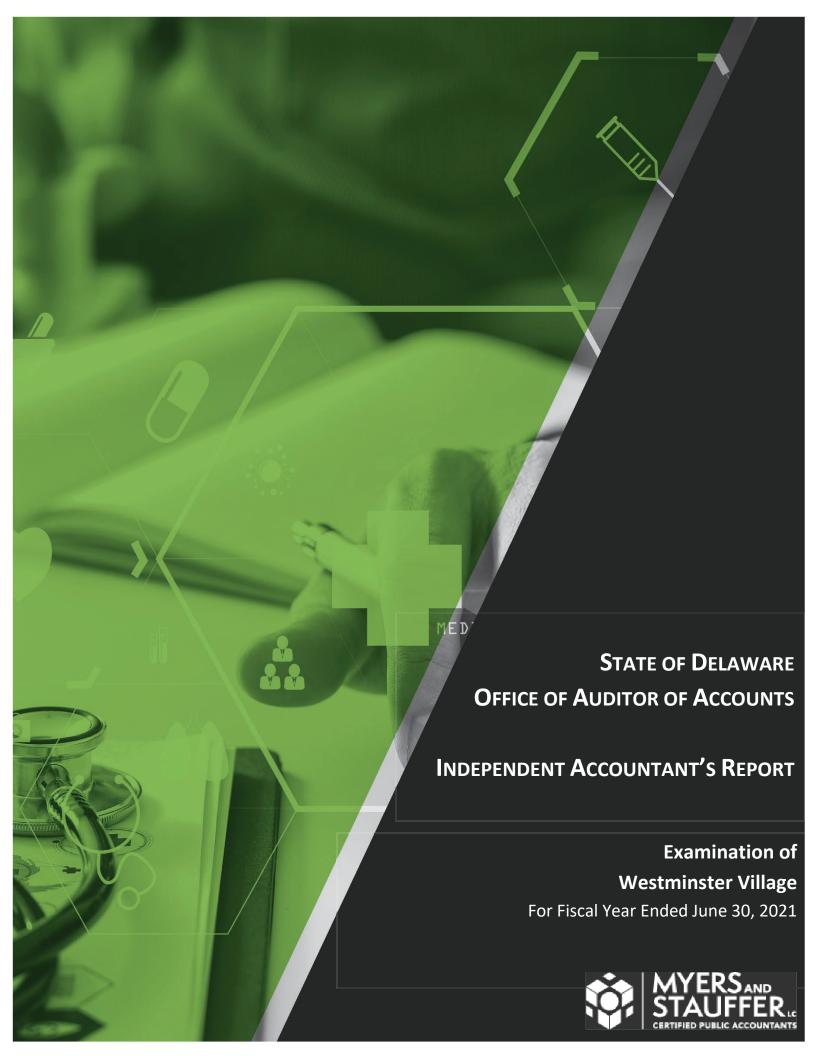


FISCAL YEAR ENDED JUNE 30, 2021



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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: Westminster Village

Period: Fiscal Year Ended June 30, 2021

We have examined management's assertions that Westminster Village (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

		_		_			
Type of Cost	Description	Reported Amounts		Adjustment Amounts		Adjusted Amounts	
Expenses							
Primary Patient C	are Costs per Trial Balance of Costs	\$	3,362,558				
	Adjustments to Primary Patient Care Costs						
5	To adjust the employee benefits reclassification to reflect verified salaries and benefits			\$	(108,910)		
6	To adjust the nursing salary reclassification based on verified statistics and benefits			\$	6,436		
Net Primary Pation	ent Care Costs	\$	3,362,558	\$	(102,474)	\$	3,260,084
Primary Patient C	are Cost Per Day (*)	\$	171.4	\$	(4.2)	\$	132.
Secondary Patien	t Care Costs per Trial Balance of Costs	\$	588,772				
	Adjustments to Secondary Patient Care Costs						
2	To reclassify ancillary expense to the proper cost center			\$	(3,654)		
5	To adjust the employee benefits reclassification to reflect verified salaries and benefits			\$	(3,291)		
Net Secondary Pa	tient Care Costs	\$	588,772	\$	(6,945)	\$	581,82
Secondary Patien	t Care Cost Per Day (*)	\$	30.0	\$	(0.3)	\$	23.0
Support Service (	Costs per Trial Balance of Costs	\$	1.328.865				
	Adjustments to Support Service Costs	Ÿ	1,520,005				
1	To remove non-allowable alcoholic beverages expense			\$	(1,193)		
5	To adjust the employee benefits reclassification to reflect verified salaries and benefits			Ś	(35,223)		
Net Support Service Costs		\$	1.328.865	-	(36,416)	Ś	1.292.44
Support Service (		\$	67.7	\$	(1.5)	-	52.
A dustinint 41 0	Routine Costs per Trial Balance of Costs	Ś	1.988.716				
Administrative &	Adjustments to Administrative & Routine Costs	\$	1,988,716				
2 & 7	To reclassify ancillary expense to the proper cost center			\$	(226,042)		
3	To reverse the contributions expense offset			\$	13.603		
4	To adjust the property insurance reclassification to reflect calculated amounts			Ś	(7.053)		
5	To adjust the employee benefits reclassification to reflect verified salaries and benefits			\$	(21,251)		
6	To adjust the employee benefits reclassification to reflect verified statistics and benefits  To adjust the nursing salary reclassification based on verified statistics and benefits			\$	(6,436)		
8	To remove non-allowable personal resident purchases expense			\$	(1,343)		
9	To remove non-allowable personal resident purchases expense  To remove non-allowable telephone expense related to patient use			\$	(34,611)		
11	To adjust the home office pass down expense to the verified amount			Ś	100,589		
	re & Routine Costs	\$	1,988,716	-	(182,544)	4	1,806,17
Administrative & Routine Costs  Administrative & Routine Cost Per Day (*)		\$	1,588,716		(7.4)	-	73.

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

	Westminster Village Schedule of Adjustments to the Trial Balance for the		ar Ended June	30, 2021		
Type of Cost	Description		Reported Amounts	Adjustment Amounts	Adjusted Amounts	
Expenses						
Capital Costs per	Trial Balance of Costs	\$	804,694			
	Adjustments to Capital Costs					
4	To adjust the property insurance reclassification to reflect calculated amounts			\$ 7,053		
10	To remove non-allowable television expense related to patient use			\$ (11,890)		
Net Capital Costs	<b>i</b>	\$	804,694	\$ (4,837)	\$ 799,857	
Net Capital Cost Per Day (*)		\$	41.0	\$ (0.2)	\$ 32.5	
Ancillary Costs p	er Trial Balance of Costs	\$	1,068,048			
	Adjustments to Ancillary Costs					
2 & 7	To reclassify ancillary expense to the proper cost center			\$ 229,696		
Net Ancillary Costs			1,068,048	\$ 229,696	\$ 1,297,744	
Ancillary Cost Per Day (*)		\$	54.4	\$ 9.3	\$ 52.7	
Other Costs per	Trial Balance of Costs	\$	433			
Other costs per	Adjustments to Other Costs	,	433			
	None			\$ -		
Net Other Costs		\$	433	\$ -	\$ 433	
Other Cost Per Day (*)		\$	0.0		\$ 0.0	

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

Westminster Village Schedule of Adjustments to Patient Days for the Fiscal Year Ended June 30, 2021								
Census Type	Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts				
Census								
Bed days available				27,371				
Medicaid Non-Supe	er Skilled Patient Days	10,221						
	Adjustments to Medicaid Patient Days		-					
Medicaid Super Skil	lled Patient Days							
	Adjustments to Medicaid Super Skilled Patient Days		-					
Medicare Patient D	ays	3,122						
	Adjustments to Medicare Patient Days		-					
Private Pay Patient	Days	6,154						
	Adjustments to Private Pay Patient Days		86					
Medicare/Private P	ay Hospice Patient Days	-						
	Adjustments to Medicare/Private Pay Hospice Patient Days		-					
Other Patient Days		125						
	Adjustments to Other Patient Days		(86)					
Total Patient Days		19,622	-	19,622				
Minimum Occupano	cy			24,634				

Westminster Village Schedule of Adjustments to the Nursing Wage Survey for the Fiscal Year Ended June 30, 2021										
Nurse Type	Description	Reported Amounts		Adjustment Amounts	Adjusted Amounts					
Nursing Wage Survey										
II-A Administrat	tive Nurses									
	Director of Nursing - Number Paid		1	-						
	Director of Nursing - Total Payroll	\$	3,852	\$ -	\$	3,85				
	Director of Nursing - Total Hours		80.0	-		80.				
	Assistant Director of Nursing - Number Paid		1	-						
	Assistant Director of Nursing - Total Payroll	\$	3,680	\$ -	\$	3,68				
	Assistant Director of Nursing - Total Hours		80.0	-		80.				
	Registered Nurses - Number Paid		2	-						
	Registered Nurses - Total Payroll	\$	7,167	\$ -	\$	7,16				
	Registered Nurses - Total Hours		160.0	-		160.				
	Licensed Practical Nurses - Number Paid		1	-						
	Licensed Practical Nurses - Total Payroll	\$	2,411	\$ -	\$	2,41				
	Licensed Practical Nurses - Total Hours		82.0	-		82.				
	Nurse Aides - Number Paid		3	-						
	Nurse Aides - Total Payroll	\$	4,575	\$ -	\$	4,57				
	Nurse Aides - Total Hours		217.5	-		217.				
II-B All Remainii	ng Nursing Staff									
	Registered Nurses - Number Paid		7	\$ -						
	Registered Nurses - Total Payroll	\$	15,258	\$ -	\$	15,25				
	Registered Nurses - Total Hours		378.0	-		378.				
	Licensed Practical Nurses - Number Paid		10	-		1				
	Licensed Practical Nurses - Total Payroll	\$	23,900	\$ -	\$	23,90				
	Licensed Practical Nurses - Total Hours		721.0	-		721.				
	Nurse Aides - Number Paid		34	-		3				
	Nurse Aides - Total Payroll	\$	40,181	\$ -	\$	40,18				
	Nurse Aides - Total Hours		2,139.0			2,139.				

# Westminster Village Resident Fund and General Commentary for the Fiscal Year Ended 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 Westminster Village (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

#### Westminster Village Schedule of Findings for the Fiscal Year Ended June 30, 2021

#### Findings and Responses

Finding 21-01 Adjustment Number(s) Impacted: 1, 8, 9, and 10

Condition: The Provider included non-allowable alcoholic beverages, personal resident purchases, and personal patient use telephone and cable television expense with

reimbursable cost.

Provider Reimbursement Manual 15-1, Chapter 21, Section 2102.3 states that costs not related to patient care are costs which are not appropriate or Criteria:

necessary and proper in developing and maintaining the operation of patient care facilities and activities.

Delaware State Plan Attachment 4.19-D, Section II. C. Excluded Services requires the removal of personal resident purchases from allowable costs.

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 rates submitted on the cost

report for the support service, administrative and routine, and capital cost centers are overstated.

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

Management's Response:

Management will offset these non-allowable expenses going forward.

Finding 21-02 Adjustment Number(s) Impacted: 2 and 7

Condition: The Provider grouped ancillary expenditures 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. Ancillary expenditures are to be grouped to the ancillary cost

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 expenses, resulting in a compliance finding. The calculated reimbursement rates submitted on the cost report for the

secondary and administrative and routine cost centers are overstated while the ancillary cost center is understated.

Management should submit expenses on the Medicaid cost report in accordance with account groupings identified in the State of Delaware Department of Recommendation:

Health and Social Services, Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Facilities.

Management's Response:

Management will properly group expenses going forward.

Finding 21-03 Adjustment Number(s) Impacted: 3

Condition: The Provider improperly recovered contribution revenue on the cost report.

Criteria: Provider Reimbursement Manual 15-1, Chapter 6, Section 600 states that for cost reporting periods beginning on or after October 1, 1983, grants, gifts, and income from endowments, whether or not the donor restricts the use for a specific purpose, are not deducted from a provider's operating costs in computing

Cause: Allowable contribution revenue was offset against operating costs on the State of Delaware Medicaid Cost Report.

Effect: Management recovered contribution revenue, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the

administrative and routine cost center is understated.

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

Management's Response:

Management will discontinue this offset of revenue going forward.

Finding 21-04 Adjustment Number(s) Impacted: 4

The Provider improperly reclassified property insurance on the cost report. Condition:

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. Property insurance expenditures are to be grouped to the capital

The Provider did not utilize the appropriate insurance premium allocations when determining the amount of property insurance to reclassify on the State of Cause:

Delaware Medicaid Cost Report.

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

administrative and routine cost center is overstated while the capital cost center is understated.

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

Management's Response:

Management will estimate property insurance to align with the cost reporting period going forward.

Finding 21-05 Adjustment Number(s) Impacted: 5 and 6

Condition: The Provider improperly allocated employee benefits expense and improperly reclassified nursing salaries 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.

Provider Reimbursement Manual 15-1, Chapter 21, Section 2302.7 states that cost finding is a determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an

operation by the alignment of direct costs and the allocation of indirect costs.

Cause: The Provider included a portion of salaries with benefits when calculating the employee benefits allocation and erroneously carved out a portion of the

Assistant Director of Nursing (ADON) salaries for independent and assisted living when the ADON position is healthcare only.

Effect: Management did not properly allocate fringe benefits expense and did not properly reclassify nursing salaries, 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 overstated.

Recommendation: Management should utilize the most current and accurate documentation when allocating fringe benefits expense and when reclassifying nursing salaries on

the State of Delaware Medicaid Cost Report.

Management's Response:

Management will update the mapping of the ADON to correct this going forward.

Finding 21-06 Adjustment Number(s) Impacted: 11

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

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

the Provider, cannot be considered allowable cost as home office costs to be allocated to providers.

Cause: The home office expense allocation did not include all direct non-capital home office cost and improperly included bulk purchasing rebates as an increase to

Effect: Management did not include all direct non-capital home office cost and improperly included bulk purchasing rebates as an increase to expense resulting in a

compliance finding. The calculated reimbursement rate submitted on the cost report for the administrative and routine cost center is understated.

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

Management's Response:

Management will update the calculation of home office expense going forward.

Finding 21-07 Schedule of Adjustments to Patient Days

Condition: Verified patient days agreed in total but variances between Private Pay and Other were noted.

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 5G should reflect Private Pay patient days and Line 5I

should reflect Other patient days.

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 will save detailed monthly census reports at the time of the cost report submission and perform a reconciliation going forward.