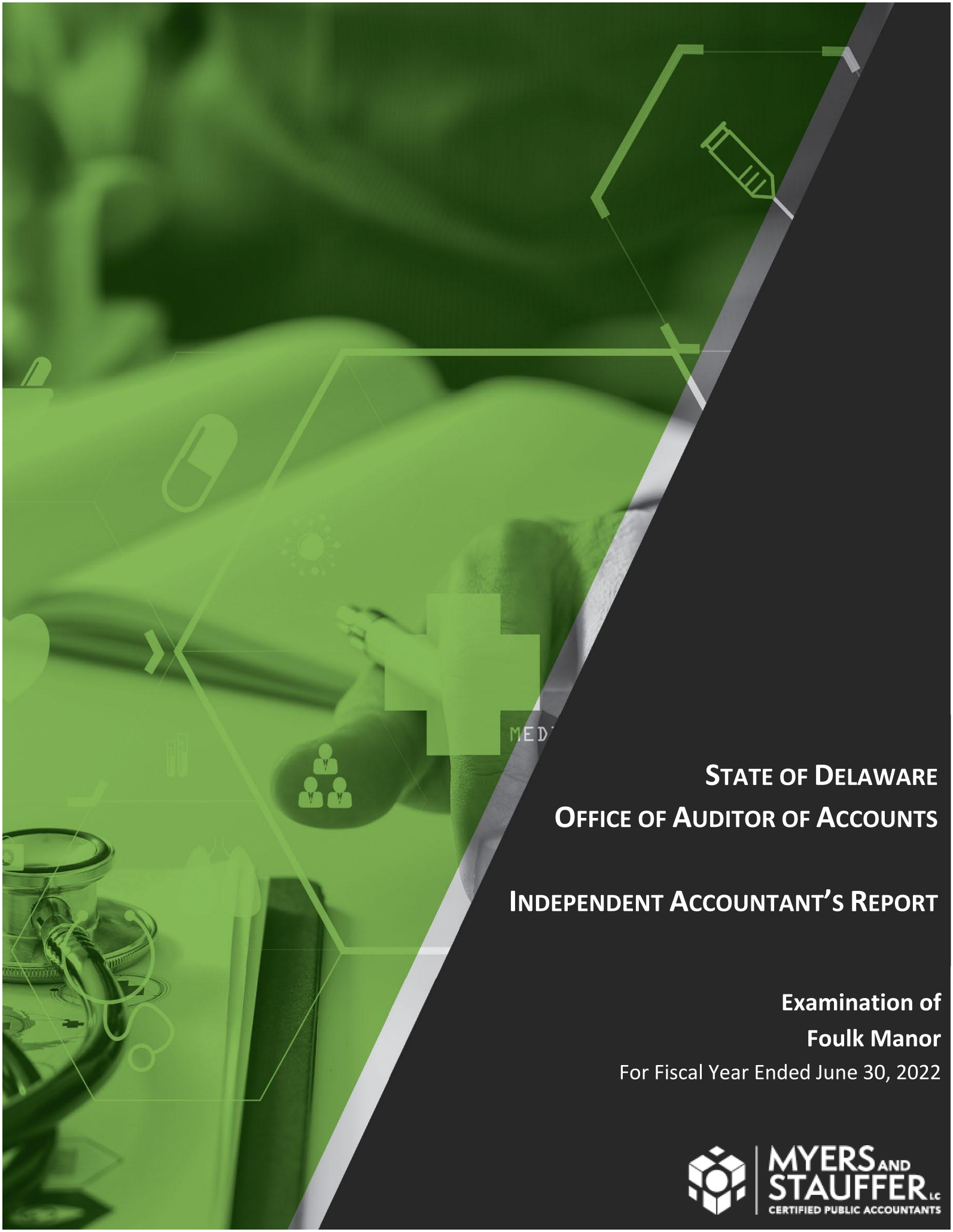
FOULK MANOR

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
Foulk Manor
For Fiscal Year Ended June 30, 2022

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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: Foulk Manor
Period: Fiscal Year Ended June 30, 2022

We have examined management's assertions that Foulk Manor (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

Foulk Manor 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		$ 2,059,525		
	Adjustments to Primary Patient Care Costs			
3	To add back costs found in the general ledger not submitted to the cost report		$ 242,631	
8	To reclass staff salaries and direct benefits for the nursing supervisor, DON/ADON, and staff development coordinator to the appropriate cost center		$ 110,330	
9	To reflect the verified employee benefits		$ 17,958	
10	To reclassify contracted food prep staff expense to the appropriate cost center		$ (7,933)	
Net Primary Patient Care Costs		**$ 2,059,525**	**$ 362,986**	**$ 2,422,511**
Primary Patient Care Cost Per Day (*)		**$ 138.6**	**$ 24.0**	**$ 160.3**
Secondary Patient Care Costs per Trial Balance of Costs		$ 312,168		
	Adjustments to Secondary Patient Care Costs			
2	To reclassify ancillary medical supplies expense to the appropriate cost center		$ (1,139)	
3	To add back costs found in the general ledger not submitted to the cost report		$ 15,957	
4	To adjust the non-nursing allocation based on verified statistics		$ 2,536	
Net Secondary Patient Care Costs		**$ 312,168**	**$ 17,354**	**$ 329,522**
Secondary Patient Care Cost Per Day (*)		**$ 21.0**	**$ 1.1**	**$ 21.8**
Support Service Costs per Trial Balance of Costs		$ 785,272		
	Adjustments to Support Service Costs			
3	To add back costs found in the general ledger not submitted to the cost report		$ 106,061	
4	To adjust the non-nursing allocation based on verified statistics		$ 4,275	
10	To reclassify contracted food prep staff expense to the appropriate cost center		$ 7,933	
11	To reclassify music licensing expense to the appropriate cost center		$ 1,558	
Net Support Service Costs		**$ 785,272**	**$ 119,827**	**$ 905,099**
Support Service Cost Per Day (*)		**$ 52.8**	**$ 7.9**	**$ 59.9**
Administrative & Routine Costs per Trial Balance of Costs		$ 1,242,005		
	Adjustments to Administrative & Routine Costs			
1	To remove bad debt expense		$ 8,340	
3	To add back costs found in the general ledger not submitted to the cost report		$ 154,193	
4	To adjust the non-nursing allocation based on verified statistics		$ 21	
8	To reclass staff salaries and direct benefits for the nursing supervisor, DON/ADON, and staff development coordinator to the appropriate cost center		$ (110,330)	
9	To reflect the verified employee benefits		$ (17,958)	
11	To reclassify music licensing expense to the appropriate cost center		$ (1,558)	
12	To reflect verified insurance premiums expense		$ (14,154)	
14	To remove related party management fees		$ (127,800)	
15	To reflect the verified pass down of home office cost		$ 26,133	
Net Administrative & Routine Costs		**$ 1,242,005**	**$ (83,113)**	**$ 1,158,892**
Administrative & Routine Cost Per Day (*)		**$ 83.6**	**$ (5.5)**	**$ 76.7**

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

Foulk Manor 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		$ 139,607		
	Adjustments to Capital Costs			
3	To add back costs found in the general ledger not submitted to the cost report		$ 285	
5	To remove depreciation expense not adequately documented		$ (82,574)	
6	To adjust depreciation expense to verified		$ (5,873)	
7	To offset expense related to barber & beauty revenue against applicable expense		$ (4,853)	
13	To reflect verified real estate tax expense		$ 3,953	
15	To reflect the verified pass down of home office cost		$ 4,651	
Net Capital Costs		**$ 139,607**	**$ (84,411)**	**$ 55,196**
Net Capital Cost Per Day (*)		**$ 9.4**	**$ (5.6)**	**$ 3.7**
Ancillary Costs per Trial Balance of Costs		$ 17,229		
	Adjustments to Ancillary Costs			
2	To reclassify ancillary medical supplies expense to the appropriate cost center		$ 1,139	
Net Ancillary Costs		**$ 17,229**	**$ 1,139**	**$ 18,368**
Ancillary Cost Per Day (*)		**$ 1.2**	**$ 0.1**	**$ 1.2**
Other Costs per Trial Balance of Costs		$ 3,540,497		
	Adjustments to Other Costs			
	None.		$ -	
Net Other Costs		**$ 3,540,497**	**$ -**	**$ 3,540,497**
Other Cost Per Day (*)		**$ 238.3**	**$ -**	**$ 234.3**

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

Foulk Manor 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				16,790
Medicaid Non-Super Skilled Patient Days		3,916		
	Adjustments to Medicaid Patient Days		(494)	
Medicaid Super Skilled Patient Days		-		
	Adjustments to Medicaid Super Skilled Patient Days		-	
Medicare Patient Days		-		
	Adjustments to Medicare Patient Days		-	
Private Pay Patient Days		10,938		
	Adjustments to Private Pay Patient Days		(16)	
Medicare/Private Pay Hospice Patient Days		-		
	Adjustments to Medicare/Private Pay Hospice Patient Days		-	
Other Patient Days		5		
	Adjustments to Other Patient Days		-	
Total Patient Days		**14,859**	**(510)**	**14,349**
Minimum Occupancy				**15,111**

Foulk Manor 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	$ 3,545	$ -	**$ 3,545**
	Director of Nursing - Total Hours	80.0	-	**80.0**
	Assistant Director of Nursing - Number Paid	1	-	**1**
	Assistant Director of Nursing - Total Payroll	$ 3,378	$ -	**$ 3,378**
	Assistant Director of Nursing - Total Hours	80.0	-	**80.0**
	Registered Nurses - Number Paid	1	-	**1**
	Registered Nurses - Total Payroll	$ 3,038	$ -	**$ 3,038**
	Registered Nurses - Total Hours	80.0	-	**80.0**
	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	9	-	**9**
	Registered Nurses - Total Payroll	$ 19,509	$ 6	**$ 19,515**
	Registered Nurses - Total Hours	459.3	-	**459.3**
	Licensed Practical Nurses - Number Paid	7	-	**7**
	Licensed Practical Nurses - Total Payroll	$ 17,741	$ -	**$ 17,741**
	Licensed Practical Nurses - Total Hours	495.4	-	**495.4**
	Nurse Aides - Number Paid	18	-	**18**
	Nurse Aides - Total Payroll	$ 27,956	$ (131)	**$ 27,825**
	Nurse Aides - Total Hours	1,280.9	-	**1,280.9**

Foulk Manor Resident Fund and General Commentary for the Fiscal Year Ending June 30, 2022
Commentary

1) Supporting documentation from the prior ownership period covering July 1, 2021 through November 17, 2021 was not received resulting in $1.6 million of unsupported salaries and $153,000 of unsupported payroll tax.

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 Foulk Manor (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

Findings and Responses

Finding 22-01 **Adjustment Number(s) Impacted: 1 and 5**

Condition: The provider included bad debt expense and expense not adequately documented with reimbursable cost.

Criteria: Provider Reimbursement Manual 15-1, Chapter 3, Section 300 requires the removal of bad debts, charity, and courtesy allowances as they are not to be included in allowable costs.

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.

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

Effect: Management did not properly address non-allowable expense and did not provide supporting documentation, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the administrative and routine is understated, while the capital cost center is overstated.

Recommendation: Management should submit expenses on the Medicaid cost report in accordance with appropriate regulations when completing the State of Delaware Medicaid Cost Report and ensure that internal control policies over record retention are followed to comply with the five year record retention requirement.

Management's Response: Stronger internal controls are in place to handle record retention requirements. FYE 06/30/2022 was split between two managers which caused record retention issues.

Finding 22-02 **Adjustment Number(s) Impacted: 2, 8, 10, and 11**

Condition: The provider grouped ancillary medical supplies, non-patient centered nursing salaries and direct benefits, contracted food preparation staff, and music licensing 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. Non-patient nursing centered salaries and direct benefits, contracted food preparation staff, music licensing, and ancillary medical supplies expenses are to be grouped to the primary, support service, and ancillary 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 primary, support service, and ancillary cost centers are understated, while the secondary and administrative and routine 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: Stronger internal controls and processes are in place to confirm that expenses are submitted properly.

Finding 22-03 **Adjustment Number(s) Impacted: 3**

Condition: The cost report did not include expense incurred during the time period of November 18, 2021 through December 31, 2021.

Criteria: Provider Reimbursement Manual 15-1, Chapter 23, Section 2302.1 states that under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

Cause: Management included the year end income statement closing entries when merging the trial balance of the prior owner and the current owner.

Effect: Management did not properly include all allowable expense, resulting in a compliance finding. The calculated reimbursement rates submitted on the cost report for the primary, secondary, support service, administrative and routine, capital cost centers are understated.

Recommendation: Management should utilize the most up to date financial information when completing the State of Delaware Medicaid Cost Report.

Management's Response: Due to the management change on 11/18/2021, the stub period of 11/18/2021-12/31/2021 was inadvertently left out of the year end reporting. This should not be an issue in future filings.

Finding 22-04	**Adjustment Number(s) Impacted: 4**
Condition:	The provider incorrectly calculated the indirect non-nursing expenses.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 23, Section 2304 requires that cost information developed by the provider be current, accurate, and sufficiently detailed to support payments made for services rendered to beneficiaries.
Cause:	The submitted statistics used in the calculation of indirect non-nursing expense removal did not reflect verified documentation.
Effect:	Management did not properly address indirect non-nursing expenses, resulting in a compliance finding. The calculated reimbursement rates submitted on the cost report for the secondary, support service, and administrative and routine cost centers are understated.
Recommendation:	Management should review the submitted cost report expenses to ensure they are appropriate when completing the State of Delaware Medicaid Cost Report.
Management's Response:	Stronger internal controls and processes are in place to confirm that expenses are submitted properly.

Finding 22-05	**Adjustment Number(s) Impacted: 6**
Condition:	Depreciation expense related to the same asset was submitted twice on the cost report.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 1, Section 104.10 states that historical cost is the cost incurred by the present owner in acquiring the asset and preparing it for use.
Cause:	Asset additions for the same asset were erroneously assigned different inventory numbers on the fixed asset listing, leading to the duplication of expense.
Effect:	Management included duplicate depreciation expense, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the capital cost center is overstated.
Recommendation:	Management should review the supporting schedules for accuracy to ensure they are appropriate when completing the State of Delaware Medicaid Cost Report.
Management's Response:	Stronger internal controls and processes are in place to confirm that expenses are submitted properly. Duplicate depreciation entries were discovered and corrected by 12/31/2022.

Finding 22-06	**Adjustment Number(s) Impacted: 7**
Condition:	Capital expense was not properly stated because the provider did not offset the associated income.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 23, Section 2302.5 states that applicable credits are receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs.
Cause:	Management did not properly recover barber and beauty income against indirect barber and beauty expense.
Effect:	Management did not properly recover revenue accounts, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the capital cost center is overstated.
Recommendation:	Management should review working trial balance revenue accounts and recover income against the associated expense, when appropriate.
Management's Response:	Stronger internal controls and processes are in place to confirm that certain revenue accounts are properly recovered against the associated expense.

Finding 22-07	**Adjustment Number(s) Impacted: 9**
Condition:	The provider improperly allocated non-patient centered nursing 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 properly classify non-patient centered nursing salary expense when calculating the employee benefits allocation.
Effect:	Management did not properly allocate social service fringe benefits expenses, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the primary cost center is understated, while the administrative and routine cost center is 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:	Stronger internal controls and processes are in place to confirm that benefit expenses are submitted properly.

Finding 22-08	**Adjustment Number(s) Impacted: 12**
Condition:	The provider included general liability insurance 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 to expense realized during the cost report period.
Effect:	Management did not properly address expenses incurred outside of the cost report period, 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:	Stronger internal controls and processes are in place to confirm that expenses are submitted properly.

Finding 22-09	**Adjustment Number(s) Impacted: 13**
Condition:	Real estate tax accrued and submitted to the capital cost center did not trace to supporting documentation.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 21, Section 2122.7 states that reasonable costs claimed by a provider, including taxes must be actually incurred.
Cause:	A cost report adjustment was not proposed to properly adjust accrued real estate tax to incurred amounts during the cost report period.
Effect:	Management did not properly address expenses incurred during cost report period, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the capital cost center is understated.
Recommendation:	Management should review submitted cost report expense to ensure they are appropriate when completing the State of Delaware Medicaid Cost Report.
Management's Response:	Stronger internal controls and processes are in place to confirm that expenses are submitted properly.

Finding 22-10	**Adjustment Number(s) Impacted: 14**
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 will complete a home office statement for related party management on an annual basis moving forward.

Finding 22-11	**Adjustment Number(s) Impacted: 15**
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 that home office costs, which are not otherwise allowable costs when incurred directly by the Provider, cannot be considered allowable as home office costs to be allocated to providers.
Cause:	The home office expense allocation included non-allowable therapy expenses.
Effect:	Management included non-allowable therapy costs and improperly calculated home office expense, resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the administrative and routine and capital cost centers are understated.
Recommendation:	Management should submit home office costs in accordance with appropriate regulations when completing the State of Delaware Medicaid Cost Report.
Management's Response:	Management will submit home office costs properly going forward.

Finding 22-12	**Schedule of Adjustments to Patient Days**
Condition:	Verified patient days variances between Medicaid and Private Pay 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 5B should reflect total Medicaid Hospice patient days and Line B should reflect total Private Pay 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 ensure that finalized census reports are used to accurately report patient days.

Finding 22-13 **Schedule of Adjustments to the Nursing Wage Survey**

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

Criteria: The State of Delaware Department of Health and Social Services Division of Medicaid and Medical Assistance Instructions for Completion of Nursing Home: Nursing Wage Survey provides instructions, by occupational group, on the appropriate grouping of total number of staff, total pay, and total hours. Total pay for the non-administrative registered nurses and nurse aides are to be included in Section II.B.

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

Effect: Management did not properly report total pay, resulting in a compliance finding. The calculated total pay for the non-administrative registered nurses were understated, while the total pay for nurse aides were overstated on the nursing wage survey.

Recommendation: Management should submit total pay on the nursing wage survey in accordance with the State of Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance Instructions for Completion of Nursing Home: Nursing Wage Survey.

Management's Response: Management will ensure that the nursing wage survey is in accordance with the State instructions.

Finding 22-14 **Comment Number(s) Impacted: 1**

Condition: Salary expense related to the prior ownership period covering July 1, 2021 through November 17, 2021 could not be verified.

Criteria: The State of Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance Medicaid Cost Report Instructions for Nursing Facilities states that the Medicaid Cost Report for Nursing Facilities 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.

Cause: New ownership was unable to obtain the proper documentation from prior ownership to support salary expense submitted on the cost report.

Effect: Management did not properly support salary expense, resulting in a compliance finding.

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

Management's Response: Due to the management change on 11/18/2021, documentation was required from the previous management. Several attempts were made to obtain the proper documentation, but not all was received prior to the closing of the audit. This should not be an issue in future filings.