# COMPLETE CARE AT SILVER LAKE

EXAMINATION
FISCAL YEAR ENDED JUNE 30, 2020

# COMPLETE CARE AT SILVER LAKE

## REPORT SUMMARY FOR FISCAL YEAR ENDED JUNE 30, 2020

## BACKGROUND

An examination of the Complete Care at Silver Lake Long-Term Care Facility fiscal records of the Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance, Medicaid Long-Term Care Facilities' Statement of Reimbursement Costs for Skilled and Intermediate Care Nursing Facilities – Title XIX and Nursing Wage Survey (cost report and nursing wage survey, respectively) for fiscal year ended June 30, 2020.

The State Auditor is authorized under 29 Del. C., §2906 to conduct post-audits of all financial transactions of all state agencies.

This engagement was conducted in accordance with federal requirements (42 CFR 447.253 and 483 Subpart B) and state requirements (Title XIX Delaware Medicaid State Plan, Attachment 4.19D) (criteria), as applicable to the Complete Care at Silver Lake Long-Term Care Facility fiscal records. The criteria were used to prepare the Schedule of Adjustments to the Trial Balance, Patient Days, and Nursing Wage Survey for fiscal year ended June 30, 2020, found in the report.

## KEY INFORMATION AND FINDINGS

The State of Delaware is required to ensure that the fiscal records at the nursing care facilities are retained and properly support the cost report, or the financial report showing the cost and charges related to Medicaid activities. These costs must be compliant with federal and state regulations. Under the Delaware Medicaid State Plan, the state is required to examine a sample of facilities to ensure the facilities' cost reports, patient days, and nursing wage surveys are compliant.

It is my pleasure to report than an **unqualified opinion*** was issued for this examination and Complete Care at Silver Lake Long-Term Care Facility complied, in all material respects, with the criteria mentioned above. There were total of ten (10) findings issued including eight adjustments and two comments related to the Trial Balance, Patient Days, or Nursing Survey Report that are stated below:

1. The Provider grouped ancillary and rental expense to improper cost centers.
2. The Provider maintains self-insurance for workers compensation and general liability expense. The self-insurance fund is not setup through an independent fiduciary.
3. The Provider did not properly adjust depreciation expense to match depreciation duties.
4. The Provider did not utilize American Hospital Association (AHA) Useful Life Guidelines when calculating depreciation expense on asset additions for the period July 1, 2019 through June 30, 2020.
5. The Provider incorrectly allocated the contra meal accounts, which are used to adjust food and dietary expenses.
6. The Provider submitted related party profit with allowable expense.
7. The Provider's adjustment for allocated home office expense did not account for all required adjustments allowable at the facility.
8. Verified patient days agreed in total but variances between Medicaid, Medicare and Other types were noted.
9. The Provider did not properly calculate total patient days available on the cost report.
10. The Provider did not maintain supporting documentation for patient census information.

*Unqualified Opinion - An unqualified opinion is considered a clean report. An unqualified opinion doesn't have any adverse comments, and it doesn't include any disclaimers about any clauses or the audit process.

# STATE OF DELAWARE
# OFFICE OF AUDITOR OF ACCOUNTS

# INDEPENDENT ACCOUNTANT'S REPORT

**Examination of**
**Complete Care at Silver Lake**
For Fiscal Year Ended June 30, 2020

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

**Independent Accountant's Report**

State of Delaware
Office of Auditor of Accounts
401 Federal Street
Dover, DE 19901

Department of Health and Social Services
Division of Medicaid and Medical Assistance
Medicaid's Long Term Care Facilities
1901 N. Dupont Highway, Lewis Building
New Castle, DE 19720

| | |
|---|---|
| Provider: | Complete Care at Silver Lake |
| Period: | Fiscal Year Ended June 30, 2020 |

We have examined management's assertions that Complete Care at Silver Lake (Provider) has complied with federal requirements (42 Code of Federal Regulations [CFR] 447.253 and 483 Subpart B) and state requirements (Title XIX Delaware Medicaid State Plan, Attachment 4.19D) (criteria), as applicable, relative to the Provider's fiscal records of the Department of Health and Social Services (DHSS), Division of Social Services, Medicaid Long-Term Care Facilities' Statement of Reimbursement Costs for Skilled and Intermediate Care Nursing Facilities – Title XIX and Nursing Wage Survey (cost report and survey, respectively) for the fiscal year ended June 30, 2020. The Provider's management is responsible for the assertions and the information contained in the cost report and survey, which were reported to DHSS for purposes of the criteria described above. The criteria was used to prepare the Schedule of Adjustments to the Trial Balance, Patient Days, and Nursing Wage Survey. Our responsibility is to express an opinion on the assertions based on our examination.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to our engagement.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to attestation engagements contained in *Governmental Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether management's assertions are in accordance with the criteria in all material respects. An examination includes performing procedures to obtain evidence about management's assertions. The nature, timing, and extent of the procedures selected depend on our professional judgment, including an assessment of the risks of material misstatement of management's assertions, whether due to fraud or error. We believe the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

The accompanying Schedule of Adjustments to the Trial Balance, Patient Days, and Nursing Wage Survey were prepared from information contained in the Provider's cost report for the purpose of complying with the DHSS's requirements for the Medicaid program reimbursement, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

The items listed as adjustments on the accompanying Schedule of Adjustments to the Trial Balance, Patient Days, and Nursing Wage Survey do not materially impact the Provider's assertion.

In our opinion, management's assertions, referred to above, are presented in accordance with the criteria, in all material respects.

In accordance with *Government Auditing Standards*, we also issued our report dated January 5, 2024 on our consideration of the Provider's internal control over reporting for the cost report and survey and our tests of its compliance with certain provisions of laws, regulations, contracts and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting and compliance. That report is an integral part of an examination performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our examination.

This report is intended solely for the information and use of the State of Delaware Office of Auditor of Accounts, DHSS, Division of Medicaid and Medical Assistance, and Medicaid's Long Term Care Facilities and is not intended to be and should not be used by anyone other than the specified parties. However, under 29 Del. C. §10002, this report is public record and its distribution is not limited. This report, as required by statute, was provided to the Office of the Governor, the Office of the Controller General, the Office of the Attorney General, the General Assembly, and the Office of Management and Budget.

Myers and Stauffer LC
Owings Mills, Maryland
January 5, 2024

| Complete Care at Silver Lake<br>Schedule of Adjustments to the Trial Balance for the Fiscal Year Ending June 30, 2020 | | | | |
|---|---|---|---|---|
| **Type of Cost** | **Description** | **Reported Amounts** | **Adjustment Amounts** | **Adjusted Amounts** |
| **Expenses** | | | | |
| **Primary Patient Care Costs per Trial Balance of Costs** | | $ 3,840,849 | | |
| | **Adjustments to Primary Patient Care Costs** | | | |
| **8** | To remove related party profit related to career staffing | | $ (8,461) | |
| **11** | To properly reflect verified health and workers compensation insurance | | $ 1,825 | |
| **Net Primary Patient Care Costs** | | **$ 3,840,849** | **$ (6,636)** | **$ 3,834,213** |
| **Primary Patient Care Cost Per Day (*)** | | **$ 98.9** | **$ (0.2)** | **$ 97.0** |
| | | | | |
| **Secondary Patient Care Costs per Trial Balance of Costs** | | $ 573,269 | | |
| | **Adjustments to Secondary Patient Care Costs** | | | |
| **1** | To reclassify ancillary Rx expense to the proper cost center | | $ (8,597) | |
| **7** | To reclassify a portion of the provider's submitted meal recovery against the proper cost center | | $ (15,031) | |
| **11** | To properly reflect verified health and workers compensation insurance | | $ 90 | |
| **Net Secondary Patient Care Costs** | | **$ 573,269** | **$ (23,538)** | **$ 549,731** |
| **Secondary Patient Care Cost Per Day (*)** | | **$ 14.8** | **$ (0.6)** | **$ 13.9** |
| | | | | |
| **Support Service Costs per Trial Balance of Costs** | | $ 1,529,761 | | |
| | **Adjustments to Support Service Costs** | | | |
| **2** | To reclassify rental expense to the proper cost center | | $ (3,477) | |
| **7** | To reclassify a portion of the provider's submitted meal recovery against the proper cost center | | $ 14,949 | |
| **11** | To properly reflect verified health and workers compensation insurance | | $ 138 | |
| **Net Support Service Costs** | | **$ 1,529,761** | **$ 11,610** | **$ 1,541,371** |
| **Support Service Cost Per Day (*)** | | **$ 39.4** | **$ 0.3** | **$ 39.0** |
| | | | | |
| **Administrative & Routine Costs per Trial Balance of Costs** | | $ 2,182,015 | | |
| | **Adjustments to Administrative & Routine Costs** | | | |
| **3** | To reclassify rental expense to the proper cost center | | $ (7,701) | |
| **4** | To adjust general liability insurance expense based on the Medicare Cost Report | | $ (29,328) | |
| **9** | To remove related party profit related to physician services | | $ (2,587) | |
| **10** | To reflect verified home office passdown expense | | $ 5,587 | |
| **11** | To properly reflect verified health and workers compensation insurance | | $ 289 | |
| **Net Administrative & Routine Costs** | | **$ 2,182,015** | **$ (33,740)** | **$ 2,148,275** |
| **Administrative & Routine Cost Per Day (*)** | | **$ 56.2** | **$ (0.9)** | **$ 54.3** |

**(*) Adjusted Cost Per Day is calculated utilizing days at minimum occupancy.**

| Complete Care at Silver Lake<br>Schedule of Adjustments to the Trial Balance for the Fiscal Year Ending June 30, 2020 | | | | |
|---|---|---|---|---|
| **Type of Cost** | **Description** | **Reported Amounts** | **Adjustment Amounts** | **Adjusted Amounts** |
| **Expenses** | | | | |
| **Capital Costs per Trial Balance of Costs** | | $ 623,609 | | |
| | **Adjustments to Capital Costs** | | | |
| **2** | To reclassify rental expense to the proper cost center | | $ 3,477 | |
| **3** | To reclassify rental expense to the proper cost center | | $ 7,701 | |
| **5** | To reflect verified depreciation expense | | $ (98,561) | |
| **6** | To reflect verified fixed assets useful lives | | $ 4,192 | |
| **10** | To reflect verified home office passdown expense | | $ 1,546 | |
| **Net Capital Costs** | | **$ 623,609** | **$ (81,645)** | **$ 541,964** |
| **Net Capital Cost Per Day (*)** | | **$ 16.1** | **$ (2.1)** | **$ 13.7** |
| | | | | |
| **Ancillary Costs per Trial Balance of Costs** | | $ 740,104 | | |
| | **Adjustments to Ancillary Costs** | | | |
| **1** | To reclassify ancillary Rx expense to the proper cost center | | $ 8,597 | |
| **Net Ancillary Costs** | | **$ 740,104** | **$ 8,597** | **$ 748,701** |
| **Ancillary Cost Per Day (*)** | | **$ 19.1** | **$ 0.2** | **$ 18.9** |
| | | | | |
| **Other Costs per Trial Balance of Costs** | | $ 7,866 | | |
| | **Adjustments to Other Costs** | | | |
| | None | | $ - | |
| **Net Other Costs** | | **$ 7,866** | **$ -** | **$ 7,866** |
| **Other Cost Per Day (*)** | | **$ 0.2** | **$ -** | **$ 0.2** |

**(*) Adjusted Cost Per Day is calculated utilizing days at minimum occupancy.**

| Complete Care at Silver Lake<br>Schedule of Adjustments to Patient Days for the Fiscal Year Ending June 30, 2020 | | | | |
|---|---|---|---|---|
| **Census Type** | **Description** | **Reported Amounts** | **Adjustment Amounts** | **Adjusted Amounts** |
| **Census** | | | | |
| **Bed days available** | | | | 43,920 |
| **Medicaid Non-Super Skilled Patient Days** | | 33,000 | | |
| | Adjustments to Medicaid Patient Days | | (1) | |
| **Medicaid Super Skilled Patient Days** | | - | | |
| | Adjustments to Medicaid Super Skilled Patient Days | | - | |
| **Medicare Patient Days** | | 4,151 | | |
| | Adjustments to Medicare Patient Days | | (7) | |
| **Private Pay Patient Days** | | 1,456 | | |
| | Adjustments to Private Pay Patient Days | | - | |
| **Medicare/Private Pay Hospice Patient Days** | | 96 | | |
| | Adjustments to Medicare/Private Pay Hospice Patient Days | | - | |
| **Other Patient Days** | | 133 | | |
| | Adjustments to Other Patient Days | | 8 | |
| **Total Patient Days** | | **38,836** | **-** | **38,836** |
| **Minimum Occupancy** | | | | **39,528** |

| Complete Care at Silver Lake<br>Schedule of Adjustments to the Nursing Wage Survey for the Fiscal Year Ending June 30, 2020 | | | | |
|---|---|---|---|---|
| **Nurse Type** | **Description** | **Reported Amounts** | **Adjustment Amounts** | **Adjusted Amounts** |
| **Nursing Wage Survey** | | | | |
| **II-A Administrative Nurses** | | | | |
| | Director of Nursing - Total Payroll | $ 4,230 | $ - | **$ 4,230** |
| | Director of Nursing - Total Hours | 80.0 | - | **80.0** |
| | Assistant Director of Nursing - Total Payroll | $ 3,402 | $ - | **$ 3,402** |
| | Assistant Director of Nursing - Total Hours | 80.0 | - | **80.0** |
| | Registered Nurses - Total Payroll | $ 9,740 | $ - | **$ 9,740** |
| | Registered Nurses - Total Hours | 240.0 | - | **240.0** |
| | Licensed Practical Nurses - Total Payroll | $ - | $ - | **$ -** |
| | Licensed Practical Nurses - Total Hours | - | - | **-** |
| | Nurse Aides - Total Payroll | $ - | $ - | **$ -** |
| | Nurse Aides - Total Hours | - | - | **-** |
| **II-B All Remaining Nursing Staff** | | | | |
| | Registered Nurses - Total Payroll | $ 40,121 | $ - | **$ 40,121** |
| | Registered Nurses - Total Hours | 1,112.1 | - | **1,112.1** |
| | Licensed Practical Nurses - Total Payroll | $ 26,988 | $ - | **$ 26,988** |
| | Licensed Practical Nurses - Total Hours | 1,036.8 | - | **1,036.8** |
| | Nurse Aides - Total Payroll | $ 51,601 | $ - | **$ 51,601** |
| | Nurse Aides - Total Hours | 3,421.2 | - | **3,421.2** |

**Commentary**

**1)** The provider calculated bed days available based on 365 days instead of the leap year count of 366.

**2)** The provider did not support the 17 in-house days across 11 patients, payer source for 10 patients and Medicaid eligibility for four patients.

**Independent Accountant's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Examination of Financial Statements Performed in Accordance With *Government Auditing Standards***

State of Delaware
Office of Auditor of Accounts
401 Federal Street
Dover, DE 19901

Department of Health and Social Services
Division of Medicaid and Medical Assistance
Medicaid's Long Term Care Facilities
1901 N. Dupont Highway, Lewis Building
New Castle, DE 19720

We have examined management's assertions that Complete Care at Silver Lake (Provider) has complied with federal requirements (42 Code of Federal Regulations [CFR] 447.253 and 483 Subpart B) and state requirements (Title XIX Delaware Medicaid State Plan, Attachment 4.19D), as applicable, relative to the Provider's fiscal records of the Department of Health and Social Services (DHSS), Division of Social Services, Medicaid Long-Term Care Facilities' Statement of Reimbursement Costs for Skilled and Intermediate Care Nursing Facilities – Title XIX and Nursing Wage Survey (cost report and survey, respectively) for the fiscal year ended June 30, 2020, and have issued our report thereon dated January 5, 2024. We conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to financial examinations contained in *Government Auditing Standards*, issued by the Comptroller General of the United States of America.

**Internal Control Over Reporting**

In planning and performing our examination, we considered the Provider's internal control over financial reporting in order to determine our examination procedures for the purpose of expressing our opinions on management's assertions, but not for the purposes of expressing an opinion on the effectiveness of the Provider's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over financial reporting.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency or combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of the cost report or survey will not be prevented, or detected and corrected on a timely basis. *A significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies or material weaknesses. We

did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

**Compliance and Other Matters**

As part of obtaining reasonable assurance about whether the Provider's cost report and survey are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of reported amounts. However, providing an opinion on compliance with those provisions was not an objective of our examination, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

**Purpose of this Report**

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Provider's internal control or on compliance. This report is an integral part of an examination performed in accordance with *Government Auditing Standards* in considering the Provider's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

This report is intended solely for the information and use of the State of Delaware Office of Auditor of Accounts, DHSS, Division of Medicaid and Medical Assistance, and Medicaid's Long Term Care Facilities and is not intended to be and should not be used by anyone other than the specified parties. However, under 29 Del. C. §10002, this report is public record and its distribution is not limited. This report, as required by statute, was provided to the Office of the Governor, the Office of the Controller General, Office of the Attorney General, the General Assembly, and the Office of Management and Budget.

Myers and Stauffer LC
Owings Mills, Maryland
January 5, 2024

**Findings and Responses**

| | |
|---|---|
| **Finding 20-01** | **Adjustment Number(s) Impacted: 1, 2, and 3** |
| Condition: | The Provider grouped ancillary and rental expense to improper Cost Centers. |
| Criteria: | State of Delaware Department of Health and Social Services Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Facilities provides descriptions by cost center line on the appropriate grouping of expense. Equipment rental expense and ancillary expenditures are to be grouped to the capital and ancillary cost centers, respectively. |
| Cause: | Management's working trial balance account grouping to the cost report does not align with the requirements in the Medicaid cost report instructions. |
| Effect: | Management did not properly group expense resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the ancillary and capital cost centers are understated while the secondary, support services, and administrative cost centers are overstated. |
| Recommendation: | Management should submit expenses on the Medicaid cost report in accordance with account groupings identified in the State of Delaware Department of Health and Social Services Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Facilities. |
| Management's Response: | Management did not provide a response. |

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|---|---|
| **Finding 20-02** | **Adjustment Number(s) Impacted: 4 and 11** |
| Condition: | The Provider maintains self insurance for workers compensation and general liability insurance expense. The self insurance fund is not setup through an independent fiduciary. |
| Criteria: | Provider Reimbursement Manual 15-1, Chapter 21, Section 2161 requires the self insurance fund to be setup through a third party independent fiduciary to allow fund contributions. In lieu of fund contributions, actual claims paid for the cost report period can be submitted as expense. |
| Cause: | The Provider does not meet the requirements to be considered a self insured program. A cost report adjustment was not proposed to properly adjust accrued expense for workers compensation and general liability insurance to claims paid. |
| Effect: | Management does not qualify as self insured under Provider Reimbursement Manual 15-1, Chapter 21, Section 2161 resulting in adjustment to claims paid and a compliance finding. The calculated reimbursement rate submitted on the cost report for the Primary, Secondary, and Support Service cost centers are understated while the Administrative cost center is overstated. |
| Recommendation: | Management should ensure insurance expense is submitted in accordance with applicable regulations when completing the State of Delaware Medicaid Cost Report. |
| Management's Response: | Management did not provide a response. |

**Finding 20-03** **Adjustment Number(s) Impacted: 5**

Condition: The Provider did not properly adjust depreciation expense to match depreciation schedules.

Criteria: Provider Reimbursement Manual 15-1, Chapter 10, Section 110 (A) (2) when SNF enters into a sale and leaseback agreement on or after October 23, 1992, or in the case of other providers, when the conditions in subsection A are not met, and the agreement is with a nonrelated purchaser involving plant facilities or equipment, the amount that may be included as rental or lease expense may not exceed the amount that the provider would have included in its allowable costs had the provider retained legal title to the facility or equipment (i.e., the costs of ownership). The costs of ownership include items such as interest expense on mortgages, taxes, depreciation, and insurance costs.

Cause: When calculating allowable depreciation expense for the sale and leaseback agreement, the Provider did not correctly recalculate depreciation from depreciation schedules.

Effect: Management did not accurately reduce lease expense to costs of ownership on the cost report resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the capital cost center is overstated.

Recommendation: Management should utilize the most current and accurate documentation when calculating allowable lease expense to submit on the State of Delaware Medicaid Cost Report.

Management's Response: Management did not provide a response.

**Finding 20-04** **Adjustment Number(s) Impacted: 6**

Condition: The Provider did not utilize American Hospital Association (AHA) Useful Life Guidelines when calculating depreciation expense on asset additions for the period July 1, 2019 through June 30, 2020.

Criteria: Provider Reimbursement Manual 15-1, Chapter 1, Section 104.17 requires the AHA Useful Life Guidelines to be used for estimated useful life of an asset for all assets acquired on or after January 1, 1981.

Cause: Management's capitalization policy and submitted depreciation expense does not align with AHA guidelines.

Effect: Submitted depreciation expense was not calculated in accordance with AHA guidelines for estimated useful life of an asset resulting in a compliance finding. The calculated administrative and routine cost center reimbursement rate is overstated.

Recommendation: Management should ensure that AHA Useful Life Guidelines are used when submitting depreciation expense for all assets on the State of Delaware Medicaid Cost Report.

Management's Response: Management did not provide a response.

**Finding 20-05** **Adjustment Number(s) Impacted: 7**

Condition: The Provider incorrectly allocated the contra meal accounts, which are used to adjust food and dietary expenses.

Criteria: Provider Reimbursement Manual 15-1, Chapter 23, Section 2300 requires that cost data for allocations must be based on an approved method of cost finding and on the accrual basis of accounting.

Cause: The Provider did not utilize the correct working trial balance accounts in the allocation of contra meal accounts to the food and dietary cost centers.

Effect: Management did not correctly allocate expense resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the secondary cost center is overstated while the support service cost center is understated.

Recommendation: Management should utilize the coded working trial balance accounts when calculating the allocation of costs on the State of Delaware Medicaid Cost Report.

Management's Response: Management did not provide a response.

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|---|---|
| **Finding 20-06** | **Adjustment Number(s) Impacted: 8 and 9** |
| Condition: | The Provider submitted related party profit with allowable expense. |
| Criteria: | Provider Reimbursement Manual 15-1, Chapter 10, Section 1000 states costs applicable to services, facilities, and supplies furnished to the Provider by organizations related to the Provider by common ownership or control are includable in the allowable cost of the Provider at the cost to the related organization. |
| Cause: | Management determined two entities, Genesis CareerStaff and Genesis Physician Services, qualified under the related party exception. Both failed to meet either the first qualifier of being a bona fide separate organization or having a substantial part of the related party's business activity of the type carried on with the provider transacted with other organizations not related to the Provider. |
| Effect: | Management did not remove related party profit from expense resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the primary and the administrative and routine cost centers are overstated. |
| Recommendation: | Management should ensure related party expenses are submitted in accordance with appropriate regulations when completing the State of Delaware Medicaid Cost Report. |
| Management's Response: | Management did not provide a response. |

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|---|---|
| **Finding 20-07** | **Adjustment Number(s) Impacted: 10** |
| Condition: | The Provider's adjustment for allocated home office expense did not account for all required adjustments allowable at the facility. |
| Criteria: | Provider Reimbursement Manual 15-1, Chapter 21, Section 2150 requires Home office costs that are not otherwise allowable costs when incurred directly by the Provider cannot be allowable as home office costs to be allocated to providers. |
| Cause: | Non-allowable portion of case manager salaries was submitted with allowable expense, bonus salaries were not included on the home office costs statement, and interest expense related to Genesis Healthcare of Maine was not directly allocated. |
| Effect: | Management included non-allowable marketing salaries, direct interest expense and did not include bonus salaries, resulting in a compliance finding. -The calculated reimbursement rate submitted on the cost report for the administrative and routine and the capital cost centers are |
| Recommendation: | Management should submit home office costs in accordance with appropriate regulations. |
| Management's Response: | Management did not provide a response. |

| | |
|---|---|
| **Finding 20-08** | **Schedule of Adjustments to Patient Days** |
| Condition: | Verified patient days agreed in total but variances between Medicaid, Medicare, and Other payer types were noted. |
| Criteria: | State of Delaware Department of Health and Social Services Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Facilities provides descriptions by census line on the appropriate classification of patient days. Line 5D should reflect total Medicaid patient days, Line 5F should reflect Medicare patient days (excluding hospice days), and Line 5I should reflect any other patient days that do not fit on another line. |
| Cause: | Management did not utilize a finalized census when preparing the cost report as payer classification variances existed. |
| Effect: | Management did not properly group patient days resulting in a compliance finding. |
| Recommendation: | Management should utilize a finalized census to accurately report patient days on the State of Delaware Medicaid Cost Report. |
| Management's Response: | Management did not provide a response. |

| | |
|---|---|
| **Finding 20-09** | **Comment Number(s) Impacted: 1** |
| Condition: | The Provider did not properly calculate total patient days available on the cost report. |
| Criteria: | Delaware Medicaid Nursing Facility Cost Report instructions Patient Days section requires line 4 of Page 6 Patient Days reflect total bed days available for the year. This is determined by multiplying the number of available beds by the number of days in the reporting period. |
| Cause: | Management calculated bed days available based on 365 days rather than 366 actual days in the reporting period. |
| Effect: | Management did not properly calculate total patient days available resulting in a compliance finding. The calculated reimbursement rates submitted on the cost report for all cost centers are overstated. |
| Recommendation: | Management should ensure that all calculated fields are accurate on the State of Delaware Medicaid Cost Report prior to submission. |
| Management's Response: | Management did not provide a response. |

| | |
|---|---|
| **Finding 20-10** | **Comment Number(s) Impacted: 2** |
| Condition: | The Provider did not maintain supporting documentation for patient census information. |
| Criteria: | The Medicaid Cost Report for Nursing Facilities should be supported by a trial balance and necessary schedules. The Facility should have internal controls in place to ensure that the trial balance and schedules be available for audit within the State of Delaware by the Medicaid Agency or its designated representative for a period of five years after the date of filing of the Medicaid Cost Report with the Medicaid Agency. |
| Cause: | The facility changed ownership outside of the cost report period and all patient related documents transferred to the new owner New management was unable to access the requested patient records related to the cost report period. |
| Effect: | Management was unable to provide the detail support for patient census data recorded on the Cost Report, resulting in a compliance finding. Not being able to support the number of patient days could result in an adjustment that would affect the Facility's calculated reimbursement rate. |
| Recommendation: | Management should ensure they have internal controls in place to comply with requirement to keep supporting data for a period of five years. |
| Management's Response: | Management did not provide a response. |