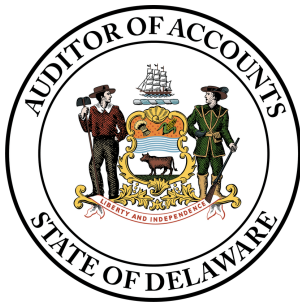




CHURCHMAN VILLAGE

LONG-TERM CARE FACILITY EXAMINATION
FISCAL YEAR ENDED JUNE 30, 2022

**STATE OF DELAWARE
OFFICE OF AUDITOR OF ACCOUNTS**

INDEPENDENT ACCOUNTANT'S REPORT

**Examination of
Churchman Village**
For Fiscal Year Ended June 30, 2022



**MYERS AND
STAUFFER_{LC}**
CERTIFIED PUBLIC ACCOUNTANTS

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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: Churchman Village
Period: Fiscal Year Ended June 30, 2022

We have examined management's assertions that Churchman 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, 2022. 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 December 1, 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

Myers and Stauffer LC
Owings Mills, Maryland
December 1, 2025

Churchman Village
Schedule of Adjustments to the Trial Balance for the Fiscal Year Ending June 30, 2022

Type of Cost	Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Expenses				
Primary Patient Care Costs per Trial Balance of Costs		\$ 4,001,898		
	Adjustments to Primary Patient Care Costs			
5	To reflect the verified Employee Benefits allocation		\$ (2,685)	
6	To reclassify data processing expense to the appropriate cost center		\$ (3,600)	
7	To reclassify medical transportation expense to the appropriate cost center		\$ (22,508)	
9	To reclassify contracted LPN and CNA expense to the appropriate cost center		\$ 1,278	
15	To allocate workers compensation expense to the appropriate cost center		\$ (3,978)	
Net Primary Patient Care Costs		\$ 4,001,898	\$ (31,493)	\$ 3,970,405
Primary Patient Care Cost Per Day (*)		\$ 135.0	\$ (0.9)	\$ 119.7
Secondary Patient Care Costs per Trial Balance of Costs		\$ 630,353		
	Adjustments to Secondary Patient Care Costs			
2	To reclassify nursing supplies expense to the appropriate cost center		\$ 8,830	
5	To reflect the verified Employee Benefits allocation		\$ (83)	
8	To reclassify x-ray, PICC, and ultrasound expense to the appropriate cost center		\$ (21,460)	
9	To reclassify contracted LPN and CNA expense to the appropriate cost center		\$ (1,278)	
10	To remove non-nursing independent living expense		\$ (1,800)	
11	To remove non-nursing independent living expense		\$ (4,273)	
12	To remove non-nursing independent living expense		\$ (19,895)	
15	To allocate workers compensation expense to the appropriate cost center		\$ (123)	
17	To remove expense not paid within one year		\$ (9,331)	
Net Secondary Patient Care Costs		\$ 630,353	\$ (49,413)	\$ 580,940
Secondary Patient Care Cost Per Day (*)		\$ 21.3	\$ (1.5)	\$ 17.5
Support Service Costs per Trial Balance of Costs		\$ 1,359,452		
	Adjustments to Support Service Costs			
3	To reclassify laundry detergent expense to the appropriate cost center		\$ 739	
5	To reflect the verified Employee Benefits allocation		\$ (734)	
15	To allocate workers compensation expense to the appropriate cost center		\$ (1,087)	
Net Support Service Costs		\$ 1,359,452	\$ (1,082)	\$ 1,358,370
Support Service Cost Per Day (*)		\$ 45.9	\$ (0.0)	\$ 40.9
Administrative & Routine Costs per Trial Balance of Costs		\$ 1,985,553		
	Adjustments to Administrative & Routine Costs			
1	To amortize startup expense over the allowable five year period		\$ (3,010)	
2	To reclassify nursing supplies expense to the appropriate cost center		\$ (8,830)	
3	To reclassify laundry detergent expense to the appropriate cost center		\$ (739)	
5	To reflect the verified Employee Benefits allocation		\$ (809)	
6	To reclassify data processing expense to the appropriate cost center		\$ 3,600	
14	To reflect verified general and professional liability insurance expense		\$ (5,153)	
15	To allocate workers compensation expense to the appropriate cost center		\$ (1,198)	
18	To remove non-allowable related party management fees		\$ (530,870)	
Net Administrative & Routine Costs		\$ 1,985,553	\$ (547,009)	\$ 1,438,544
Administrative & Routine Cost Per Day (*)		\$ 67.0	\$ (16.5)	\$ 43.4

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

Churchman Village
Schedule of Adjustments to the Trial Balance for the Fiscal Year Ending June 30, 2022

Type of Cost	Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Expenses				
Capital Costs per Trial Balance of Costs		\$ 1,482,613		
	Adjustments to Capital Costs			
4	To replace related party rent expense with actual property cost		\$ (250,597)	
13	To remove expense not adequately documented		\$ (66,024)	
16	To remove expense not paid within one year		\$ (1,995)	
19	To reclassify ancillary rental expense to the appropriate cost center		\$ (34,689)	
Net Capital Costs		\$ 1,482,613	\$ (353,305)	\$ 1,129,308
Net Capital Cost Per Day (*)		\$ 50.0	\$ (10.6)	\$ 34.0
Ancillary Costs per Trial Balance of Costs		\$ 1,171,581		
	Adjustments to Ancillary Costs			
5	To reflect the verified Employee Benefits allocation		\$ 4,404	
7	To reclassify medical transportation expense to the appropriate cost center		\$ 22,508	
8	To reclassify x-ray, PICC, and ultrasound expense to the appropriate cost center		\$ 21,460	
15	To allocate workers compensation expense to the appropriate cost center		\$ (478)	
19	To reclassify ancillary rental expense to the appropriate cost center		\$ 34,689	
Net Ancillary Costs		\$ 1,171,581	\$ 82,583	\$ 1,254,164
Ancillary Cost Per Day (*)		\$ 39.5	\$ 2.5	\$ 37.8
Other Costs per Trial Balance of Costs		\$ 99,555		
	Adjustments to Other Costs			
5	To reflect the verified Employee Benefits allocation		\$ (93)	
15	To allocate workers compensation expense to the appropriate cost center		\$ (139)	
Net Other Costs		\$ 99,555	\$ (232)	\$ 99,323
Other Cost Per Day (*)		\$ 3.4	\$ (0.0)	\$ 3.0

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

Churchman Village Schedule of Adjustments to Patient Days for the Fiscal Year Ending June 30, 2022				
Census Type	Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Census				
Bed days available				36,865
Medicaid Non-Super Skilled Patient Days		16,144		
	Adjustments to Medicaid Patient Days		104	
Medicaid Super Skilled Patient Days		-		
	Adjustments to Medicaid Super Skilled Patient Days		-	
Medicare Patient Days		9,750		
	Adjustments to Medicare Patient Days		97	
Private Pay Patient Days		3,115		
	Adjustments to Private Pay Patient Days		140	
Medicare/Private Pay Hospice Patient Days		-		
	Adjustments to Medicare/Private Pay Hospice Patient Days		-	
Other Patient Days		637		
	Adjustments to Other Patient Days		(374)	
Total Patient Days		29,646	(33)	29,613
Minimum Occupancy				33,179

Churchman Village Schedule of Adjustments to the Nursing Wage Survey for the Fiscal Year Ending June 30, 2022				
Nurse Type	Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Nursing Wage Survey				
II-A Administrative Nurses				
	Director of Nursing - Number Paid	1	-	1
	Director of Nursing - Total Payroll	\$ 4,498	\$ -	\$ 4,498
	Director of Nursing - Total Hours	80.0	-	80.0
	Assistant Director of Nursing - Number Paid	1	-	1
	Assistant Director of Nursing - Total Payroll	\$ 4,206	\$ -	\$ 4,206
	Assistant Director of Nursing - Total Hours	80.0	-	80.0
	Registered Nurses - Number Paid	3	-	3
	Registered Nurses - Total Payroll	\$ 9,112	\$ -	\$ 9,112
	Registered Nurses - Total Hours	210.0	-	210.0
	Licensed Practical Nurses - Number Paid	1	-	1
	Licensed Practical Nurses - Total Payroll	\$ 2,536	\$ -	\$ 2,536
	Licensed Practical Nurses - Total Hours	81.1	-	81.1
	Nurse Aides - Number Paid	-	-	-
	Nurse Aides - Total Payroll	\$ -	\$ -	\$ -
	Nurse Aides - Total Hours	-	-	-
II-B All Remaining Nursing Staff				
	Registered Nurses - Number Paid	14	-	14
	Registered Nurses - Total Payroll	\$ 31,448	\$ -	\$ 31,448
	Registered Nurses - Total Hours	760.2	-	760.2
	Licensed Practical Nurses - Number Paid	10	-	10
	Licensed Practical Nurses - Total Payroll	\$ 32,158	\$ -	\$ 32,158
	Licensed Practical Nurses - Total Hours	893.5	-	893.5
	Nurse Aides - Number Paid	30	-	30
	Nurse Aides - Total Payroll	\$ 44,726	\$ -	\$ 44,726
	Nurse Aides - Total Hours	1,978.7	-	1,978.7

Churchman Village
Resident Fund and General Commentary for the Fiscal Year Ending June 30, 2022

Commentary

- 1) Patient personal fund accounts were not adequately documented.
- 2) Resolution was not provided for Medicaid residents with balances in excess of \$2,000.
- 3) Patient census could not be supported for 10 of the 11 sampled residents.



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 Churchman 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, 2022, and have issued our report thereon dated December 1, 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
December 1, 2025

Churchman Village
Schedule of Findings for the Fiscal Year Ended June 30, 2022

Findings and Responses

Finding 22-01 Adjustment Number(s) Impacted: 1

Condition: Start-up expense is included on the cost report without being amortized over a 60 month period.

Criteria: Provider Reimbursement Manual 15-1, Chapter 21, Section 2132.3 requires start-up costs to be amortized ratably over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.

Cause: Start-up expenses were submitted in total on the State of Delaware Medicaid Cost Report when they should have been amortized over a 60 month period.

Effect: Management did not properly amortize start-up expense, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the administrative and routine cost center is overstated.

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 22-02 Adjustment Number(s) Impacted: 2, 3, 6, 7, 8, 9 and 19

Condition: The provider grouped nursing supplies, laundry detergent, data processing, medical transportation, x-ray, PICC, and ultrasound, contracted LPN and CNA, and ancillary rental expense to improper cost centers.

Criteria: 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, for the appropriate grouping of expense. Contracted LPN and CNA, nursing supplies, laundry detergent, data processing, medical transportation, x-ray, PICC, and ultrasound, and ancillary rental expenses are to be grouped to the primary, secondary, support service, administrative and routine, and ancillary 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 rates submitted on the cost report for the support service and ancillary cost centers are understated, while the primary, secondary, administrative and routine, 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: Management agrees with the adjustments; however, a change of ownership occurred on 10/1/2024 and we no longer own the provider.

Finding 22-03 Adjustment Number(s) Impacted: 4

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

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

Cause: 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 the adjustment to cost 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 overstated.

Recommendation: Management should ensure accuracy of the working trial balance used to complete 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 22-04	Adjustment Number(s) Impacted: 5
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:	The provider did not include therapy salaries when calculating the employee benefits allocation.
Effect:	Management did not properly allocate fringe benefits expenses, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the ancillary cost center is understated, while the primary, secondary, support service, administrative and routine, and other cost centers are overstated.
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 adjustments; however, a change of ownership occurred on 10/1/2024 and we no longer own the provider.
Finding 22-05	Adjustment Number(s) Impacted: 10, 11, 12, 13, 16 and 17
Condition:	The provider included non-nursing independent living expense, expense not adequately documented, and invoices not paid within one year with reimbursable cost.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 21, Section 2102.3 requires the removal from allowable costs of any costs not related to patient care, which are not appropriate, necessary, or proper in developing and maintaining the operation of patient care facilities and activities. 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 must 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 are available for audit by the State of Delaware Medicaid Agency or its designated representative for a period of five years after the date of filing of the Medicaid Cost Report. Provider Reimbursement Manual 15-1, Chapter 23, Section 2305 requires short term liabilities to be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.
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 secondary and capital cost centers are overstated.
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 22-06	Adjustment Number(s) Impacted: 14 and 15
Condition:	The provider included general liability and workers compensation insurance expense incurred outside of the cost report period.
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.
Cause:	A cost report adjustment was not proposed to properly adjust accrued expense for general liability and workers compensation insurance to premiums paid during the cost report period.
Effect:	Management did not properly address expenses incurred outside of the cost report period and did not properly group expense, resulting in a compliance finding. The calculated reimbursement rates submitted on the cost report for the primary, secondary, support service, administrative and routine, ancillary, and other cost centers are overstated.
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 22-07 Adjustment Number(s) Impacted: 18

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, home office costs must be deleted from reimbursement.

Cause: 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.

Effect: Management did not complete and submit a home office cost statement, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the administrative and routine cost center is overstated.

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

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 22-08 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 Pay, and Other payer types were noted.

Criteria: 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 census line, on the appropriate classification of patient days. Line 5A should reflect total Medicaid Non-Super Skilled patient days, Line A should reflect total Medicare patient days, Line B should reflect total Private Pay patient days, and Line D should reflect total 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 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 22-09 Comment Number(s) Impacted: 1 and 3

Condition: Sampled patient personal funds and census days for 11 of the 12 residents were unable to be verified.

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

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 did not provide supporting documentation for patient personal funds and sampled census days.

Effect: Management was not able to confirm the establishment and maintenance of full, complete, and separate accounting for patient personal funds and was not able support census days, resulting in a compliance finding.

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