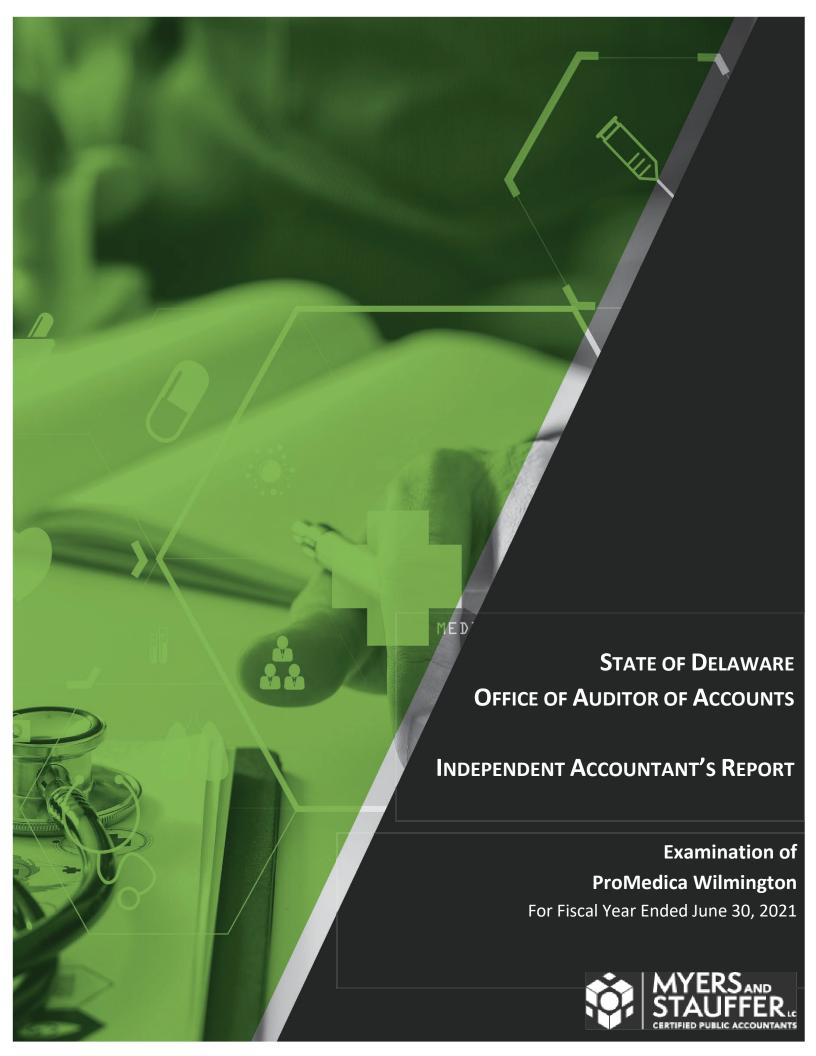


FISCAL YEAR ENDED JUNE 30, 2021



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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: **ProMedica Wilmington** 

Period: Fiscal Year Ended June 30, 2021

We have examined management's assertions that ProMedica Wilmington (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 dated 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

ProMedica Wilmington						
Type of Cost	Schedule of Adjustments to the Trial Balance for the F  Description		Reported Amounts			Adjusted Amounts
Expenses						
	are Costs per Trial Balance of Costs	\$	5,993,472			
rilliary ratient Ca	Adjustments to Primary Patient Care Costs	Ş	3,333,472			
2	To reclassify nursing repairs expense to the proper cost center			\$ (5	411)	
7	To properly allocate vacation, sick, and holiday based on verified salaries				571)	
8	To properly allocate vacation, sick, and holiday based on verified salaries				813)	
9	To reclassify nursing minor equipment expense to the proper cost center				295)	
12	To adjust workers compensation to claims paid during the cost report period				505	
13	To adjust health insurance to claims paid during the cost report period			\$ (143		
Net Primary Patie		Ś	5.993.472		092) \$	5,796,38
	are Cost Per Day (*)		152.2			3,790,381
Primary Patient Ca	sie Cost Fei Day ( )	\$	152.2	3	(4.3) \$	127.:
Secondary Patient	Care Costs per Trial Balance of Costs	\$	814,831			
	Adjustments to Secondary Patient Care Costs					
2	To reclassify nursing repairs expense to the proper cost center			\$ 5	411	
3	To reclassify IV therapy supplies expense to the proper cost center			\$ (9	705)	
4	To reclassify IV purchased services expense to the proper cost center				287)	
5	To remove non-allowable psychiatric purchased service expense				600)	
7	To properly allocate vacation, sick, and holiday based on verified salaries			\$	95	
8	To properly allocate benefits based on verified salaries			\$	351	
9	To reclassify nursing minor equipment expense to the proper cost center			\$ 30	295	
10	To reclassify oxygen expense to the proper cost center				347)	
12	To adjust workers compensation to claims paid during the cost report period			\$	120	
13	To adjust health insurance to claims paid during the cost report period			-	917)	
Net Secondary Pat	<del></del>	\$	814,831		416 \$	816,24
	Care Cost Per Day (*)	Ś	20.7	-	0.0 \$	18.0
,			-			
Support Service Co	osts per Trial Balance of Costs	\$	1,495,175			
	Adjustments to Support Service Costs					
1	To remove non-allowable portion of cable television expense			\$ (10	934)	
7	To properly allocate vacation, sick, and holiday based on verified salaries			\$	597	
8	To properly allocate benefits based on verified salaries			\$ 2	197	
12	To adjust workers compensation to claims paid during the cost report period			\$	572	
13	To adjust health insurance to claims paid during the cost report period			\$ (23	414)	
Net Support Service	ce Costs	\$	1,495,175	\$ (30	982) \$	1,464,193
Support Service Co	ost Per Day (*)	\$	38.0	\$	(0.7) \$	32.3
Administrative & I	Routine Costs per Trial Balance of Costs	\$	2,351,147			
	Adjustments to Administrative & Routine Costs					
7	To properly allocate vacation, sick, and holiday based on verified salaries				418	
8	To properly allocate benefits based on verified salaries				572	
11	To adjust general liability insurance to claims paid during the cost report period			\$ (154		
12	To adjust workers compensation to claims paid during the cost report period			\$	606	
13	To adjust health insurance to claims paid during the cost report period			-	795)	
Net Administrative	e & Routine Costs	\$	2,351,147		222) \$	2,188,92
Administrative & I	Routine Cost Per Day (*)	\$	59.7	\$	(3.6) \$	48.

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

	ProMedica Wilmingto Schedule of Adjustments to the Trial Balance for the		Ending June 30	), 2021	
Type of Cost	Description		Reported Amounts	Adjustment Amounts	Adjusted Amounts
Expenses					
Capital Costs per	Trial Balance of Costs	\$	501,845		
	Adjustments to Capital Costs				
6	To reclassify ancillary lease expense to the proper cost center			\$ (20,109)	
14	To adjust the home office expense to the verified amount			\$ 2,742	
Net Capital Costs		\$	501,845	\$ (17,367)	\$ 484,478
Net Capital Cost P	er Day (*)	\$	12.7	\$ (0.4)	\$ 10.7
Ancillary Costs pe	r Trial Balance of Costs	\$	1,648,226		
	Adjustments to Ancillary Costs				
3	To reclassify IV therapy supplies expense to the proper cost center			\$ 9,705	
4	To reclassify IV purchased services expense to the proper cost center			\$ 6,287	
6	To reclassify ancillary lease expense to the proper cost center			\$ 20,109	
7	To properly allocate vacation, sick, and holiday based on verified salaries			\$ 461	
8	To properly allocate benefits based on verified salaries			\$ 1,693	
10	To reclassify oxygen expense to the proper cost center			\$ 10,347	
12	To adjust workers compensation to claims paid during the cost report period			\$ 809	
13	To adjust health insurance to claims paid during the cost report period			\$ (33,103)	
Net Ancillary Cost	s	\$	1,648,226	\$ 16,308	\$ 1,664,534
Ancillary Cost Per	Ancillary Cost Per Day (*)			\$ 0.4	\$ 36.7
Other Costs ner T	rial Balance of Costs	\$	3,378		
coots per 1	Adjustments to Other Costs	7	3,378		
	None			\$ -	
Net Other Costs			3,378		\$ 3,378
Other Cost Per Day (*)			0.1		\$ 0.1

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

ProMedica Wilmington Schedule of Adjustments to Patient Days for the Fiscal Year Ending June 30, 2021						
Census Type	Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts		
Census						
Bed days available				50,37		
Medicaid Non-Supe	er Skilled Patient Days	24,755				
	Adjustments to Medicaid Patient Days		(606)			
Medicaid Super Ski	lled Patient Days	-				
	Adjustments to Medicaid Super Skilled Patient Days					
Medicare Patient Days		11,539				
	Adjustments to Medicare Patient Days					
Private Pay Patient	Days	1,695				
	Adjustments to Private Pay Patient Days		-			
Medicare/Private Pay Hospice Patient Days		705				
	Adjustments to Medicare/Private Pay Hospice Patient Days		-			
Other Patient Days		686				
	Adjustments to Other Patient Days		-			
Total Patient Days		39,380	(606)	38,77		
Minimum Occupan	cy			45,33		

	Schedule of Adjustments to the Nursing Wage S	divey for the ristar	rear Ename Jun	C 30, 2021	
Nurse Type	Description		Reported Amounts	Adjustment Amounts	Adjusted Amounts
Nursing Wage Su	rvey				
II-A Administrati	ve Nurses				
	Director of Nursing - Number Paid		1	-	
	Director of Nursing - Total Payroll	\$	3,449	\$ -	\$ 3,44
	Director of Nursing - Total Hours		80.0	-	80.
	Assistant Director of Nursing - Number Paid		-	-	-
	Assistant Director of Nursing - Total Payroll	\$	-	\$ -	\$ -
	Assistant Director of Nursing - Total Hours		-	-	-
	Registered Nurses - Number Paid		7	-	
	Registered Nurses - Total Payroll	\$	24,030	\$ -	\$ 24,03
	Registered Nurses - Total Hours		552.4	-	552.
	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		-	-	-
II-B All Remainin	g Nursing Staff				
	Registered Nurses - Number Paid		16	-	1
	Registered Nurses - Total Payroll	\$	55,655	\$ -	\$ 55,65
	Registered Nurses - Total Hours		1,245.9	-	1,245.
	Licensed Practical Nurses - Number Paid		18	-	1
	Licensed Practical Nurses - Total Payroll	\$	53,976	\$ -	\$ 53,97
	Licensed Practical Nurses - Total Hours		1,439.1	-	1,439.
	Nurse Aides - Number Paid		34	-	3
	Nurse Aides - Total Payroll	\$	56,529	\$ -	\$ 56,52
	Nurse Aides - Total Hours		2,672.2	-	2,672.

# ProMedica Wilmington Resident Fund and General Commentary for the Fiscal Year Ending June 30, 2021

Commentary

None.



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 ProMedica Wilmington (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

Owings Mills, Maryland

Myers and Stauffer LC

March 25, 2025

#### ProMedica Wilmington Schedule of Findings for the Fiscal Year Ending June 30, 2021

Findings and Responses

Finding 21-01 Adjustment Number(s) Impacted: 1

Condition: The provider included non-allowable personal patient use 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 are furnished solely for the personal comfort of the patients.

Non-allowable expenses were submitted with allowable costs on the State of Delaware Medicaid Cost Report. Cause:

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 support service cost center is overstated.

Recommendation: Management should submit cost report expense in accordance with appropriate regulations.

Management's Response:

Management agrees with the proposed adjustments; however, regarding responses related to the adjustments, we no longer own these providers. It should most likely be brought to the attention of the new operators for proper reporting for June 30, 2025.

Finding 21-02 Adjustment Number(s) Impacted: 2, 3, 4, 6, 9, and 10

Condition: The provider grouped nursing repairs and minor equipment, IV purchased services and supplies, oxygen, and ancillary lease expenses 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. Nursing repairs and minor equipment, IV purchased services and supplies, oxygen, and ancillary lease expense 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

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

the secondary and ancillary cost centers are understated while the primary and capital 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:

Cause:

Management agrees with the proposed adjustments; however, regarding responses related to the adjustments, we no longer own these providers. It

should most likely be brought to the attention of the new operators for proper reporting for June 30, 2025.

Finding 21-03 Adjustment Number(s) Impacted: 5

Condition: The provider included psychiatric purchased services expense with reimbursable cost.

Criteria: State of Delaware Department of Health and Social Services Division of Medicaid and Medicaid Assistance Medicaid Cost Report Instructions for

Nursing Facilities Basis of Reimbursement states that reasonable cost is determined according to Medicare principles and Delaware Medical

Assistance Program policy, and is subject to state audit and adjustment.

Cause: Management did not ensure that cost removed for Medicare purposes was removed during the preparation of the 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 secondary cost center is overstated.

Management should submit expenses on the Medicaid cost report in accordance with the State of Delaware Department of Health and Social Services Recommendation:

Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Facilities.

Management's Management agrees with the proposed adjustments; however, regarding responses related to the adjustments, we no longer own these providers. It should most likely be brought to the attention of the new operators for proper reporting for June 30, 2025. Response:

Finding 21-04 Adjustment Number(s) Impacted: 7 and 8

Condition: The provider improperly allocated vacation, sick, and holiday expense and employee 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 them to the appropriate cost centers.

Cause: The Provider did not include all salaries and did not consider salary reclassifications when calculating the vacation, sick, and holiday expense and

employee benefits expense allocation.

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

the cost report for the primary cost center is overstated, while the secondary, support service, administrative and routine, and ancillary cost centers

Recommendation: Management should utilize the most current and accurate documentation when allocating fringe benefits expense on the State of Delaware Medicaid

Cost Report.

Management's

Response:

Management agrees with the proposed adjustments; however, regarding responses related to the adjustments, we no longer own these providers. It should most likely be brought to the attention of the new operators for proper reporting for June 30, 2025.

Finding 21-05 Adjustment Number(s) Impacted: 11, 12, and 13

Condition: The provider maintains self insurance for general liability, health, and workers compensation 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 health and workers compensation 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, support service,

administrative and routine, and ancillary cost centers are overstated.

Management should ensure insurance expense is submitted in accordance with applicable regulations when completing the State of Delaware Recommendation:

Medicaid Cost Report.

Management agrees with the proposed adjustments; however, regarding responses related to the adjustments, we no longer own these providers. It Management's Response:

should most likely be brought to the attention of the new operators for proper reporting for June 30, 2025.

Finding 21-06 Adjustment Number(s) Impacted: 14

The provider's cost report adjustment to include allocated home office expense was not calculated properly. Condition:

Criteria: Provider Reimbursement Manual 15-1, Chapter 21, Section 2150 requires that home office costs, which are not otherwise allowable costs when

incurred directly by the provider, cannot be allowable as home office costs to providers.

Cause: The home office expense allocation included non-allowable therapy expenses and failed to adjust workers compensation insurance expense to

reflect actual claims paid.

Effect: Management included non-allowable therapy costs and did not properly submit workers compensation expense, resulting in a compliance finding.

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

Recommendation: Management should submit home office costs in accordance with appropriate regulations.

Management agrees with the proposed adjustments; however, regarding responses related to the adjustments, we no longer own these providers. It Management's Response:

should most likely be brought to the attention of the new operators for proper reporting for June 30, 2025.

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Finding 21-07 Schedule of Adjustments to Patient Days

Condition: Verified patient days do not match the total submitted cost report days. Variances were noted between Medicaid payer types.

State of Delaware Department of Health and Social Services Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Criteria:

Nursing Facilities provides descriptions by census line on the appropriate classification of patient days. Line 5D should reflect total Medicaid patient

days.

Cause: Management did not include a Medicaid payer source when preparing the cost report as total days variances existed.

Effect: Management did not properly report total patient days, resulting in a compliance finding.

Recommendation: Management should include all Medicaid days from the finalized census to accurately report patient days on the State of Delaware Medicaid Cost

Management's Management agrees with the proposed adjustments; however, regarding responses related to the adjustments, we no longer own these providers. It Response:

should most likely be brought to the attention of the new operators for proper reporting for June 30, 2025.