you time stamp those materials?

13 A. When we send things to the Auditor's Office
14 at their request, we keep a copy in our file. Usually
15 we'll create a file by subject so we can keep up with
16 what has been sent. And then I do keep up with my
17 e-mails.

18 Q. Okay. And would you be personally
19 responsible, for example, in this instance of being the
20 liaison between the Office of the State Auditor and your
21 customer?

22 A. It would be either myself or one of my
23 employees.

24 Q. Okay. And when there are communications
25 relating to, let's say, an adjustment to a cost on your

1 Q. Okay. So if the correspondence would be in
2 that file, you would have possession of these documents,
3 correct?

4 A. Yes.

5 Q. Okay. Has anyone asked you to produce
6 those documents?

7 A. No.

8 Q. Okay. All right.

9 Have you been asked by your customer or
10 anyone acting on behalf of your customer to provide any
11 opinions relating to the collection of identified costs
12 in this appeal?

13 A. Say that again.

14 Q. Has anybody asked to you provide an opinion
15 as to whether or not the amounts identified for
16 recoupment by the State from your customer should not be
17 provided?

18 A. No.

19 Q. No? Okay.

20 A. No.

21 Q. Has anybody asked you any opinion about
22 what you perceive to be the timeliness or the
23 untimeliness of the request for reimbursement by the
24 State in this appeal?

25 A. Say that again.

1 Q. And you did not bring it with you today?

2 A. No, I did not.

3 Q. Did anyone ever indicate to you that there
4 had been a request for such opinions?

5 A. My client asked me for our opinion --

6 Q. Okay.

7 A. -- on whether some of the audit reports --
8 or rate periods were expired, and I had gave them that.

9 Q. Well, what do you recall about that opinion
10 and the reasons that you provided to your customer for
11 your opinion?

12 A. There are three rate periods -- three cost
13 report periods under audit, and, in my opinion, the
14 initial cost report period, the six-month period is not
15 subject to audit. It's not auditable. That's one --

16 Q. Okay.

17 A. That's one issue.

18 Q. All right.

19 A. And then the other issue is, there are
20 three rate periods in the six-month cost report audit,
21 and, it's my opinion that the first two rate periods are
22 expired, and the report was issued after the statute of
23 limitations expired.

24 And those are my two opinions that I
25 offered.

1 of its costs in support of reimbursement; is that
2 correct?

3 A. That's correct.

4 Q. Okay. It is also required that if there
5 are transactions between related parties and entities,
6 there's documentation to show what the actual costs are
7 for those goods or services; is that fair to say?

8 A. That's correct.

9 Q. Now, it is my understanding that you have
10 customers other than Countrywood who participate in the
11 South Carolina Medicaid Program, correct?

12 A. Correct.

13 Q. Approximately how many customers do you
14 have that are nursing facilities providing services
15 through the South Carolina Medicaid Program?

16 A. Approximately 75.

17 Q. What percentage of your company's business
18 is directed toward customers who participate in the
19 South Carolina Medicaid Program?

20 A. Probably over 60 percent, right near 60.

21 Q. And would that be 60 percent of your
22 billings, or 60 percent of your activity?

23 A. 60 percent of the firm's revenues come from
24 nursing homes.

25 Q. Are there members of your staff that are

1 He?

2 A. He.

3 Q. -- managed the management company.

4 A. I mean, they weren't -- this wasn't a
5 long-term customer of ours. I mean, Countrywood is a
6 customer of ours, and I didn't do any other work for
7 them other than the cost reports, so I don't know the
8 deep relationship there. But he was the management
9 company. Either he was an owner, or he was a -- he was
10 the contact that I dealt with.

11 Q. Okay. What types of information would
12 Mr. Nielson have provided to you?

13 A. Mr. Nielson didn't provide me with any
14 information. He was the point person. The accounting
15 was completed between the nursing facility and then his
16 employee, so I got to work with one of his accountants.

17 Q. Okay. Who would that have been?

18 A. I can't remember.

19 Q. What's the name of the management company,
20 if you recall?

21 A. I think it was Nielson Financial Services.

22 Q. Okay. And did Mr. Nielson or his company
23 have a relationship with his customer that predated
24 yours?

25 A. Yes.

1 change ownership, you get a new rate effective the date
2 of the change, and those rates are listed on those
3 exhibits.

4 Q. Right.

5 A. But what the old operator's rates were, I
6 can't recall.

7 Q. Okay. But you do recall they were lower
8 than whatever --

9 A. I'm sure.

10 Q. -- it was for Countrywood?

11 A. Yes. I'm sure they were lower.

12 Q. And you have heard testimony earlier today
13 by Mr. Saxon that this six-month report does set a -- a
14 baseline for reimbursement that exceeds the six-month
15 period.

16 Would you agree with that?

17 A. Yes.

18 Q. After the six-month report was prepared by
19 your office, when was the next report prepared?

20 A. The next report was prepared for the year
21 ending September 30th, 2008.

22 Q. Okay. And would that have set the rate for
23 September 30th, '08, to -- whatever it was --
24 October 1st, '09?

25 A. The '08 -- the 9/30/08 report set the rate

1 A. Yes.

2 Q. Okay. All right.

3 So you're saying -- I believe you told me
4 that your opinion that you've offered to your customer
5 was that this six-month period was, in your words, not
6 auditable; is that correct?

7 A. That's correct.

8 Q. Okay. And then you said that the first
9 two, in your words, rate periods cannot be a basis for
10 recoupment; is that --

11 A. That's correct.

12 Q. -- your opinion?

13 Okay. Now, in offering that opinion,
14 you're not suggesting to your customer that everything
15 in that report is good, fine, and dandy, and it's
16 perfect. You're just saying a curtain has dropped, and
17 they can't collect; is that what you're saying?

18 A. Correct. I told them that the -- those
19 rate periods had expired for recoupment.

20 Q. Okay. And so you've got these costs when
21 you come on board, and they start up, and they set
22 these -- all these reimbursements that your customer
23 receives.

24 Now, are you suggesting that the auditors
25 have to come in like every six months or so in order to

1 this six-month period?

2 You knew that.

3 A. I was aware it was being audited, sure.

4 Q. Okay. And did you ever go to the auditor
5 and say, Hey, guys. You're wasting your time. You
6 can't collect this?

7 A. I did.

8 Q. When did you do that?

9 A. I did it the day that I received that
10 e-mail --

11 Q. Okay.

12 A. -- from Larry.

13 Q. On July the 15th, 2011?

14 A. I did.

15 Q. Did you send an e-mail back to him?

16 A. No. I called Mr. Von Kannel on the
17 telephone.

18 Q. You didn't send him a letter or anything
19 like that?

20 A. I did not.

21 Q. I guess Mr. Von Kannel didn't agree with
22 you, did he?

23 A. He did not.

24 Q. All right. Did you attempt to cooperate
25 with the Office of the State Auditor in gathering

1 me here this morning?

2 A. It would have been together.

3 Q. Together in the same --

4 A. Probably, yeah, the same process.

5 Q. Was it an e-mail or a letter?

6 A. E-mail.

7 Q. And who would that have been directed to?

8 A. It would have been directed to Bob Hagan

9 and Jerry Hicks.

10 Q. Okay. If I were to read the e-mail to Bob
11 Hagan and Gary Hicks, would that tell me, not only the
12 opinions you stated, but the reasons for your opinions?

13 A. If the e-mail that I sent to them was --
14 had general topics, because we were going to have a
15 conference call to discuss it.

16 Q. Okay.

17 A. So it most likely told them about the
18 expired rate periods and the third cost report period
19 and included a spreadsheet of how much money was
20 involved in that process.

21 Q. Was that --

22 A. And then we had the conference call about
23 it. That's wherever I like -- but -- recollect but...

24 Q. Okay. Because, of course, the customer
25 wants to know --

1 A. Yes.

2 Q. Okay. To the best of your knowledge, who
3 would that have been, sitting here today?

4 A. Palmetto Health Care had a similar issue
5 with expired periods.

6 Q. Okay.

7 A. And right now Pruitt Corporation has a
8 similar experience with its third cost report periods.

9 Q. Okay. And have you had similar discussions
10 with the ownership of those providers of Medicaid
11 services?

12 A. Yes.

13 Q. And have you provided a similar opinion to
14 those customers?

15 A. Verbally, yes.

16 Q. Okay. Nothing in writing?

17 A. No.

18 Q. Okay. When you provided the information to
19 Mr. Hagan and --

20 A. Mr. Hicks.

21 Q. -- Hicks, were you acting as an attorney
22 for them?

23 A. No.

24 Q. Are you licensed as an attorney?

25 A. I am not.

1 A. If I have a question about reimbursement, I
2 will read through the entire Plan, because there's no
3 index.

4 Q. And you know that.

5 A. I know that because I've read it.

6 Q. I mean, you've read it more than once,
7 haven't you?

8 A. Sure, I have.

9 Q. Okay. And you know that there is, as you
10 say, no index.

11 It's an organic document, is it not? It
12 changes from time to time?

13 A. It changes every year.

14 Q. And as a part of your professional
15 diligence, you make sure that you try to keep up with
16 those changes, correct?

17 A. I do.

18 Q. All right. Now, you deal with Mr. Saxon
19 from time to time.

20 A. Yes.

21 Q. Do you have a -- do you respect his
22 professionalism?

23 A. Very much so.

24 Q. Okay. And his knowledge?

25 A. Very much so.

1 11/29/07 to 9/30/08?

2 When were those cost reports prepared, to
3 the best of your recollection?

4 A. They were probably prepared 120 days after
5 the year-end date.

6 Q. Okay.

7 A. Because they would have been due within 90
8 days, and you normally get a 30-day extension.

9 Q. And so tell me -- because my math is not
10 wonderful.

11 A. So that would be four months --

12 Q. You're a CPA, Terry.

13 A. -- after. So June, July, August,
14 September. So the first report, ended May 31st, '08.
15 It would have been prepared sometime before September of
16 '08.

17 And then the September 30th, '08 report
18 would have been prepared sometime before January 31st of
19 '09.

20 Q. Okay. And in order to prepare the 9/30/08
21 report, you had to utilize information beginning from
22 the first day of operation; is that correct?

23 A. That's correct.

24 Q. Okay. So it would have included all the
25 information that you utilized in preparing the 5/31/08

1 information.

2 Were you -- did you participate in
3 responding to the written discovery in this case?

4 A. To my knowledge, no.

5 Q. So just for purposes of the record, you
6 have not been asked to produce your report to Mr. Hagan
7 and Mr. Hicks?

8 A. What report?

9 Q. You said you had an e-mail to them
10 expressing your opinion about reimbursability and
11 collectability in this case.

12 A. I have an e-mail about those.

13 Q. Okay.

14 A. But...

15 Q. All right. And an e-mail is in writing,
16 isn't it? I mean, it's electronic, but you can produce
17 a copy, can't you?

18 MR. WESTBROOK: Let me just interject here.

19 And, Al, if we didn't do something that you
20 need, I'll be happy to --

21 MR. NICKELS: That's fine.

22 MR. WESTBROOK: -- go back and do that.

23 MR. NICKELS: That's fine.

24 MR. WESTBROOK: But -- and I apologize.

25 MR. NICKELS: All right.

1 conference call for us to talk about it.

2 Q. Okay.

3 A. I can get you that.

4 Q. All right.

5 A. If that's what you need.

6 Q. Well, but --

7 A. But I wasn't aware that you were asking for
8 that.

9 Q. All right. Okay.

10 And my -- the second question --

11 A. So I'm sorry.

12 Q. -- is, Apart from this e-mail, have you
13 prepared anything in writing that addresses the opinions
14 you have expressed to me today or you plan to express to
15 the hearing officer in this appeal?

16 A. Opinions, no. I mean --

17 Q. Oh, okay.

18 A. -- they're not really opinions. I mean, no
19 one called me up and said, Hey, give me your
20 professional opinion.

21 We brought these issues up as options to
22 the customer, and we had a conference call to discuss
23 it.

24 Q. All right. So let me put it to you --

25 A. So I can give you all those e-mails.

1 MR. NICKELS: That's fair. Okay.

2 Q. And once again, Mr. Schmoyer, just so that
3 I am clear, the information that you rely upon for these
4 opinions that you've expressed to me is contained in the
5 materials that are in Mr. Saxon's deposition, correct?

6 A. That is correct.

7 Q. Nothing else?

8 A. Nothing else.

9 MR. NICKELS: All right. Those are all the
10 questions I have at this time.

11 EXAMINATION

12 BY MR. WESTBROOK:

13 Q. Okay. I want to follow-up on the last
14 question, Mr. Schmoyer.

15 You recall that in this case, Countrywood
16 filed a motion for partial summary judgment, and there
17 was a memorandum in response.

18 Do you recall that?

19 A. Yes.

20 Q. And you reviewed that, didn't you.

21 A. Yes..

22 Q. And that memorandum has a lot of exhibits
23 to it, does it not?

24 A. It does.

25 Q. And many of those exhibits -- maybe all of

1 this process.

2 Q. All right.

3 A. But the sections that I'm relying on did
4 not change.

5 Q. All right. And finally, I don't think the
6 final reports themselves were ever made exhibits to the
7 Saxon deposition.

8 Would you have relied on the final report
9 to any extent to form your opinion, the final reports
10 from SAO?

11 A. Yes. Yeah, certainly.

12 Q. Okay. So let me just repeat Mr. Nickel's
13 question. Can you think at this point in time of
14 anything else, any other written documents that you
15 would rely on to form your opinions?

16 A. No.

17 MR. WESTBROOK: Okay. That's all the
18 questions I have.

19 MR. NICKELS: Thank you.

20 (The deposition concluded at approximately
21 12:34 p.m.)

22

23

24

25

1 CERTIFICATE OF REPORTER

2 I, Nisha Gordon, Court Reporter and Notary
3 Public for the State of South Carolina at Large, do
4 hereby certify:

5 That the foregoing deposition was taken before
6 me on the date and at the time and location stated on
7 page 1 of this transcript; that the deponent was duly
8 sworn to testify to the truth, the whole truth, and
9 nothing but the truth; that the testimony of the
10 deponent and all objections made at the time of the
11 examination were recorded stenographically by me and
12 were thereafter transcribed; that the foregoing
13 deposition as typed is a true, accurate, and complete
14 record of the testimony of the deponent and of all
15 objections made at the time of the examination to the
16 best of my ability.

17 I further certify that I am neither related to
18 nor counsel for any party to the case pending or
19 interested in the events thereof.

20 Witness my hand, I have hereunto affixed my
21 official seal this 14th of August, 2014, at Greenville,
22 Greenville County, South Carolina.

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Nisha Gordon
Notary Public
State of Carolina at Large
My Commission Expires:
June 14, 2022

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September 22, 2014

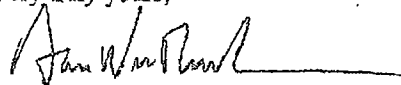
Betsy Schindler, Hearing Officer
South Carolina Department of Health
& Human Services
Division of Appeals and Hearings
1801 Main Street, 9th Floor
Post Office Box 8206
Columbia, SC 29202-8206

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:

I am enclosing herewith Petitioner's Response to Respondent's Objection to Admission of Parol Evidence in the above matter. 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, Esquire
Alice V. Harris, Esquire

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SEP 22 2014

SCDHHS APPEALS



With offices in the District of Columbia, Florida, Georgia, Massachusetts, North Carolina, South Carolina, Tennessee and West Virginia

R0696

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	)	<u>PETITIONER'S RESPONSE TO</u>
and Human Services,	)	<u>RESPONDENT'S OBJECTION TO</u>
	)	<u>ADMISSION OF PAROL</u>
Respondent.	)	<u>EVIDENCE</u>
	)	

Petitioner submits this response to Respondent's Objection to Admission of Parole Evidence.

On September 16, 2014, the afternoon before the final hearing in this matter, the Respondent, South Carolina Department of Health and Human Services ("DHHS"), submitted a brief objecting to the admission of what it characterized as parole evidence. As detailed at the final hearing, Respondent argued that the parole evidence rule prohibited testimony by DHHS expert witness Jeff Saxon and Petitioner's expert witness Terry Schmoyer to "explain" the contracts at issue in this appeal.

The two contracts at issue are Petitioner's Exhibits 4 and 6: the July 1, 2011 contract between DHHS and the State Auditor's Office (the "SAO Contract") and the October 1, 2006 contract between DHHS and Petitioner (the "Facility Contract"). The key provision at issue in the SAO Contract is Article III(D). The key provisions at issue in the Facility Contract are Article V(F) and the definition of "contract period" in Article II. As noted at the final hearing

by Petitioner's counsel, the language in these provisions is clear, unambiguous, and needs no extrinsic evidence to interpret it.

The parol evidence rule prohibits admission of extrinsic evidence for the purpose of explaining, varying, or contradicting the terms of a contract. *Cullen v. McNeal*, 390 S.C. 470, 482, 702 S.E.2d 379, 384 (Ct. App. 2010). Petitioner, however, did not offer the testimony of Mr. Saxon or Mr. Schmoyer for that purpose.

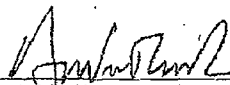
Instead, Petitioner offered the testimony for a different purpose - to demonstrate the parties' intent that South Carolina nursing homes (including Petitioner) are beneficiaries of the SAO Contract. A third-party has the right to enforce a contract if it is the contract's intended, rather than incidental, beneficiary. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 344, 340, 611 S.E.2d 485, 487 (2005). Both Mr. Saxon and Mr. Schmoyer testified that Article III(D)(1) of the SAO Contract was revised to its present language following negotiations between DHHS and the South Carolina Health Care Association (the "Association"), an organization whose membership comprises most of the nursing homes in the state. The clear purpose of the testimony, therefore, was to prove that nursing homes are intended beneficiaries of the SAO Contract.

Respondent included an objection to Mr. Schmoyer's testimony on the grounds that he was not a party to and did not participate in the drafting of the contracts at issue in this matter. This argument is misplaced. Mr. Schmoyer testified as to his knowledge of the negotiations and agreement between DHHS and the Association that led to a revision of the SAO Contract limiting SAO review to two cost reports at a time. Mr. Schmoyer's testimony was clearly relevant. Respondent cited no authority limiting testimony about third-party beneficiary status to contractual parties or drafters.

CONCLUSION

The SAO Contract and Facility Contract are perfectly clear and need no interpretation. Petitioner offered the testimony of Mr. Saxon and Mr. Schmoeyer not to explain, vary, or contradict either contract. Instead, the testimony was offered as evidence that nursing homes, including Petitioner, are intended beneficiaries of the SAO Contract. For these reasons, the Hearing Officer correctly admitted the testimony.

NELSON MULLINS RILEY & SCARBOROUGH LLP

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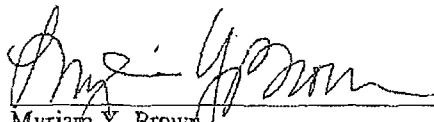
September 22, 2014

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 emailing a copy of the same to the following address(es):

Pleadings: Petitioner's Response to Respondent's Objection to Admission of Parol Evidence

Counsel Served: W. Allen Nickles, III, Esq.
Nickles Law Firm, LLC
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wanickles@nickleslaw.com


Myriam Y. Brown
Administrative Assistant

September 22, 2014

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SCDHHS APPEALS

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October 17, 2014

Via Electronic Mail and Hand Delivery

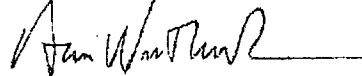
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RE: Countrywood Nursing, LLC v. SC DHHS
Appeal Case Nos. 12-AUD-010, 12-AUD-011, and 12-AUD-012
Our File No. 39092/09001

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)

With offices in the District of Columbia, Florida, Georgia, Massachusetts, North Carolina, South Carolina, Tennessee and West Virginia



R0701

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"). Pet. 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

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November 8, 2012

Via Email & U.S. Mail

Betsy K. Schindler, Hearing Officer
SC Department of Health & Human Services
Division of Appeals and Hearings
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: Countrywood v. SCDHHS
AC #12-AUD-10 through AC #12-AUD-12

Dear Ms. Schindler:

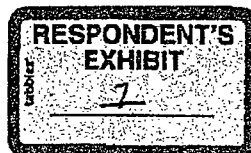
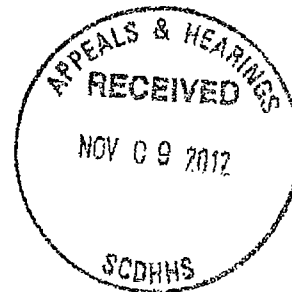
Please find Respondent's Memorandum in Opposition to Petitioner's Motion for Partial Summary Judgment, with attachments, in the above appeal. This same material is being provided to counsel for Petitioner by email and U.S. Mail.

I appreciate your attention to this matter.

Sincerely,


W. Allen Nickles, III

WAN/pfb
Enclosure
cc: Byron Roberts, Esquire (via email only)
Rick Hepfer, Esquire (via email only)
File #12-089



R0712

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 MEMORANDUM
	)	IN OPPOSITION TO PETITIONER'S
South Carolina Department of Health	)	MOTION FOR PARTIAL SUMMARY
and Human Services,	)	JUDGMENT
	)	
<u>Respondent.</u>	)	

By memorandum dated October 10, 2012, Petitioner seeks relief from returning overpayments received from the State for Medicaid services, asserting that the audit report identifying such overpayments was not issued in a timely fashion. For the following reasons, Petitioner's request is without merit and should be denied.

STANDARD OF REVIEW

Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Rule 56(b), SCRPC; Green v. Cottrell, 346 S.C. 53, 550 S.E. 2d 324 (Ct. App. 2001); Bruce v. Durney, 341 S.C. 563, 534 S.E. 2d 720 (Ct. App. 2000). The purpose of summary judgment is to expedite the disposition of cases not requiring the services of a fact finder. George v. Fabri, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001)

Under Rule 56(b), the party seeking summary judgment has the initial burden of demonstrating the absence of a genuine issue of material fact. Carolina Alliance for Fair Employment v. South Carolina Department of Labor, Licensing, and Regulation, 337 S.C 476,

523 S.E. 2d 795 (Ct. App. 1999) In determining whether a genuine issue of fact exists, the evidence and all reasonable inferences drawn from it must be viewed in the light most favorable to the nonmoving party. Sauner v. Pub. Serv. Auth. of S.C., 354 S.C. 397, 404, 581 S.E.2d 161, 165 (2003)

Where, as here, a contest involves 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) If there is any question about the meaning or intent of the document, however, 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) 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)

STATEMENT OF FACTS

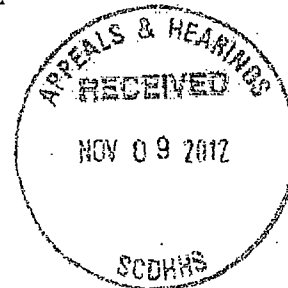
The South Carolina Department of Health and Human Services ("DHHS") is the single state agency designated to administer the South Carolina Medicaid program. As such, DHHS has the responsibility of determining whether providers of Medicaid services, such as Petitioner, have submitted records of costs sufficient to support reimbursement of services. Because costs are paid in advance, providers must submit to audit reviews and repay any amounts found to have been unjustified.

In this instance, Petitioner contends that it should be exempt from returning overpayments because the audit report designating adjustments to Petitioner's costs was issued

more than three years following the initial six month cost report that established reimbursements for the rate periods 11/29/07 through 09/30/09. In support of this argument, Petitioner divides the "rate cycle" determined by its initial reports into separate periods of 11/29/07 – 5/31/08 (6 months); 06/01/08 – 09/30/08 (4 months); and 10/01/08 – 09/30/09 (12 months). Petitioner characterizes these varying time frames as "contract periods" and asserts that deadlines for issuing audit reports run from each.

Jeff Saxon is the Program Manager II for DHHS responsible for administration of the State's Medicaid reimbursement program. Mr. Saxon has had this responsibility for more than thirty years and has been involved in the State's Medicaid plan and associated contracts throughout that period. As Mr. Saxon points out in his affidavit, the time limit for issuance of audit reports is governed by the State Plan. This Plan provides for two distinct forms of cost reports. In the present case, the only cost report under review was prepared by the Petitioner for its first six months of operation. Accordingly, this report sets the rates for the entire period under appeal: 11/29/07 – 9/30/09. See, Saxon Affidavit provided as Exhibit A.

As explained by Mr. Saxon and as clearly indicated in the State Plan, the audit report deadline for the periods on appeal fell three years following 9/30/09. It is not disputed that the reports issued by the State Auditor's Office ("SAO") in this instance occurred on 11/22/11, within the three year period designated in the State Plan and Petitioner's contract. For this reason, there can be no factual dispute that the challenged audit reports were issued in a timely fashion and that Petitioner's attempt to avoid justifying their reported costs is without merit.



LEGAL ARGUMENT

I. The State Plan establishes that audit reports must be issued within three years of the close of the rate period established by a cost report.

Petitioner appears to argue that auditors should be compelled to issue multiple audit reports following review of a single six month cost report. As explained by Mr. Saxon, this is not consistent with the controlling provisions of the State Plan or the routine operations of the South Carolina Medicaid program. Accordingly, Petitioner's attempt to interpret the contract between DHHS and the SAO to require multiple audit reports within a single rate cycle is not supportable. See, Peake v. S.C. Dept. of Motor Vehicles, 375 S.C. 589, 599, 654 S.E.2d 284, 289 (Ct. App. 2007)

The contract entered by Petitioner specifies that "the contract period will be the rate period as defined by the South Carolina State Plan." As addressed above, the State Plan identifies both initial six month cost reports and annual cost reports. Six month reports set the rates for extended periods of time, here 11/29/07 through 9/30/09. Differences in reimbursements during this extended period are based not upon changes in Petitioner's costs, but amendments to the State Plan. Because the "rate period" determined by Petitioner's initial report extended far beyond the six month period reported and reviewed, Petitioner has enjoyed significantly enhanced reimbursements. See, Saxon Affidavit Attachment 5 (showing "extra" reimbursement in the amount of \$131,665.00 for non-recurring expenses claimed during Petitioner's six month reports)

In making its motion for summary judgment, Petitioner ignores completely the treatment of six month reports in the State Plan and attempt to apply annual report deadlines. As Mr. Saxon indicates in his affidavit, this is not proper and is not in keeping with longstanding DHHS

practice. Similarly, Petitioner misconstrues the applicability of 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). This 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 court held that this language required audit reports to be issued within three years of the contract ending date. By way of contrast, Petitioner stipulates that the audit periods applicable to its contracts are governed by the "rate period as defined by the South Carolina State Plan." See Saxon Affidavit Attachment 3A (Contract Art. II, Definitions; "Contract Period") As addressed above, the State Plan provides that for six month cost reports, the rate period (rate cycle) extends beyond the reporting date to all periods governed by the six month reports. See Saxon Affidavit. Because the language construed in C.A.N. does not appear in Petitioner's contracts and does not appear in the State Plan, its holding does not apply to the present appeals.

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). Additionally, 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).

As addressed above, the language of the State Plan as incorporated in Petitioner's contract establishes the deadline for issuance of an audit report based upon the conclusion of a "rate period." The "rate period" in this instance began on 11/29/07 and ended on 9/30/09. Accordingly, there can be no question that the challenged reports issued on 11/22/11 fell within the three year period allowed by contract and State Plan. For this reason, Petitioner's motion for summary judgment must be denied.

II. The contract between DHHS and the SAO does not limit review to two cost report periods.

Petitioner contends that the contract between DHHS and SAO limits audit reviews to two cost report periods. This is incorrect. Instead, the contract between DHHS and the SAO clearly provides that the State Auditor 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." Saxon Affidavit Attachment 4 (DHHS/SAO contract Art. III, ¶ B.3 (p. 3 of 14)) Attempts by DHHS or others to limit audit reviews in a manner inconsistent with governing law would be invalid.

As explained by Mr. Saxon in his affidavit, the two reporting periods referenced in the contract establishes a minimum obligation on the part of the State Auditor. See, Saxon Affidavit Attachment 4 (DHHS/State Auditor contract Art. III, ¶ D.1 (p. 4 of 14)) Indeed, the contract between Petitioner and DHHS makes clear that auditors shall have access to Petitioner's records for a period of six years following any contract, including amendments or extensions. See, Saxon Affidavit Attachment 3A (Contract Art. V, ¶ G.2 (p. 9 of 20))

III. The contract between DHHS and the SAO does not create any right enforceable by Petitioner.

Petitioner is not a party to the contract between DHHS and the State Auditor. Instead, as confirmed by Mr. Saxon, this contract is for the purpose of formalizing the relationship between two agencies of the State. Accordingly, Petitioner can identify 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)

IV. Petitioner has no equitable claim to retain overpayments for Medicaid services.

The contract between Petitioner and DHHS stipulates that Petitioner shall maintain records for a period of six years after the last payment made under contract and that these records are subject to inspection during that six year period. See, Saxon Affidavit Attachment 3A (Contract Art. V, ¶ G.1 and G.2 (p. 9 of 20)) The contract is subject to termination for breach of the records retention and inspection requirements. See, Saxon Affidavit Attachment 3A (Contract Art. VII, ¶ C (p. 11 of 20))

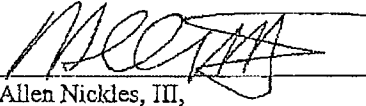
Because Petitioner must maintain records and afford access to inspection, there can be no basis for asserting prejudice by way of unreasonable delay. Indeed, any equitable claim asserted by Petitioner would fail because the alleged "delay" in issuing audit reports was neither unreasonable nor prejudicial 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)

In this instance, Petitioner has the opportunity to contest any adjustments to its costs preserved for review on appeal. If the adjustments were in error, Petitioner will be entitled to retain the challenged reimbursements. If the adjustments are sustained, Petitioner is not "injured" or "prejudiced" by returning unearned funds. Moreover, the public interests in confining Medicaid reimbursement to costs demonstrated as reasonable and necessary will be served by the hearing of Petitioner's appeal on the merits.

CONCLUSION

For the reasons stated above and supported in the attached materials, Petitioner cannot establish that the challenged audit reports were issued in an untimely fashion. Additionally, Petitioner has no enforceable claim in equity to retain overpayments for Medicaid services. For these reasons, Petitioner's motion for summary judgment must be denied and an appeal hearing scheduled for any adjustments properly preserved for review.

NICKLES LAW FIRM, LLC

By: 

W. Allen Nickles, III,
1519 Richland Street
Columbia, South Carolina 29201
(803) 779-8080

Attorneys for Respondent

November 8, 2012
Columbia, South Carolina

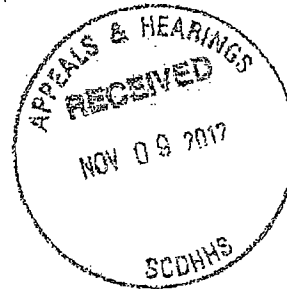


EXHIBIT A

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND) AFFIDAVIT

Jeff Saxon, being first duly sworn, deposes and says:

1. I am employed by the South Carolina Department of Health and Human Services (DHHS) in the position of Program Manager II. My duties in this position include: setting major Medicaid provider reimbursement policies relating to all contracting and enrolled Medicaid providers; presenting reimbursement policy plans and proposals to executive staff, state and federal agencies, federal and state legislative staff and provider organizations; testing reimbursement policy to ensure efficiency and to address budgetary constraints by directing research and trend analysis activities; providing consultation on the development, submission, and implementation of agency reimbursement methodology and rate setting into the SC Medicaid State Plan; representing DHHS in provider appeal/litigation activities as it relates to SC Medicaid reimbursement policy/rate setting methodologies.

2. I have over 30 years of experience in matters relating to reimbursement of Medicaid costs to nursing home facilities in South Carolina. I have been involved in preparation of contracts between DHHS and Medicaid providers, the contract between DHHS and the Office of the State Auditor, and amendments to the South Carolina State Plan under Title XIX of the Social Security Act.

3. I have been informed that certain Medicaid providers have objected to the recoupment of overpayments for services on the basis that audit reports were not issued within the time frame designated in the providers' contracts and the State Plan. I have reviewed these objections and offer the following observations:

- Provider contracts indicate that for purposes of the issuance of final audit reports, "the contract period will be the rate period as defined by the South Carolina State Plan." See Contract Article II "contract period" and Article V, ¶ F "time limit for issuance of final audit report." See Attachment 3A.
- The State Plan addresses two separate and distinct forms of cost report. The routine cost report is for an annual period ending September 30. These reports set a rate for the designated annual period. Accordingly, final audit reports in this circumstance must be issued within three (3) years of the close of the annual rate period. See State Plan provision I.A., p. 1 and provision III, p. 12. See Attachment 3B (State Plan, dated October 1, 2007 Attachment 4.19-D).
- The second form of cost report identified in the State Plan derives from a six month period of operation. This cost report applies in the case of a new facility, replacement facility, change of ownership and increase in bed capacity by more than 50%. This cost report sets the rate for extended periods of time. The rate

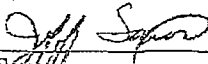
established as a result of this report is subject to modification only in the event of amendments to the State Plan. The final audit reports in this circumstance must be issued within three years of the close of the final rate period determined by the six month cost report. See State Plan provision III.E., pp. 21-25. See Attachment 3C (State Plan, dated October 1, 2007 Attachment 4.19-D).

4. The relationship between DHHS and the Office of the State Auditor is governed by law and guided by contract. For example, the Office of the State Auditor has a statutory responsibility to examine costs incurred in the delivery of public services. With regard to Medicaid providers, at a minimum, the Office of the State Auditor performs agreed upon procedures involving two cost report periods and issues final reports not later than three years after the end of the closed rate period that is associated with the preceding cost report period. This contract is consistent with the State Plan provisions identified in Paragraph 3 above. The Office of the State Auditor may perform agreed upon procedures on any cost report filed by Medicaid providers, as long as the final report is issued according to the terms of Article V of the provider contract. See Attachment 4.

5. Because the six month cost report sets the rate for extended periods, Medicaid providers are able to leverage their costs in an advantageous fashion. For example, because the six month report is based upon current costs, reimbursement for non-routine costs such as equipment and furnishings can result in reimbursement that substantially exceeds the costs incurred by the Medicaid provider. By way of example, the costs for furniture and equipment reported by Countrywood Nursing Center in its six month report for the period 11/29/07 – 5/31/08 shows an aggregate amount of \$67,996.00. Because this report sets the rate through 9/30/09, the reimbursement impact is \$131,665.00. See Attachment 5.

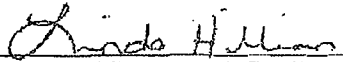
6. In summary, in keeping with the State Plan, the Medicaid provider contract and the contract with the Office of the State Auditor, the deadline for issuing a final audit report for a cost report setting rates through September 30, 2009 would be September 30, 2012. Any adjustments in a report issued on or before September 30, 2012 would be subject to recoupment and/or appeal. See Attachment 6.

Affiant further sayeth not.



Jeff Saxton

Sworn to and subscribed before me
This 7th day of November, 2012.



Notary Public for South Carolina
My commission expires: 6/3/15

ATTACHMENT 3A

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

Daniela 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 1 3733 N

R0726

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TESTIMONIAL

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 et seq. 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 '80 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, of 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, P.E.N. 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., P.E.N. 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. O. 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 § 23-360, 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 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 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
Director

BY:

Authorized Signature

Print Name

WITNESSES:

WITNESSES:

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.

Signature

ATTACHMENT 3B

PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF SOUTH CAROLINA

The Medicaid Agency Rate Setting Policies, Procedures and Methods for Nursing Facilities, Facilities for the Mentally Retarded, and Long Term Care Institutions for Mental Diseases

I. Cost Finding and Uniform Cost Reports

- A) Each nursing facility shall complete and file with the Medicaid Agency, Division of Long Term Care Reimbursements, an annual financial and statistical report supplied by the Medicaid Agency. Effective for the cost reporting period ending September 30, 2001, all nursing facilities will be required to submit their financial and statistical report using the new SENIORS (South Carolina Electronic Nursing Home Income/Expense Operating Report System) program software provided by the Medicaid Agency. Nursing facilities must report their operations from October 1 through September 30 on a fiscal year basis. Government owned and ICF/MR facilities may report their operations from July 1 through June 30. Hospital based facilities with fiscal year ends other than September 30 will be allowed effective with the 1990 cost reports to use their fiscal year end due to the reporting difficulties of nonconcurrent Medicare and Medicaid fiscal year ends. However, no additional inflation adjustment will be made.

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

Nursing facilities which incur home office cost/management fees through a related organization are responsible for submitting a hard copy of an annual cost report detailing the cost of the related organization (home office) to the Medicaid Agency. The cost report period should be from October 1 to September 30. However, large chain operations which do business in other states may request a different cost reporting period for their home office cost report; however, no additional inflation adjustment will be made.

- B) All nursing facilities are required to detail their cost for the entire reporting period or for period of participation in the plan, if less than the full cost reporting period. These costs are recorded by the facility on the basis of generally accepted accounting principles and the accrual method of accounting. The cash method of accounting is acceptable for public institutions. Effective October 1, 2006, nursing facilities which have an annual Medicaid utilization of 1,500 days or less will not be required to file an annual financial and statistical report.

SC 06-013
EFFECTIVE DATE: 10/01/06
RO APPROVED: 12/19/06
SUPERSEDES: MA 02-006

- 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 SCMHHS.

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

ATTACHMENT 3C

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. Effective October 1, 2007 a transportation escort add-on will be included in each qualifying facility's reimbursement rate. This add on is described on pages 14 through 16.
11. For rates effective October 1, 2007, the provider's reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive, profit and transportation escort add-on.

D. Payment for Hospital-based and Non-profit Facilities

Hospital-based and non-profit facilities will be paid in accordance with Sections III A, B, and C.

E. Payment determination for a new facility, replacement facility, change of ownership through a purchase of fixed assets, change of ownership through a lease of fixed assets, when a facility changes its bed capacity by more than fifty percent (50%), or when temporary management is assigned by the state agency to run a facility.

1. Payment determination for a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

The following methodology shall be utilized to determine the rate to be paid to a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

Based on a six (6) month's projected budget of allowable costs covering the first six months of the Provider's operation under the Medicaid program, the Medicaid agency will set an interim rate to cover the first six (6) months of operation or through the last day of the sixth (6th) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate except that all standards to be used will be one hundred twenty percent (120%) of the standards for the size of facility to adjust for lower initial occupancy. The one hundred twenty percent (120%) adjustment is determined by considering the average eighty percent (80%) occupancy for the first six (6) months of operation of a new facility versus the minimum of ninety-six percent (96%) occupancy required for all facilities that have been in operation for more than six (6) months.

SC 07-007
EFFECTIVE DATE: 10/01/07
RO APPROVED: 01/30/08
SUPERSEDES: MA 03-014

Within ninety (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date.

This report will be used to determine allowable reimbursement of the provider for the initial rate cycle. A new prospective rate, based upon the Uniform Financial and Statistical Report, will be determined using the methodology as previously stated in Section III C of this plan except for the following methodology:

- a) Payment for the first six months will be retrospectively adjusted to actual costs not to exceed 120% of the standards and actual occupancy.
- b) No inflation adjustment will be made to the first six (6) months cost.
- c) Effective on the first (1st) day of the seventh (7th) month of operation through the September 30 rate, the per diem costs effective July 1, 1994 will be adjusted to reflect the higher of:
 1. Actual occupancy of the provider at the last month of the initial cost report; or
 2. 90% occupancy.

Facilities that decertify and recertify nursing facility beds that results in a change in its bed capacity by more than fifty percent (50%) will not be entitled to a new budget.

SC 07-007
EFFECTIVE DATE: 10/01/07
RO APPROVED: 01/30/08
SUPERSEDES: MA 04-007

2. Payment determination for a replacement facility, or a change of ownership through a purchase of fixed assets:

A change in ownership will be defined as a transaction that results in a new operating entity. A purchase of the leased fixed assets by a lessee (owner of operating entity) will not be considered a change of ownership unless allowable Medicaid capital costs will be reduced (i.e., purchase price less than historical costs). Each change of ownership request will be reviewed individually to determine whether a six-month cost report will be required. Effective November 22, 1991, to qualify for a "new facility rate" based upon a six month cost report under a change of ownership, a sale or lease of assets between unrelated parties must occur. A new operator who leases a facility from a related party will not be entitled to a "new facility rate". Also, facilities in the process of obtaining a certificate of need due to a sale or lease between related parties prior to November 22, 1991 will be grandfathered in under the existing system.

The following methodology shall be utilized to determine the rate to be paid to a replacement facility and a new owner, where a change of ownership has occurred through a purchase of fixed assets:

Based on a six (6) month's projected budget of allowable costs covering the first six months of the provider's operation under the Medicaid program, the Medicaid Agency will set an interim rate to cover the first six (6) months of operation through the last day of the sixth (6th) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate as described in Section III C of this plan, with the exception of inflation. No inflation adjustment will be made to the interim rates for the first six (6) months cost.

Within (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical Report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date.

SC 07-007
EFFECTIVE DATE: 10/01/07
RO APPROVED: 01/30/08
SUPERSEDES: SC 06-013

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 18, 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

SC: MA 07-007

EFFECTIVE DATE: 10/01/07

RO APPROVED: 01/30/08

SUPERSEDES: MA 02-006

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.

SC 07-007
EFFECTIVE DATE: 10/01/07
RO APPROVED: 01/30/08
SUPERSEDES: SC 06-013

ATTACHMENT 4

CONTRACT

BETWEEN

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

THE SOUTH CAROLINA STATE AUDITOR'S OFFICE

FOR THE PURCHASE AND PROVISION OF
SPES

AGREED-UPON PROCEDURE ACTIVITIES RELATED TO MEDICAID
INSTITUTIONAL PROVIDERS

DATED AS OF

JULY 1, 2011

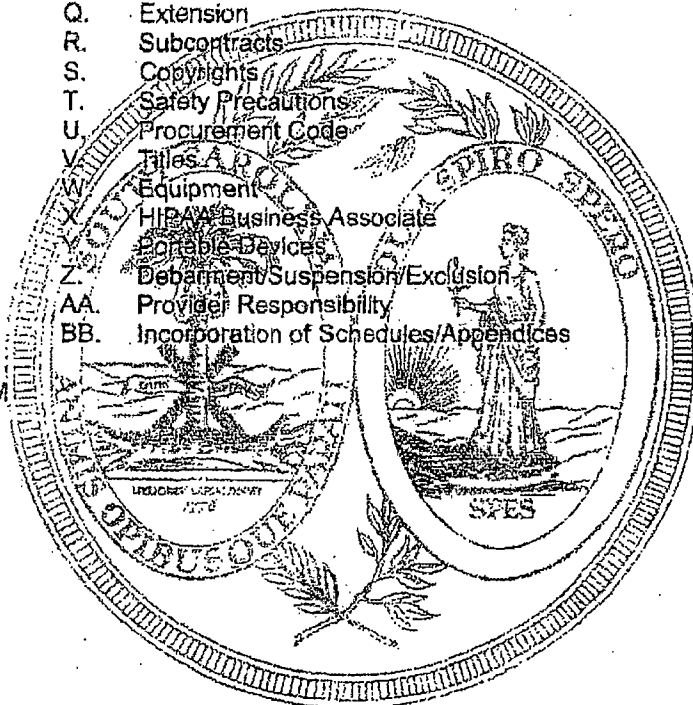
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TESTIMONIUM

APPENDIX A

14

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).

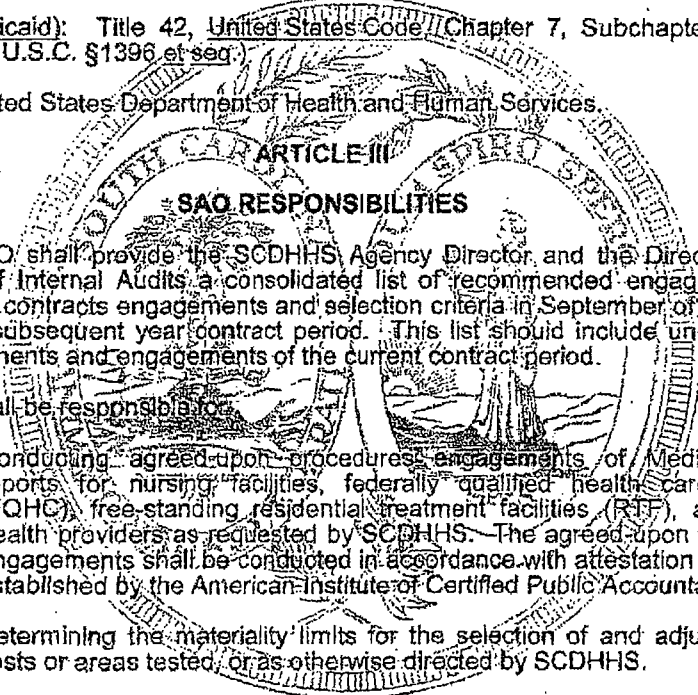
South Carolina State Plan for Medical Assistance (State Plan): A comprehensive written commitment by SCDHHS, submitted under section 1902(a) of the Social Security Act, to administer or supervise the administration of the Medicaid Program in accordance with federal requirements.

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 procedure 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.

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 C 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 an 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 SAO shall take necessary steps to insure or protect its recipients, itself, and its personnel. The SAO agrees to comply with all applicable local, state, and federal occupational and safety acts, rules and regulations.

U. Procurement Code

When applicable, the SAO 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: Richard H. Gilbert, Jr.
Authorized Signature

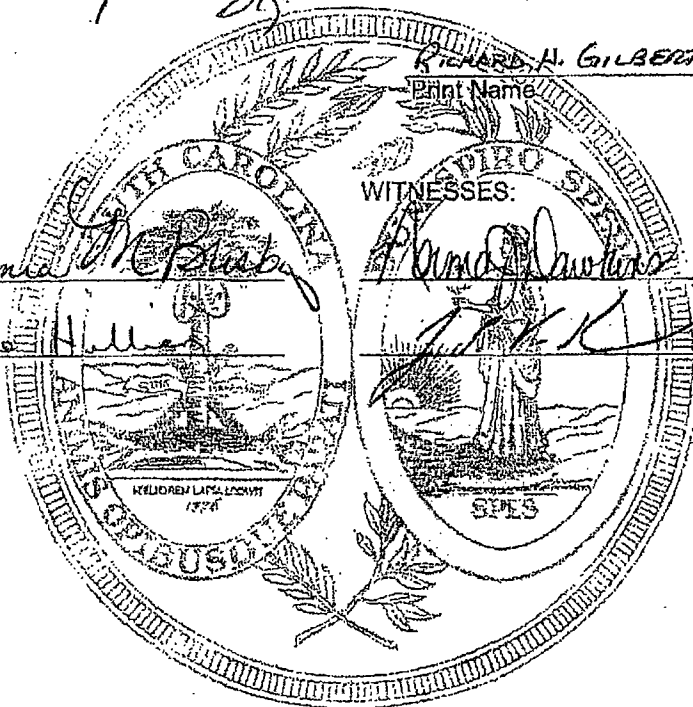
Richard H. Gilbert, Jr.
Print Name

WITNESSES:

Antonia M. Blaylock
Linda Hillier

WITNESSES:

James A. Lawrence
J. H. 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 § 164.506(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.

ATTACHMENT 5

Countrywood Nursing Center
 Projected Reimbursement Impact of One-Time Non-Recurring Items Claimed on 6 Month Cost Reports

Facility	Non-Recurring Expense Claimant			Patient Days (Per C/TU)		Per Day Impact (1)		Medicaid Days Paid (2)		Reimbursement Impact		
	Furniture & Equipment	Other	Total	EB	JB	EB	JB	EB	JB	EB	JB	Total
Countrywood	67,996	-	67,996	6,749	11,159	10.67	6.07	13,075	8,913	131,655	54,102	185,767
										Extra	Typical	

Notes:

One time non-recurring expenses reflected above were reported by Provider on both the six month and first 9/30 period end cost reports. The calculations above represent estimated amounts paid to the provider for these expenses by cost report period. The inclusion of the one-time non-recurring expenses on six month cost reports results in the Provider being paid over three and times more than they would have received through a typical annual cost report.

- Does not include impact of inflation.

- Obtained from DH&HS receivable letter. These days represent total medicaid days paid for the rates set by each cost report. These days may not include hospice days for some of the facilities.

ATTACHMENT 6

Statute Issue
Change in Ownership - Purchase of Fixed Assets

Countrywood Nursing Center

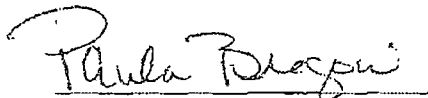
<u>Cost Report Period</u>	<u>Contract Period</u>	<u>Issuance Date</u>	<u>DHHS/SAO Position</u>	<u>Provider Position</u>
11/29/07 - 5/31/08	11/29/07 - 5/31/08			5/31/11
	6/1/08 - 9/30/08			9/30/11
	10/1/08 - 9/30/09	11/22/11	9/30/12	9/30/12

CERTIFICATE OF SERVICE

I, Paula Bregovi, the undersigned employee of Nickles Law Firm, LLC, attorneys for Respondent hereby certify that I have served the foregoing Memorandum in Opposition to Petitioner's Motion for Partial Summary Judgment by depositing a copy of same in the United States Mail, postage prepaid and addressed as follows:

William A. Prince, Esquire
Alice V. Harris, Esquire
Post Office Box 11070
Columbia, South Carolina 29211

This 8th day of November, 2012.


Paula Bregovi

Columbia, South Carolina