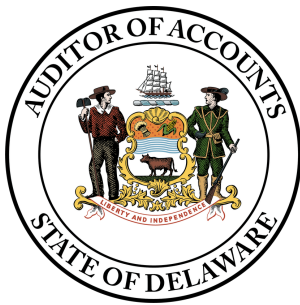




COMPLETE CARE AT HILLSIDE, LLC

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
Complete Care at Hillside LLC**
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: Complete Care at Hillside LLC
Period: Fiscal Year Ended June 30, 2022

We have examined management's assertions that Complete Care at Hillside LLC (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

Complete Care at Hillside LLC 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		\$ 3,949,320		
	Adjustments to Primary Patient Care Costs			
2	To reclassify medical management system subscription to the proper cost center		\$ (26,058)	
3	To reclassify medical waste pickup services to the proper cost center		\$ (720)	
4	To reclassify medical equipment and inspections to the proper cost center		\$ (840)	
5	To reclassify individual ambulance services to the proper cost center		\$ (2,086)	
8	To adjust self insured health insurance to actual claims paid		\$ (43,500)	
9	To reflect the verified worker's compensation benefit allocation		\$ (26,807)	
Net Primary Patient Care Costs		\$ 3,949,320	\$ (100,011)	\$ 3,849,309
Primary Patient Care Cost Per Day (*)		\$ 121.7	\$ (2.9)	\$ 110.5
Secondary Patient Care Costs per Trial Balance of Costs		\$ 499,639		
	Adjustments to Secondary Patient Care Costs			
8	To adjust self insured health insurance to actual claims paid		\$ (1,424)	
9	To reflect the verified worker's compensation benefit allocation		\$ (878)	
Net Secondary Patient Care Costs		\$ 499,639	\$ (2,302)	\$ 497,337
Secondary Patient Care Cost Per Day (*)		\$ 15.4	\$ (0.1)	\$ 14.3
Support Service Costs per Trial Balance of Costs		\$ 1,520,649		
	Adjustments to Support Service Costs			
3	To reclassify medical waste pickup services to the proper cost center		\$ 720	
4	To reclassify medical equipment and inspections to the proper cost center		\$ 840	
8	To adjust self insured health insurance to actual claims paid		\$ (4,067)	
9	To reflect the verified worker's compensation benefit allocation		\$ (2,506)	
Net Support Service Costs		\$ 1,520,649	\$ (5,013)	\$ 1,515,636
Support Service Cost Per Day (*)		\$ 46.9	\$ (0.1)	\$ 43.5
Administrative & Routine Costs per Trial Balance of Costs		\$ 1,888,307		
	Adjustments to Administrative & Routine Costs			
2	To reclassify medical management system subscription to the proper cost center		\$ 26,058	
6	To remove Home Office pass down costs due to a lack of a home office cost statement		\$ (346,940)	
8	To adjust self insured health insurance to actual claims paid		\$ (15,194)	
9	To reflect the verified worker's compensation benefit allocation		\$ (9,340)	
Net Administrative & Routine Costs		\$ 1,888,307	\$ (345,416)	\$ 1,542,891
Administrative & Routine Cost Per Day (*)		\$ 58.2	\$ (9.9)	\$ 44.3

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

Complete Care at Hillside LLC				
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		\$ 1,171,998		
	Adjustments to Capital Costs			
1	To reclassify oxygen related rental expense to the proper cost center		\$ (11,282)	
7	To adjust submitted related party rent to actual cost		\$ (122,508)	
Net Capital Costs		\$ 1,171,998	\$ (133,790)	\$ 1,038,208
Net Capital Cost Per Day (*)		\$ 36.1	\$ (3.8)	\$ 29.8
Ancillary Costs per Trial Balance of Costs		\$ 811,722		
	Adjustments to Ancillary Costs			
1	To reclassify oxygen related rental expense to the proper cost center		\$ 11,282	
5	To reclassify individual ambulance services to the proper cost center		\$ 2,086	
Net Ancillary Costs		\$ 811,722	\$ 13,368	\$ 825,090
Ancillary Cost Per Day (*)		\$ 25.0	\$ 0.4	\$ 23.7
Other Costs per Trial Balance of Costs		\$ 9		
	Adjustments to Other Costs			
	None		\$ -	
Net Other Costs		\$ 9	\$ -	\$ 9
Other Cost Per Day (*)		\$ 0.0	\$ -	\$ 0.0

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

Complete Care at Hillside LLC 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				38,690
Medicaid Non-Super Skilled Patient Days		25,703		
	Adjustments to Medicaid Patient Days		(70)	
Medicaid Super Skilled Patient Days		-		
	Adjustments to Medicaid Super Skilled Patient Days		-	
Medicare Patient Days		5,215		
	Adjustments to Medicare Patient Days		(326)	
Private Pay Patient Days		569		
	Adjustments to Private Pay Patient Days		43	
Medicare/Private Pay Hospice Patient Days		-		
	Adjustments to Medicare/Private Pay Hospice Patient Days		15	
Other Patient Days		963		
	Adjustments to Other Patient Days		339	
Total Patient Days		32,450	1	32,451
Minimum Occupancy				34,821

Complete Care at Hillside LLC 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	\$ 4,490	\$ -	\$ 4,490
	Director of Nursing - Total Hours	80.0	-	80.0
	Assistant Director of Nursing - Number Paid	1	-	1
	Assistant Director of Nursing - Total Payroll	\$ 3,200	\$ -	\$ 3,200
	Assistant Director of Nursing - Total Hours	80.0	-	80.0
	Registered Nurses - Number Paid	3	-	3
	Registered Nurses - Total Payroll	\$ 9,658	\$ -	\$ 9,658
	Registered Nurses - Total Hours	240.0	-	240.0
	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 Remaining Nursing Staff				
	Registered Nurses - Number Paid	7	-	7
	Registered Nurses - Total Payroll	\$ 18,396	\$ -	\$ 18,396
	Registered Nurses - Total Hours	476.0	-	476.0
	Licensed Practical Nurses - Number Paid	12	-	12
	Licensed Practical Nurses - Total Payroll	\$ 31,705	\$ -	\$ 31,705
	Licensed Practical Nurses - Total Hours	975.5	-	975.5
	Nurse Aides - Number Paid	38	-	38
	Nurse Aides - Total Payroll	\$ 36,232	\$ -	\$ 36,232
	Nurse Aides - Total Hours	1,925.6	-	1,925.6

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 Complete Care at Hillside LLC (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

Complete Care at Hillside LLC
Schedule of Findings for the Fiscal Year Ending June 30, 2022

Findings and Responses

Finding 22-01 Adjustment Number(s) Impacted: 1, 2, 3, 4, and 5

Condition: The provider grouped oxygen, management system subscription, medical waste pickup services, medical equipment inspection, and ambulance 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. Medical waste pickup services, medical equipment inspection, management system subscription, oxygen, and ambulance expense should be grouped to the support service, administrative and routine, and ancillary cost centers, respectively.

Cause: Management's working trial balance account grouping 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 support service, administrative and routine, 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 did not provide a response.

Finding 22-02 Adjustment Number(s) Impacted: 6

Condition: The provider included related party management fees instead of submitting actual cost through the required home office cost statement.

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 did not provide a response.

Finding 22-03 Adjustment Number(s) Impacted: 7

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 a not allowable cost. The provider, however, would include in its costs the actual costs of ownership of the facility.

Cause: Management properly submitted a cost report adjustment to 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 overstated.

Recommendation: Management should ensure depreciation expense is submitted in accordance with applicable regulations when completing the State of Delaware Medicaid Cost Report.

Management's Response: Management did not provide a response.

Finding 22-04 Adjustment Number(s) Impacted: 8

Condition: The provider maintains self insurance for health 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 insurance to reflect actual 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 rates submitted on the cost report for the primary, secondary, support service, and administrative and routine cost centers are overstated.

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

Management's Response: Management did not provide a response.

Finding 22-05 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, Medicare/Private Pay Hospice, 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 5D should reflect Medicaid patient days, Line A should reflect Medicare patient days (excluding hospice days), Line B should reflect total Private Pay patient days, Line C should reflect Medicare/Private Pay Hospice patient days, and Line D 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, resulting in payer classification variances.

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 did not provide a response.