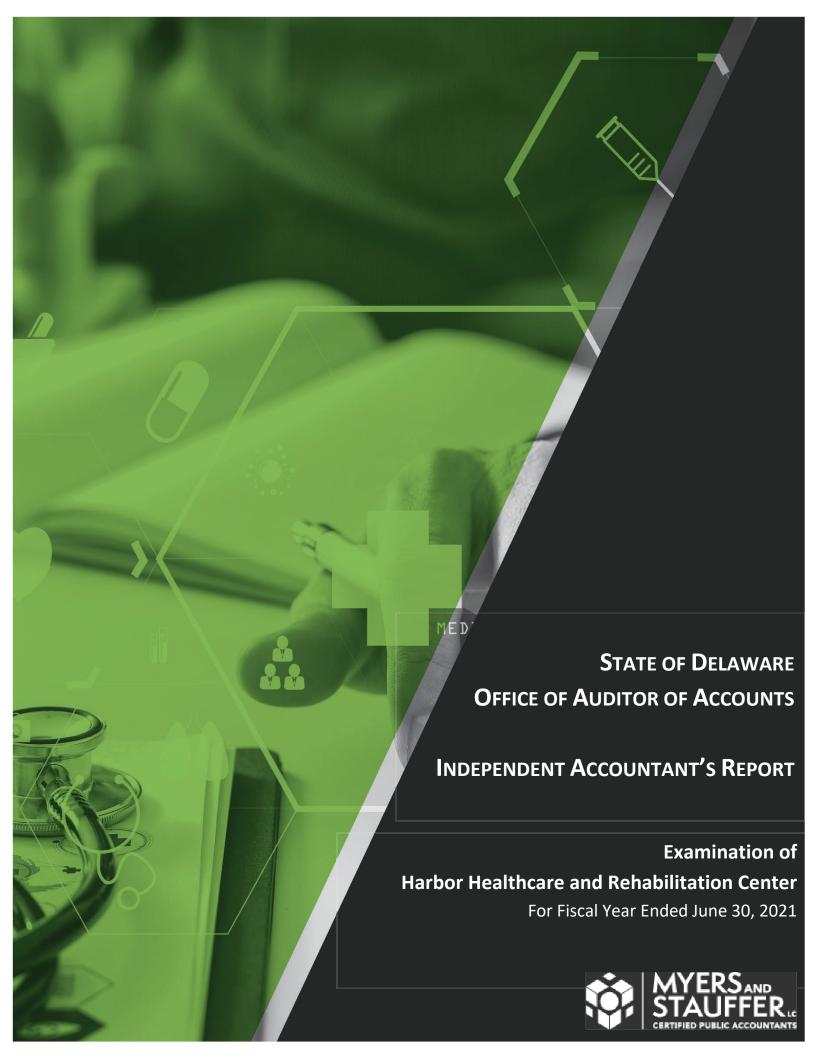


EXAMINATION FISCAL YEAR ENDED JUNE 30, 2021



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## **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: Harbor Healthcare and Rehabilitation Center

Period: Fiscal Year Ended June 30, 2021

We have examined management's assertions that Harbor Healthcare and Rehabilitation 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, 2021. 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 March 25, 2025 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

Myers and Stauffer LC

March 25, 2025

			Demonted		alia akan a ak		Aultrophysia
Type of Cost	Description	Reported Amounts		Adjustment Amounts		Adjusted Amounts	
Expenses							
Primary Patient Ca	are Costs per Trial Balance of Costs	\$	5,569,077				
	Adjustments to Primary Patient Care Costs						
3	To reclassify nursing sanitation expense to the proper cost center			\$	(4,554)		
4	To reclassify nursing data processing expense to the proper cost center			\$	(2,381)		
5	To reclassify ancillary medical transportation expense to the proper cost center			\$	(10,636)		
9	To adjust the benefits allocation based on verified workers compensation expense			\$	12,861		
Net Primary Patie	nt Care Costs	\$	5,569,077	\$	(4,710)	\$	5,564,367
Primary Patient Ca	are Cost Per Day (*)	\$	120.4	\$	(0.1)	\$	94.6
Secondary Patient	Care Costs per Trial Balance of Costs	\$	768,567				
	Adjustments to Secondary Patient Care Costs						
3	To reclassify nursing sanitation expense to the proper cost center			\$	4,554		
4	To reclassify nursing data processing expense to the proper cost center			\$	2,381		
6	To reclassify ancillary supplies expense to the proper cost center			\$	(4,070)		
9	To adjust the benefits allocation based on verified workers compensation expense			\$	561		
Net Secondary Pat	ient Care Costs	\$	768,567	\$	3,426	\$	771,993
Secondary Patient	Care Cost Per Day (*)	\$	16.6	\$	0.1	\$	13.1
Sunnort Service Co	osts per Trial Balance of Costs	\$	1.605.208				
ouppoint service of	Adjustments to Support Service Costs	Ţ	1,003,208				
9	To adjust the benefits allocation based on verified workers compensation expense			Ś	2,470		
Net Support Servi		\$	1,605,208	Ś	2,470	Ś	1,607,678
Support Service Co		\$	34.7	-	0.0	\$	27.3
Administrative & F	Routine Costs per Trial Balance of Costs	\$	2,533,216				
	Adjustments to Administrative & Routine Costs						
8	To adjust general liability and property insurance to the verified amount			\$	(48,180)		
9	To adjust the benefits allocation based on verified workers compensation expense			\$	2,721		
10	To remove related party management fees			\$	(722,603)		
Net Administrativ	e & Routine Costs	\$	2,533,216	\$	(768,062)	\$	1,765,154
Administrative & F	Routine Cost Per Day (*)	\$	54.8	ė	(13.1)	ė	30.0

<sup>(\*)</sup> Adjusted Cost Per Day is calculated utilizing days at minimum occupancy.

	Harbor Healthcare and Rehabilit Schedule of Adjustments to the Trial Balance for the			30, 2021	
Type of Cost	Description		Reported Adjustment Amounts Amounts		Adjusted Amounts
Expenses					
Capital Costs per T	rial Balance of Costs	\$	2,129,006		
	Adjustments to Capital Costs				
1	To reclassify ancillary lease expense to the proper cost center			\$ (39,966)	
2	To remove related party rent expense			\$ 136,567	
7	To remove unsupported real estate tax expense			\$ (5,336)	
8	To adjust general liability and property insurance to the verified amount			\$ 52,944	
Net Capital Costs		\$	2,129,006	\$ 144,209	\$ 2,273,215
Net Capital Cost Po	er Day (*)	\$	46.0	\$ 2.5	\$ 38.7
Ancillary Costs per	Trial Balance of Costs	\$	997,078		
	Adjustments to Ancillary Costs				
1	To reclassify ancillary lease expense to the proper cost center			\$ 39,966	
5	To reclassify ancillary medical transportation expense to the proper cost center			\$ 10,636	
6	To reclassify ancillary supplies expense to the proper cost center			\$ 4,070	
Net Ancillary Costs	3	\$	997,078	\$ 54,672	\$ 1,051,750
Ancillary Cost Per	Day (*)	\$	21.6	\$ 0.9	\$ 17.9
Other Costs per Tr	ial Balance of Costs	\$	151		
	Adjustments to Other Costs				
	None			\$ -	
Net Other Costs			151	\$ -	\$ 15:
Other Cost Per Day (*)			0.0	\$ -	\$ 0.0

<sup>(\*)</sup> Adjusted Cost Per Day is calculated utilizing days at minimum occupancy.

		Reported	Adjustment	Adjusted
Census Type	e Description	Amounts	Amounts	Amounts
Census				
Bed days available				65,33
Medicaid Non-Super	Skilled Patient Days	34,714		
	Adjustments to Medicaid Patient Days		(180)	
Medicaid Super Skille	d Patient Days			
	Adjustments to Medicaid Super Skilled Patient Days		-	
Medicare Patient Day	rs	5,780		
	Adjustments to Medicare Patient Days		73	
Private Pay Patient D	ays	2,520		
	Adjustments to Private Pay Patient Days		179	
Medicare/Private Pay	Hospice Patient Days	-		
	Adjustments to Medicare/Private Pay Hospice Patient Days		-	
Other Patient Days		3,250		
	Adjustments to Other Patient Days		67	
Total Patient Days		46,264	139	46,40
Minimum Occupancy				58,80

Harbor Healthcare and Rehabilitation Center Schedule of Adjustments to the Nursing Wage Survey for the Fiscal Year Ending June 30, 2021					
Nurse Type	Description		Reported Amounts	Adjustment Amounts	Adjusted Amounts
Nursing Wage Su	rvey				
I-A Administrati	ive Nurses				
	Director of Nursing - Number Paid		1	-	
	Director of Nursing - Total Payroll	\$	4,178	\$ -	\$ 4,1
	Director of Nursing - Total Hours		80.0	-	8
	Assistant Director of Nursing - Number Paid		1	-	
	Assistant Director of Nursing - Total Payroll	\$	6,552	\$ -	\$ 6,5
	Assistant Director of Nursing - Total Hours		141.5	-	14
	Registered Nurses - Number Paid		3	-	
	Registered Nurses - Total Payroll	\$	10,835	\$ -	\$ 10,8
	Registered Nurses - Total Hours		239.5	-	23
	Licensed Practical Nurses - Number Paid		-	-	
	Licensed Practical Nurses - Total Payroll	\$	-	\$ -	\$
	Licensed Practical Nurses - Total Hours		-	-	
	Nurse Aides - Number Paid		-	-	
	Nurse Aides - Total Payroll	\$	-	\$ -	\$
	Nurse Aides - Total Hours		-	-	
B All Remainin	g Nursing Staff				
	Registered Nurses - Number Paid		16	-	
	Registered Nurses - Total Payroll	\$	46,710	\$ -	\$ 46,7
	Registered Nurses - Total Hours		1,148.4	-	1,14
	Licensed Practical Nurses - Number Paid		16	-	
	Licensed Practical Nurses - Total Payroll	\$	44,208	\$ -	\$ 44,2
	Licensed Practical Nurses - Total Hours		1,313.2	-	1,31
	Nurse Aides - Number Paid		60	-	
	Nurse Aides - Total Payroll	\$	91,770	\$ 100	\$ 91,8
	Nurse Aides - Total Hours		4.090.2		4,09

## Harbor Healthcare and Rehabilitation Center Resident Fund and General Commentary for the Fiscal Year Ending June 30, 2021

#### Commentary

- $\textbf{1)} \ \text{The provider did not support any of the sampled resident funds disbursements}.$
- $\textbf{2)} \ \textbf{Accounts payable related to assumed liabilities from the previous ownership were unpaid.}$



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 Harbor Healthcare and Rehabilitation 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, 2021, and have issued our report thereon dated March 25, 2025. 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 instances of noncompliance detailed on the schedule of findings that warrant the attention of those charged with governance. These findings do not materially impact the Provider's assertion and are not 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

Myers and Stauffer LC

Owings Mills, Maryland March 25, 2025

#### Harbor Healthcare and Rehabilitation Center Schedule of Findings for the Fiscal Year Ending June 30, 2021

#### **Findings and Responses**

Finding 21-01	Adjustment Number(s) Impacted: 1, 3, 4, 5, and 6

Condition: The provider grouped nursing sanitation and data processing, ancillary lease, ancillary transportation, and ancillary supplies expenses to improper cost centers.

The State of Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Criteria: Facilities provides descriptions, by cost center line, for the appropriate grouping of expense. Nursing sanitation and data processing, ancillary lease, ancillary

transportation, and ancillary supplies expenses are to be grouped to the secondary and ancillary cost centers, respectively.

Management's working trial balance account grouping to the cost report does not align with the requirements in the Medicaid cost report instructions. Cause:

Management did not properly group expenses, resulting in a compliance finding. The calculated reimbursement rates submitted on the cost report for the Effect:

secondary and ancillary cost centers are understated while the primary and capital cost center rates 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 agrees with adjustments 3, 4, and 5; however, a change of ownership occurred on 10/1/2024 and we no longer own the provider.

Management disagrees with adjustments 1 and 6, as they believe the cost center should contain the cost of actual oxygen, not the equipment used to distribute

Per Provider Reimbursement Manual 15-1, Chapter 22, Section 2203.2, the direct ancillary service (oxygen) and the associated cost to deliver the ancillary service Auditor's Response:

should be classified as ancillary expense. Some expenses could be utilized in both an ancillary or non-ancillary capacity; however, the invoices provided detailed the specific patient the oxygen was ordered for. Since the expense was directly billable to a patient, we believe the ancillary classification is appropriate.

Under the Delaware State Plan Attachment 4.19-D, Facility rates for the four non-primary components of secondary, support, administrative, and capital are computed from annual provider cost report data on reimbursable costs. Reimbursable costs are defined to be those that are allowable based on Medicare

principles, according to HIM 15. As such, we are required to follow Medicare principles for defining allowable costs.

Finding 21-02 Adjustment Number(s) Impacted: 2

Condition: The provider did not submit accurate costs of ownership of the facility.

Provider Reimbursement Manual 15-1, Chapter 10, Section 1011.5 requires rent paid to the related party lessor by the provider be deemed not allowable cost. The Criteria:

provider, however, would include in its costs the actual costs of ownership of the facility.

A cost report adjustment was proposed to properly disallow related party rent and replace disallowed cost with the actual costs of ownership of the facility.

However, management did not calculate depreciation accurately.

Effect: Management did not accurately submit costs related to the realty company on the cost report, resulting in a compliance finding. The calculated reimbursement

rate submitted on the cost report for the capital cost center is understated.

Management should ensure accuracy of the working trial balance used to complete the State of Delaware Medicaid Cost Report. Recommendation:

Management's Response:

Management agrees with the adjustments; however, a change of ownership occurred on 10/1/2024 and we no longer own the provider.

Finding 21-03 Adjustment Number(s) Impacted: 7

Condition: The provider did not provide supporting documentation for one general ledger entry on one account.

Criteria: The State of Delaware Department of Health and Social Services Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Facilities states that 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: Management was not able to locate supporting documentation within their systems.

Management was unable to provide supporting documentation, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report Effect:

for the capital cost center is overstated.

Recommendation: Management should ensure that internal control policies over record retention are in place to comply with the five year record retention requirement.

Management's Response:

 $Management\ agrees\ with\ the\ adjustments;\ however,\ a\ change\ of\ ownership\ occurred\ on\ 10/1/2024\ and\ we\ no\ longer\ own\ the\ provider.$ 

Finding 21-04 Adjustment Number(s) Impacted: 8

Condition: The provider included insurance expense incurred outside of the cost report period and grouped property insurance expense to improper cost centers.

Criteria: Provider Reimbursement Manual 15-1. Chapter 23. Section 2302.1 requires that, under the accrual basis of accounting, expenditures for expense and asset items

be recorded in the period in which they are incurred, regardless of when they are paid.

The 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, of the appropriate grouping of expense. General liability and property insurance expense should be grouped

under the administrative and routine and capital cost centers, respectively.

Cause: A cost report adjustment was not proposed to properly adjust accrued expense for insurance to premiums paid during the cost report period.

Management did not properly address expenses incurred outside of the cost report period and did not properly group expense, resulting in a compliance finding. Effect:

The calculated reimbursement rate submitted on the cost report for the administrative and routine cost center is overstated while the capital cost center rate is

understated.

Recommendation: Management should review submitted cost report expense to ensure they are appropriate when completing the State of Delaware Medicaid Cost Report.

Management's Response:

Management agrees with the adjustments; however, a change of ownership occurred on 10/1/2024 and we no longer own the provider.

Finding 21-05 Adjustment Number(s) Impacted: 9

Condition: The provider improperly allocated fringe benefits expense on the cost report.

Criteria: Provider Reimbursement Manual 15-1, Chapter 21, Section 2144.7 states that some accounting systems are not designed to accumulate, on a departmentalized or

cost center basis, the various employee fringe benefits incurred by the providers. Such providers may accumulate fringe benefits for all employees in one account

during the cost reporting period and allocate fringe benefits to the appropriate cost centers.

Cause: A cost report adjustment was not proposed to properly adjust accrued expense for workers compensation to premiums paid during the cost report period.

Effect: Management did not properly allocate fringe benefits expense, resulting in a compliance finding. The calculated reimbursement rates submitted on the cost report

for the primary, secondary, support service, and administrative and routine cost centers are understated.

Management should utilize accurate documentation when allocating fringe benefits expense on the State of Delaware Medicaid Cost Report. Recommendation:

Management's Response

Management agrees with the adjustments; however, a change of ownership occurred on 10/1/2024 and we no longer own the provider.

Finding 21-06 Adjustment Number(s) Impacted: 10

Condition: The provider did not disallow related party management fees and did not submit a home office cost statement for fees.

Criteria: Provider Reimbursement Manual 15-1, Chapter 21, Section 2153 requires a provider in a chain to furnish a detailed home office cost statement as a basis for reimbursing the provider for home office costs and equity capital. If a provider or the home office does not furnish a home office cost statement then home office

costs need to be removed.

During the cost report preparation stage, management did not believe the management company equated to a home office under Provider Reimbursement

Manual 15-1, Chapter 21, Section 2150. However, per the management agreement, control exists and multiple related facilities are also under the agreement.

Management did not complete and submit a home office cost statement, resulting in a compliance finding. The calculated reimbursement rate submitted on the Effect:

cost report for the administrative and routine cost center is overstated.

Management should complete a home office cost statement for the related party management company on an annual basis. Recommendation:

Management's Response:

Management disagrees with the adjustment. Auditor contends that Medicare Home Office cost report should be completed because related party. Management contends that each entity is a separate operator. Medicare has not addressed this and has not requested a Home Office cost report.

Auditor's Response: Per review of Buena Vista's management agreement, control exists over the Harbor Healthcare facility with a similar management agreement in place at the Parkview facility. Under Provider Reimbursement Manual 15-1, Chapter 21, Section 2150, a chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization.

> Under Provider Reimbursement Manual 15-1, Chapter 21, Section 2153, the home office cost statement constitutes the documentary support required of the provider to be reimbursed for home office costs and equity capital in the provider's cost report. With no home office cost statement available we believe the removal of expense is required.

> Under the Delaware State Plan Attachment 4.19-D, facility rates for the four non-primary components of secondary, support, administrative, and capital are computed from annual provider cost report data on reimbursable costs. Reimbursable costs are defined to be those that are allowable based on Medicare principles, according to HIM 15. As such, we are required to follow Medicare principles for defining allowable costs.

Whether or not the Medicare intermediaries have addressed the above is not relevant as it does not change the requirement in 4.19-D to follow the above Medicare Principles

Finding 21-07 Schedule of Adjustments to Patient Days

Condition: Verified patient days do not match the total submitted on the cost report. Classification variances between Medicaid, Medicare, Private, and Other payer types

were noted.

The State of Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Criteria: Facilities provides descriptions, by census line, on the appropriate classification of patient days. Line 5D should reflect Medicaid patient days, Line 5F should reflect

Medicare patient days (excluding hospice days), Line 5G should reflect total Private patient 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 report total patient days and 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 agrees with the adjustments; however, a change of ownership occurred on 10/1/2024 and we no longer own the provider.

Finding 21-08 Schedule of Adjustments to the Nursing Wage Survey

Condition: The provider improperly recorded total pay for non-administrative nurses aides on the nursing wage survey.

Criteria: The State of Delaware Department of Health and Social Services Division of Medicaid and Medical Assistance Instructions for Completion of Nursing Home:

Nursing Wage Survey provides instructions by occupational group on the appropriate grouping of total number of staff, total pay, and total hours. Total number of

staff, total pay, and total hours for non-administrative nurses aides are to be included in Section II.B.

Cause: Total pay recorded on the nursing wage survey did not align with the requirements in the nursing wage survey instructions.

Effect: Management did not properly group total pay, resulting in a compliance finding. The calculated total pay for non-administrative nurses aides was understated on

the nursing wage survey.

Management should submit total pay on the nursing wage survey in accordance with the State of Delaware Department of Health and Social Services, Division of Recommendation:

Medicaid and Medical Assistance Instructions for Completion of Nursing Home: Nursing Wage Survey.

Management's Response:

Management agrees with the adjustments; however, a change of ownership occurred on 10/1/2024 and we no longer own the provider.

Finding 21-09 Comment Number(s) Impacted: 1

Condition: The provider did not provide supporting documentation for sampled patient funds disbursements.

Under CFR 483.10 (f) (10) (iii) Patient Rights, the facility must establish and maintain a system that assures full, complete, and separate accounting, according to Criteria:

generally accepted accounting principles (GAAP), of each resident's personal funds entrusted to the facility on the resident's behalf.

Cause: Management asserted that the supporting documentation for the sampled patient fund disbursements were no longer available.

Management was not able to confirm the establishment and maintenance of full, complete, and separate accounting for patient personal funds.

Recommendation: Management should ensure that internal controls over patient funds are followed, including maintenance of a full, complete, and separate accounting in

accordance with GAAP

Management's Response:

 $Management \ agrees \ with \ the \ adjustments; \ however, \ a \ change \ of \ ownership \ occurred \ on \ 10/1/2024 \ and \ we \ no \ longer \ own \ the \ provider.$