PINNACLE REHABILITATION AND CARE CENTER

EXAMINATION
FISCAL YEAR ENDED JUNE 30, 2020

PINNACLE REHAB AND CARE CENTER

REPORT SUMMARY FOR FISCAL YEAR ENDED JUNE 30, 2020

BACKGROUND

An examination of Pinnacle Rehabilitation and Care Center 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 Pinnacle Rehabilitation and Care Center 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

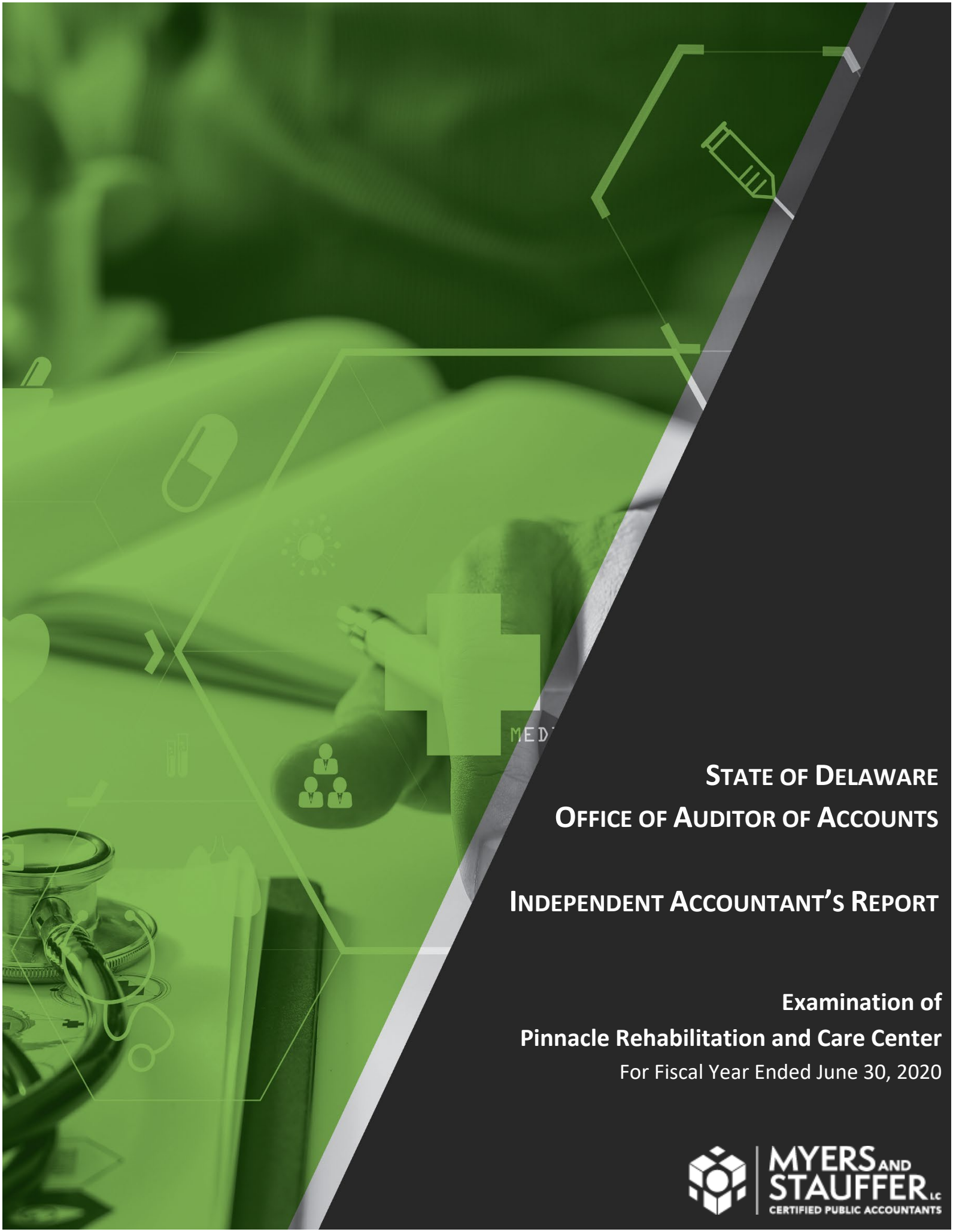
The State of Delaware is required to ensure that the fiscal records at the nursing care facilities are retained and properly support the cost report, or the financial report showing the cost and charges related to Medicaid activities. These costs must be compliant with federal and state regulations. Under the Delaware Medicaid State Plan, the state is required to examine a sample of facilities located within the state 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. Pinnacle Rehabilitation and Care Center Long-Term Care Facility complied, in all material respects, with the criteria mentioned above. There were a total of five (5) findings issued including four adjustments and one comment to the Trial Balance, Patient Days, or Nursing Survey Report that are stated below:

1. The Provider grouped ancillary prescription drugs and rental equipment expense to improper cost centers.
2. The Provider included non-allowable personal patient use telephone and cable television expense with reimbursable cost.
3. The Provider included non-allowable administrative meal expense with reimbursable cost.
4. The Provider maintains a self-insured health insurance plan. The self-insurance fund is not setup through an independent fiduciary.
5. The Provider did not properly calculate total bed days available on the cost report.

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

*Qualified Opinion - The auditor believes, on the basis of his or her audit, that the financial statements contain a departure from generally accepted accounting principles, the effect of which is material, and he or she has concluded not to express an adverse opinion.



STATE OF DELAWARE
OFFICE OF AUDITOR OF ACCOUNTS

INDEPENDENT ACCOUNTANT'S REPORT

Examination of
Pinnacle Rehabilitation and Care Center
For Fiscal Year Ended June 30, 2020

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

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: Pinnacle Rehabilitation and Care Center
Period: Fiscal Year Ended June 30, 2020

We have examined management's assertions that Pinnacle Rehabilitation and Care Center (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 April 2, 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
April 2, 2024

Pinnacle Rehabilitation and Care Center Schedule of Adjustments to the Trial Balance for the Fiscal Year Ended June 30, 2020				
Type of Cost	**Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Expenses				
Primary Patient Care Costs per Trial Balance of Costs		$ 5,431,043		
	Adjustments to Primary Patient Care Costs			
7	To reflect the verified worker's compensation expense		$ 9,104	
8	To remove employee life insurance benefits as undocumented		$ (18,219)	
9	To reflect the verified health insurance expense		$ 25,176	
Net Primary Patient Care Costs		**$ 5,431,043**	**$ 16,061**	**$ 5,447,104**
Primary Patient Care Cost Per Day (*)		**$ 107.3**	**$ 0.3**	**$ 107.7**
Secondary Patient Care Costs per Trial Balance of Costs		$ 914,331		
	Adjustments to Secondary Patient Care Costs			
1	To reclassify prescription drug expense to the proper cost center		$ (5,626)	
5	To reclassify rental expense to the proper cost center		$ (5,964)	
6	To reclassify rental expense to the proper cost center		$ (4,835)	
7	To reflect the verified worker's compensation expense		$ 260	
8	To remove employee life insurance benefits as undocumented		$ (521)	
9	To reflect the verified health insurance expense		$ 719	
Net Secondary Patient Care Costs		**$ 914,331**	**$ (15,967)**	**$ 898,364**
Secondary Patient Care Cost Per Day (*)		**$ 18.1**	**$ (0.3)**	**$ 17.8**
Support Service Costs per Trial Balance of Costs		$ 2,072,216		
	Adjustments to Support Service Costs			
7	To reflect the verified worker's compensation expense		$ 1,848	
8	To remove employee life insurance benefits as undocumented		$ (3,699)	
9	To reflect the verified health insurance expense		$ 5,111	
Net Support Service Costs		**$ 2,072,216**	**$ 3,260**	**$ 2,075,476**
Support Service Cost Per Day (*)		**$ 41.0**	**$ 0.1**	**$ 41.0**
Administrative & Routine Costs per Trial Balance of Costs		$ 2,585,591		
	Adjustments to Administrative & Routine Costs			
2	To remove non-allowable telephone expense related to patient use		$ (22,649)	
4	To remove non-allowable administrative staff meal expense		$ (7,770)	
7	To reflect the verified worker's compensation expense		$ 1,817	
8	To remove employee life insurance benefits as undocumented		$ (3,637)	
9	To reflect the verified health insurance expense		$ 5,025	
Net Administrative & Routine Costs		**$ 2,585,591**	**$ (27,214)**	**$ 2,558,377**
Administrative & Routine Cost Per Day (*)		**$ 51.1**	**$ (0.5)**	**$ 50.6**

(*) Adjusted Cost Per Day is calculated utilizing actual patient days.

Pinnacle Rehabilitation and Healthcare Center Schedule of Adjustments to the Trial Balance for the Fiscal Year Ended June 30, 2020				
Type of Cost	**Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Expenses				
Capital Costs per Trial Balance of Costs		$ 3,286,049		
	Adjustments to Capital Costs			
3	To remove non-allowable cable tv expense related to patient use		$ (13,824)	
5	To reclassify rental expense to the proper cost center		$ 5,964	
6	To reclassify rental expense to the proper cost center		$ 4,835	
Net Capital Costs		**$ 3,286,049**	**$ (3,025)**	**$ 3,283,024**
Net Capital Cost Per Day (*)		**$ 65.0**	**$ (0.1)**	**$ 64.9**
Ancillary Costs per Trial Balance of Costs		$ 1,585,046		
	Adjustments to Ancillary Costs			
1	To reclassify prescription drug expense to the proper cost center		$ 5,626	
Net Ancillary Costs		**$ 1,585,046**	**$ 5,626**	**$ 1,590,672**
Ancillary Cost Per Day (*)		**$ 31.3**	**$ 0.1**	**$ 31.4**
Other Costs per Trial Balance of Costs		$ -		
	Adjustments to Other Costs			
	None		$ -	
Net Other Costs		**$ -**	**$ -**	**$ -**
Other Cost Per Day (*)		**$ -**	**$ -**	**$ -**

(*) Adjusted Cost Per Day is calculated utilizing actual patient days.

Pinnacle Rehabilitation and Care Center Schedule of Adjustments to Patient Days for the Fiscal Year Ended June 30, 2020				
Census Type	**Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Census				
Bed days available				**55,266**
Medicaid Non-Super Skilled Patient Days		38,194		
	Adjustments to Medicaid Patient Days		-	
Medicaid Super Skilled Patient Days		-		
	Adjustments to Medicaid Super Skilled Patient Days		-	
Medicare Patient Days		8,579		
	Adjustments to Medicare Patient Days		-	
Private Pay Patient Days		3,289		
	Adjustments to Private Pay Patient Days		-	
Medicare/Private Pay Hospice Patient Days		52		
	Adjustments to Medicare/Private Pay Hospice Patient Days		-	
Other Patient Days		478		
	Adjustments to Other Patient Days		-	
Total Patient Days		**50,592**	**-**	**50,592**
Minimum Occupancy				**49,739**

Pinnacle Rehabilitation and Care Center Schedule of Adjustments to the Nursing Wage Survey for the Fiscal Year Ended June 30, 2020				
Nurse Type	**Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Nursing Wage Survey				
II-A Administrative Nurses				
	Director of Nursing - Total Payroll	$ 4,442	$ -	**$ 4,442**
	Director of Nursing - Total Hours	88.0	-	**88.0**
	Assistant Director of Nursing - Total Payroll	$ 3,808	$ -	**$ 3,808**
	Assistant Director of Nursing - Total Hours	88.0	-	**88.0**
	Registered Nurses - Total Payroll	$ 21,819	$ -	**$ 21,819**
	Registered Nurses - Total Hours	522.0	-	**522.0**
	Licensed Practical Nurses - Total Payroll	$ 3,132	$ -	**$ 3,132**
	Licensed Practical Nurses - Total Hours	96.3	-	**96.3**
	Nurse Aides - Total Payroll	$ 3,339	$ -	**$ 3,339**
	Nurse Aides - Total Hours	170.0	-	**170.0**
II-B All Remaining Nursing Staff				
	Registered Nurses - Total Payroll	$ 20,539	$ -	**$ 20,539**
	Registered Nurses - Total Hours	564.0	-	**564.0**
	Licensed Practical Nurses - Total Payroll	$ 70,551	$ -	**$ 70,551**
	Licensed Practical Nurses - Total Hours	2,257.8	-	**2,257.8**
	Nurse Aides - Total Payroll	$ 67,951	$ -	**$ 67,951**
	Nurse Aides - Total Hours	4,226.8	-	**4,226.8**

Commentary

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

2) Medicaid **c**redit balances were noted in accounts receivable. These balances remain open as of report date.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 Pinnacle Rehabilitation and Care Center (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 April 2, 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
April 2, 2024

Findings and Responses

Finding 20-01	**Adjustment Number(s) Impacted: 1, 5, and 6**
Condition:	The Provider grouped ancillary prescription drugs and rental equipment 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 for the appropriate grouping of expense. Ancillary prescription drugs and rental equipment expense should be grouped to the ancillary and capital 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 cost center is 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.
Finding 20-02	**Adjustment Number(s) Impacted: 2 and 3**
Condition:	The Provider included non-allowable personal patient use telephone and cable television expense with reimbursable cost.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 21, Section 2106.1 requires the removal from allowable costs any costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients.
Cause:	Non-allowable expenses were submitted with allowable costs on the State of Delaware Medicaid Cost Report.
Effect:	Management did not properly address non-allowable expense resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the administrative and capital cost centers are overstated.
Recommendation:	Management should submit cost report expense in accordance with appropriate regulations.
Management's Response:	Management did not provide a response.
Finding 20-03	**Adjustment Number(s) Impacted: 4**
Condition:	The Provider included non-allowable administrative meal expense with reimbursable cost.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 21, Section 2105.5 requires the removal from allowable cost any costs incurred by providers for meals served to executives or management employees in excess of the costs of meals served to ordinary employees.
Cause:	Non-allowable expenses were submitted with allowable costs on the State of Delaware Medicaid Cost Report.
Effect:	Management did not properly address non-allowable expense resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the administrative cost center is overstated.
Recommendation:	Management should submit cost report expense in accordance with appropriate regulations.
Management's Response:	Management did not provide a response.

Finding 20-04	**Adjustment Number(s) Impacted: 8**
Condition:	The Provider maintains a self-insured health insurance plan. 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 health insurance to claims paid and administration fees.
Effect:	The health insurance plan does not qualify as self insured under Provider Reimbursement Manual 15-1, Chapter 21, Section 2161, resulting in a compliance finding. Adjustment was proposed to reflect allowable expense of claims paid and administrative fees. The calculated reimbursement rates submitted on the cost report for the Primary, Secondary, Support Service, and Administrative cost center are understated.
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 20-05	**Comment Number(s) Impacted: 1**
Condition:	The Provider did not properly calculate total bed 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 the proper number of days in the year is used when calculating bed days available when preparing the State of Delaware Medicaid Cost Report prior to submission.
Management's Response:	Management did not provide a response.