New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor

Department of Military and Veterans' Affairs
New Jersey Veterans Memorial Home at Vineland

July 1, 2009 to May 31, 2012

Stephen M. Eells
State Auditor

New Jersey State Legislature

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Enclosed is our report on the audit of the Department of Military and Veterans' Affairs, New Jersey Veterans Memorial Home at Vineland for the period of July 1, 2009 to May 31, 2012. If you would like a personal briefing, please call me at (609) 847-3470.

Stephen M. Eells
State Auditor
September 27, 2012

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Scope

We have completed an audit of the Department of Military and Veterans' Affairs, New Jersey Veterans Memorial Home at Vineland for the period July 1, 2009 to May 31, 2012. Our audit included financial activities accounted for in the state's General Fund and the home's non-appropriated accounts. We also evaluated selected general controls related to MDSEase, a clinical and financial integrated software suite for long-term care and nursing homes, encompassing security management, logical access, and change management.

The prime responsibility of the home is to provide nursing care for New Jersey veterans and their spouses with chronic disabilities. As of March 31, 2012, the home had 286 residents including 59 spouses and parents of a veteran. Annual expenditures are approximately $28 million. Annual General Fund revenues are approximately $14 million and are primarily comprised of a per diem allowance from the U.S. Department of Veterans Affairs, billings to residents for care and maintenance, and reimbursements from Medicare Part A and Part B, and co-insurances.

Objectives

The objectives of our audit were to determine whether financial transactions were related to the home's programs, were reasonable, and were recorded properly in the accounting systems. We also determined whether selected general controls over the home's MDSEase integrated software suite were adequate, including policies and procedures to manage and maintain the system, user authentication to provide system security, and recovery methods to enable system continuity.

The audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation, the administrative code, circular letters promulgated by the Department of the Treasury, and policies of the Department of Military and Veterans' Affairs and the home. Provisions we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our testing of financial transactions. We also read the budget messages, reviewed financial trends, and interviewed home personnel to obtain an understanding of the programs and the internal controls, including the MDSEase integrated software general controls.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions, as well as internal control and compliance attributes. Sample populations were sorted and transactions were judgmentally selected for testing.

Conclusions

We found that financial transactions included in our testing were related to the home's programs. However, we could not determine if these transactions were reasonable and recorded properly in the accounting systems due to significant control weaknesses and lack of reconciliations noted during our review of the processing of revenues, payrolls, and purchasing. In addition, we found that the selected general controls over the home's MDSEase integrated software suite were adequate, although we did note a programming error in the software which caused incorrect amounts to be remitted to the State Treasurer.

Revenue - VA Per Diem Allowance

The calculation of billable days and rates did not follow billing procedures set by the U.S. Department of Veterans Affairs.

State nursing home care facilities providing care to veterans can recover a portion of costs from the U.S. Department of Veterans Affairs (VA) through a basic per diem rate or one half of the cost of care for each day the veteran is in the facility, whichever is less. An amended federal law, published on April 29, 2009, updated the basic per diem rate and allowed a higher per diem payout to veterans with a service connected disability rated at 70 percent or more. This higher per diem payout essentially covers the total daily cost of services furnished to these veterans. The VA billing form was updated and effective in May 2009. The law also allowed state homes to retroactively bill the VA for these eligible veterans back to March 21, 2007.

The VA basic per diem rate ranged from $67.71 in federal fiscal year 2007 to $95.82 in federal fiscal year 2012. For veterans with 70 percent or more service connected disabilities, the rate is the lesser of the federal prevailing rate or a rate not to exceed the daily cost of care. The federal prevailing rate for the same period ranged from $282.83 to $388.12. The home's federal fiscal year 2011 daily cost care rate used in the billing, based on the fiscal year 2010 costs, was $339.31 while the prevailing rate was $372.37. The actual fiscal year 2011 cost care rate was $373.92. If the allowable prevailing rate was used, an additional $65,000 in reimbursements could have been generated. The VA per diem billing is based on eligible resident days multiplied by the per diem rate. Eligible resident days are calculated based on the census from the home's Twenty-Four Hour Census Report. The billing form is faxed monthly to the VA fiscal agent.

Our review of the home's census reports used to determine VA per diem billings for fiscal years 2010 and 2011 and the VA retroactive billings from March 21, 2007 to June 2009 noted numerous errors. A total of 3,872 eligible days were not billed; while 3,133 ineligible days were billed. In addition, the use of incorrect rates resulted in inaccurate billings that totaled $101,000. As the result of these errors, the home has a net amount due from the VA totaling $306,000. There were several causes for these errors. The updated VA billing form was not used, written VA billing procedures were not established, the calculation of billable days was not adequately supported, verification of veterans with 70 percent or more service connected disabilities was not performed, new federal fiscal year billing rates that were available in October were not used until January, and correct billing rates were not always used.

Recommendation

We recommend that the home implement corrective action to ensure billable days are properly calculated and correct rates are used when billing the U.S. Department of Veterans Affairs (VA). Written VA billing procedures should be developed which document the calculation of billable days in detail and identify current costs to be used in determining the billable rate. Billing errors identified in this report should be submitted to the VA for adjustment.

Revenue – Care and Maintenance

Care and maintenance costs are underbilled because the rate calculation is not in compliance with the New Jersey Administrative Code.

Care and maintenance is the actual cost of services provided to an individual in one of the state's veterans' memorial facilities. New Jersey Administrative Code (NJAC) 5A requires residents to pay for care and maintenance based on their monthly income and ability to pay after accounting for any federal reimbursement, and this amount may not exceed the rate established annually by the Adjutant General of the Department of Military and Veterans' Affairs, which is commonly less than the actual care and maintenance costs. Residents with accountable assets over an established threshold of $20,000 (single) or $80,000 (married) must pay the full amount of care and maintenance which is classified as spend-down status. There is a three-year look back period prior to admittance. If assets fall below the threshold, 80 percent of their net income is subject to care and maintenance charges. The code also requires state homes to perform an annual asset valuation. An applicant's primary residence is not considered as part of their assets; however, the NJAC is not clear concerning the proceeds from the sale of the resident's primary home.

The daily care and maintenance rate calculated by the Department of Military and Veterans' Affairs fiscal unit is based on the prior fiscal year's operating cost. This calculation does not include certain indirect costs, such as employee fringe benefits and depreciation of facility infrastructure. The calculated daily maximum rate based on fiscal year 2011 operating costs was $258.16. The rate approved by the Adjutant General was $240 and was effective on January 1, 2012. Veterans receive a $95.82 discount which is recovered from the U.S. Department of Veterans Affairs (VA) and could be billed the $144.18 difference. The actual fiscal year 2011 cost, including indirect costs, was $373.92. The state in essence subsidizes the $133.92 per diem difference with state appropriations. The maximum rate only affects residents who are in spend-down status, which is approximately 160 of 900 residents in the state's three homes, 27 of whom are at Vineland.

Care and Maintenance Rate for Residents Under the Asset Threshold

Our tests of the calculation of the daily care and maintenance rate for residents under the asset threshold noted that the home's calculation was not always performed in accordance with the rules set forth in New Jersey Administrative Code 5A:5-5.2 and 5.3. We reviewed 30 residents' rate calculations, including 20 of the 46 residents with a community spouse. Twenty-three calculations contained errors, primarily involving those residents with a community spouse. The errors were mainly caused by the home's misinterpretation of the code regarding accountable income and allowable deductions. The home should have generated an additional $200,000 in care and maintenance receipts from the sampled residents in fiscal year 2011.

Annual Asset Valuation

As part of the annual rate calculation, the home should evaluate each resident's assets based on the financial documents requested. We noted that residents and their representatives did not always submit requested documents. Therefore, the home could not properly perform the asset valuation as required. Instead, the home utilized prior or incomplete data in determining their rate calculation which resulted in inaccurate care and maintenance charges. For example, one resident sold their primary and secondary home two years prior to their admission to the home. Proceeds from the sale of the secondary home totaled $163,000. Per our calculation, the resident should have been in spend-down status for 1,244 days. The resident paid $30,693, the maximum rate for only 262 days. The resident's representative claimed all proceeds had been spent; however, documents substantiating such spending were not provided.

Maximum Asset Limitation

The home did not enforce the maximum asset accumulation limitations on residents with asset accumulations over the threshold of $20,000 (single), and $80,000 (married). As of November 2011, two single residents' personal fund account balances were significantly over the limitations and had been for at least five years. These two residents were charged the maximum rate starting January 2012 upon our inquiry.

Delinquent Accounts

The home averaged $4.5 million annually in care and maintenance receipts for the fiscal years 2008 through 2011. As of December 31, 2011, we determined the outstanding care and maintenance receivable balance to be $681,749 of which $386,787 was owed by 13 residents. The home generally complied with Department of Military and Veterans' Affairs guidelines and the Department of the Treasury Circular Letter 11-20 OMB in regards to debt collection procedures; however, changes to the New Jersey Administrative Code should be considered that would enhance the compliance by residents and by their responsible parties in meeting their obligations.

Care and Maintenance Refunds

Federal Public Law 109-461 allowed a higher per diem rate to be paid on behalf of veterans with 70 percent or more service connected disabilities starting March 21, 2007. The law required state homes to refund care and maintenance paid by these veterans once retroactive payments were received. The home properly ceased collecting care and maintenance from these veterans starting July 2010, but had not made any refunds. We calculated refunds due 16 residents totaling $302,396 for the period March 21, 2007 to June 30, 2010. The home agreed with our calculation and has since made all refunds to these residents or their estates.

Recommendation

We recommend that the home improve the accounting controls over care and maintenance revenue by:

- assuring the rate calculation methodology is in conformity with the NJAC 5A:5;
- considering assessing the maximum rate when requested documents for the annual asset valuation are not submitted;
- enforcing the maximum asset limitations; and
- considering enhancements to the New Jersey Administrative Code that would increase compliance by residents and responsible parties in meeting their obligations.

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Revenue - Medicare Part A and Part B, and Co-insurance

Unpaid claims of $1.5 million have not been collected.

Eligible beneficiaries under Medicare Part A are covered up to 100 days per benefit period. Medicare pays 100 percent for the first 20 days and shares the cost with co-insurance the next 80 days.

The Medicare Part B plan shares the cost of health care with beneficiaries through the use of an annual deductible and coinsurance. It covers medically-necessary and preventive services.

In addition to the Medicare Part A and B plans, eligible residents are required to have a supplemental insurance. As of January 2012, all eligible residents in the home had supplemental insurance. There were 23 different secondary insurance plans of which 45 percent had AARP.

The home contracted its rehabilitation and therapy service with a vendor. The home utilizes the vendor's invoices to bill Medicare and co-insurance plans for reimbursements. When payments are received, they are manually posted to each resident's account. However, reconciliations were not performed to ensure billed claims were properly paid. The home could not provide us with the balance of unpaid claims, since the home did not track and follow-up on these claims. Using the home's records, we were able to estimate that unpaid Medicare Part A and Part B, and AARP claims totaled $1.5 million from fiscal years 2007 through 2011. There could be additional unpaid claims, since we did not review claims billed to other co-insurance plans.

Recommendation

We recommend that the home improve its accounting for medical claims by establishing a claims receivable account and implementing procedures to closely monitor claims and to identify and resubmit any unpaid claims. The home should reconcile monthly Medicare and co-insurance billings to the payments received.

Members Fund - Accounting and Reconciliation

Reconciliations are needed to ensure receipts and payments are properly received and disbursed and monies are properly accounted for by the home.

Our review noted that the home did not perform reconciliations to ensure receipts and payments are properly received and disbursed and transactions processed through the Members Fund account are properly accounted for. We noted the following exceptions that would have been recognized with proper reconciliation procedures.

- The home overpaid $1.2 million in care and maintenance fees to the state resulting in a shortage in the Members Fund account. Our analysis of care and maintenance billings from January 2006 to December 2011 noted that net billings, excluding amounts outstanding, totaled $25.5 million. However, $26.7 million were remitted to the state. In addition, due to an accounting error, the November 2009 and a portion of the December 2009 care and maintenance receipts totaling $515,300 were not remitted to the state. Therefore, net overpayments were $690,000.

- A system programming error within the home's MDSEase system, the software suite used, in part, to process various billings and maintain residents' banking activities, resulted in incorrect amounts being remitted each month to the state's General Fund for care and maintenance recoveries. Our analysis disclosed a net $351,000 was over-remitted to the state between January 2006 and December 2011. The MDSEase system was replaced after our audit period.

- Cash receipt documents totaling $2.6 million were not prepared and reported in the state's accounting system, receipts totaling $1.7 million were applied to an incorrect fiscal year, and receipts totaling $673,664 were not remitted to the state.

- The December 2008 care and maintenance receipts totaling $432,965 were not remitted to the state until August 2010 when notified by the Department of the Treasury's cash accounting unit. The original check issued in January 2009 was returned due to a missing signature. However, a cash receipt document was prepared and entered into the state's accounting system when the original check was issued.

Recommendation

We recommend that the home reconcile monthly billings to receipts and ensure all receipts are properly recorded in the accounting systems.

Purchasing

Internal controls and compliance to applicable guidelines for purchasing need to be strengthened.

The home did not comply with the Department of the Treasury Circular Letter 11-10-DPP and the Department of Military and Veterans' Affairs' (DMAVA) policies and procedures when procuring goods and services. The home has a decentralized purchasing function which allows purchases to take place at the unit level. Individuals at the unit appear to lack the expertise in purchasing or knowledge of state purchasing guidelines. It was common that purchase orders were issued and approvals were obtained after goods or services were ordered and delivered. The practice of confirming orders is not permitted per the DMAVA guidelines. It also resulted in untimely payments since the business office did not have knowledge of these purchases. Our review noted the following exceptions and issues.

- Our tests of 30 expenditure transactions disclosed 21 purchase orders were not pre-approved by the business office, 14 purchase orders were prepared after goods or services were delivered or rendered, and seven payments were made over 60 days after the vendors' invoice date.

- Eight of the 30 sampled purchases required quotes be obtained per the circular letter, but only one had the proper quotes on file.

- Delivered goods are checked in by the unit that made the purchase rather than the home's receiving department, thereby creating an internal control weakness.

- The home purchased disposable incontinence briefs totaling $386,579 from July 2009 to April 2011 of which $226,840 were for triple XL size briefs. The unit price for a triple XL size brief was $2.21 and for an XL size brief was $0.43. Manufacturers' recommendation for triple XL size briefs are for individuals weighing over 300 lbs. Thirty-six residents were using triple XL size briefs while only three met the recommended sizing chart. If the other 33 residents wore regular XL brief size, the home would have saved approximately $100,000 during the time period we reviewed. Based on our review, the home discontinued using triple XL size briefs on residents weighing less than 300 lbs in December 2011.

Our review also disclosed that the home used care and maintenance receipts to purchase wheelchairs for needy residents starting in June 2009. This practice circumvented the state's purchasing guidelines and created additional appropriations without the state's authorization. These purchases totaled $213,332 from June 2009 to December 2011. The home discontinued the practice after December 2011.

Recommendation

We recommend that the home comply with the established Department of the Treasury and DMAVA guidelines including proper approval of purchase orders and compliance to procurement guidelines for all purchases and payments.

Payroll

Controls over payroll processing need to be strengthened.

The home utilizes a computerized hand recognition time clock system to track employee attendance and leave time usage. However, bi-weekly payroll proofs are manually prepared based on the information from time attendance reports processed by unit timekeepers. The home has 23 timekeepers including backups of which six are in non-supervisory titles. Our review of 14 timekeepers' bi-weekly time reporting noted that timekeepers were capable of adjusting their own time in the system including overtime hours, compensatory time, and in/out punches. Timekeepers were also able to work overtime without approval from their supervisors. The payroll supervisor approved timekeepers' time without questioning the changes, regardless if they were properly supported.

Our review also noted that the payroll supervisor who prepares the payroll proofs for submission to the Department of the Treasury centralized payroll also receives and distributes checks. This lack of segregation of duties increases the risk of misappropriation.

Recommendation

We recommend that the home disable the timekeepers' own time editing function and their time and attendance be independently reviewed, a supervisor approve all overtime hours worked, and the pay check distribution be separate from the payroll unit.

Nurse Scheduling

Nursing overtime and utilization of temporary nursing agencies could be reduced if improved scheduling were developed.

The home's average annual overtime costs for the fiscal years 2008 through 2011 were $1.9 million of which $1.3 million were attributed to the nursing unit. The home also utilized state contracted temporary nursing service agencies at an average annual cost of $1 million, which represented the highest nursing service agency expense of the state's three homes. This expense was significantly reduced during fiscal year 2012. The minimum staffing requirement, established by the home, for registered nurses and licensed practical nurses is 40 during a 24 hour period. We reviewed three pay periods' schedules for these nurses and noted that an average of 46 nurses were scheduled daily including hires from temporary agencies. On average, eight nurses worked overtime of which four exceeded the home's requirement. The annual cost for four extra nurses approximates $500,000.

We also reviewed two invoices from two temporary nursing agencies dated April and May 2011 and noted that the home paid $17,395 for 571 hours of service. Forty percent of the hours worked by the temporary agencies were in excess of what was required. The home either had sufficient staff on duty or staff could have been reassigned from a unit that had an overage. At the beginning of fiscal year 2012, the home implemented a new policy which significantly reduced their reliance on temporary nursing agencies. Payments to nursing agencies totaled $126,000 during fiscal year 2012 as of May 31, 2012, which was less than prior year amounts.

Recommendation

We recommend the home review daily nursing schedules to ensure all registered nurses and licensed practical nurses are properly utilized, and if necessary, transfer nurses between units to alleviate the need for overtime.

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Fixed Assets

Proper fixed asset records need to be established and maintained.

The Department of Military and Veterans' Affairs (DMAVA) policy #44-02-016 and the Department of the Treasury Circular Letters 11-19-OMB and 11-18-OMB require the home to develop and maintain a fixed asset inventory to accurately account for fixed assets or equipment with an original cost of $1,000 or more and an expected useful life of three years or more. The home's fixed asset records are incomplete and inaccurate. We selected a sample of 22 fixed assets from purchase orders to trace to the home's fixed asset inventory report and found 13 were not listed. We also selected a sample of 48 assets listed on the fixed asset report to verify their physical existence. We were not able to locate 11 assets nor was there any support as to

their disposition. The home does not have a fixed asset coordinator assigned to manage and maintain fixed asset inventory as required by the department's policy. A complete and up-to-date inventory file is needed to deter theft, loss and/or misappropriation of assets.

Recommendation

We recommend the home designate a responsible individual as the fixed asset coordinator and establish and maintain a fixed asset record to account for all purchases and usage in compliance with the DMAVA's policy and the Department of the Treasury's circular letters.

State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
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Governor
Commander-in-Chief

MICHAEL L. CUNNIFF
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September 20, 2012

Mr. John J. Termyna
Assistant State Auditor
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125 South Warren Street
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Trenton, NJ 08625-0067

Dear Mr. Termyna:

Enclosed please find the NJ Veterans' Memorial Home at Vineland's "action plan", which serves in response to the New Jersey State Office of Legislative Services Audit findings of the Facility's financial practices. The Vineland-MH extends its appreciation and thanks to the members of the audit team for their observations, commentary and recommendations and wishes to reassure that we welcome and share your interest to protect and serve all those entrusted to our care. We remain committed in our quest to provide our veterans' and eligible others the highest standard of healthcare services in a fiscally responsible manner and thank you for your support to that end.

Please advise if I may be of any further services. I can be reached at 856-405-4207.

Sincerely,

Boris Reisser Jr., LNHA
Chief Executive Officer

BRJ/sd

NEW JERSEY VETERANS' MEMORIAL HOME, VINELAND

OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
JULY 1, 2009 – MAY 31, 2012

PLAN OF CORRECTION

Preface:

The Vineland Memorial Home's Business Office had a full complement of 10 FTEs in calendar year 2005. During this same year, the Facility implemented a new Medicare billing system entitled MDSease. The Vineland-MH became Medicare certified in 2006, which required our Business Office staff perform additional administrative functions and unfortunately while transitioning into this new billing process, the Facility lost one FTE, the Supervisor of Resident Accounts. Over the next four years, the Business Office lost three key full-time employees, our Medicare Biller, Assistant Business Manager and the Business Manager. Numerous attempts were made to fill these critical positions but we were unsuccessful in gaining timely approval to fill these key positions.

At the onset of calendar year 2011 the Business Office had endured without the benefit of an Assistant Business Manager for 4 ½ years, a Business Manager for 1 ½ years, and is to this day still operating without a Medicare Billing Clerk. The Facility was able to bring aboard a Business Manager and Assistant Business Manager while actively engaged in the OLS Audit.

During the OLS audit, which encompassed the time period (April 2011-June 2012), the audit team worked very closely with our Business Office staff and many of the issues presented were addressed with immediate corrective actions.

Action Plan:

Revenue – VA Per Diem Allowance

The calculation of billable days and rates did not follow billing procedures set by the U. S. Department of Veterans Affairs:

During the OLS audit, a new procedure using the updated VA form 10-5588 was implemented (per approval of the OLS audit team) to document and calculate billable VA days in detail.

A VA Award Letter is required upon resident admission for verification of veterans with 70% or greater service connected disabilities which are then certified by the Delaware VA.

The Business Office Assistant Manager maintains compliance with VA daily/monthly billing regulations using the following steps:

(1) A monthly actual facility cost spreadsheet was developed and implemented which includes all costs as stipulated in OMB- Circular A-87. The facility takes the lesser of facility monthly costs versus the maximum rate allowed under "State Veterans Home Per Diem" rate as listed under Pub. L 109-461.
(2) Each day Nursing will submit to the Business Department the previous day's facility census which records all residents out at the hospital or on pass. This daily census is recorded onto a monthly cumulative census sheet which tallies final totals of Veteran eligible days present at the facility for monthly billing purposes to be submitted on to the VA in Delaware.
(3) Daily census information is extracted on resident population changes, a copy is then submitted to our Delaware facility who inputs the information onto their grid sheet and comes up with their own actual billable Veterans days.
(4) If there is a difference in the Veteran's calculated days with the Delaware VA's calculated days for the month, each Veteran who was out for any length of time during the month must be reviewed and reconciliation will be made of the number of Veteran days. All supporting documentation is attached and kept on file in the Business office.
(5) A new form that keeps track of those Veterans and Non-Veterans Days that are out of the facility was developed to more readily isolate disputes on resident's exact billable days.

Revenue – Care and Maintenance

Care and maintenance costs are under billed due to the rate calculation not being in compliance with the New Jersey Administrative Code.

Under the guidance of the OLS team, a new care and maintenance fee computation template was implemented. The new template includes all NJAC 5A: 5 allowances and deductions including calculations for the community spouse income.

Each fiscal year, the Supervisor of Accounts mails out a new income and expense questionnaire to the resident's responsible financial representative in an effort to update our financial information as it relates to the resident's financial obligations to the facility. The Supervisor of Accounts then updates the resident's record, making the appropriate revisions to the income computations.

The new income and expense questionnaire addresses the penalties related to omitting or providing false/incomplete documentation in support of the Facility's efforts to update its financial records and aid the resident in meeting his/her financial obligations to the Facility. The resident/financial representative is aware the resident will be billed at the full daily rate, without considerations for allowable deductions for non-compliance.

Delinquent resident account reports are completed on a quarterly basis and submitted to the Department of Treasury as required. The facility remains open to any revisions to the New Jersey Administrative code that would enhance compliance by residents and responsible parties in meeting their financial obligations.

All refunds involving veterans with 70% or greater service connected disabilities have been completed. At present there are eleven veterans residing at the Vineland-MH with 70% or greater service connected disabilities that fall under the guide of Federal Public Law 109-461 when completing our care and maintenance calculations.

Revenue – Medicare Part A and Part B, and Co-insurance

Unpaid claims of $1.5 million have not been collected

On June 1, 2012 the facility implemented a new software billing/accounting system, NTT Data, with automated billing capability for Medicare Part A and Part B. The manual census grid for Medicare Part A residents will be verified against the total Medicare Days billed by NTT, and any discrepancies will be verified and resolved to ensure that all eligible Medicare Part A days have been billed.

The monthly invoice for services rendered to our Medicare Part A and Part B residents by our contracted Therapy provider is reviewed and verified by the Business Office's Special Staff Officer. Noted discrepancies are resolved with the Therapy provider and any adjustments indicated on our next monthly invoice.

Referencing Medicare Part A: Once reviewed and verified the Medicare Part A bills are submitted electronically to the Facility's Medicare Intermediary. The Facility, under the new software program, now has the capability to receive and post Medicare Remittance electronically. The Aged Receivable reports, which give an accounting of all pending receivables, will be generated on a monthly basis by the Special Staff Officer and used as a monitoring tool to address/resolve any unpaid Medicare claims. This report will be reviewed by the Special Staff Officer and the Business Office Manager accountable to addressing any unpaid claims and report on the actions being taken to resolve the pending issue.

Medicare Part A Coinsurance: Medicare Remittance are now received electronically and any coinsurance charge that did not "crossover" to the residents secondary insurance will be manually billed within 45 days of receipt of the Medicare Remittance. The Aged Receivable report will be used as a monitoring tool for any unpaid claims. Again this report will be reviewed on a monthly basis by the Special Staff Officer and the Business Office Manager who will address any unpaid claims and take the necessary actions to resolve the issue in order to receive payment.

Medicare Part B: The monthly case load to be billed will be verified against the Therapy invoice submitted to our facility from our contracted provider to ensure that all billable therapy charges have been billed and submitted to our Medicare intermediary. Discrepancies will be resolved and adjustments will be documented on our next monthly invoice. The Aged Receivable report will be used as the monitoring tool in the same manner as indicated for our Medicare Part A.

Members Fund – Accounting and Reconciliation

Reconciliations are needed to ensure receipts and payments are properly received and disbursed and monies are properly accounted for by the home.

Each finding indicated by the OLS Audit team within this section of the report is in the process of being reconciled. The following actions have been implemented to make certain receipts and payments are properly received and disbursed and monies properly accounted for by the Home.

The new billing/accounting software generates a Billing Recap Report which shows the number of resident days and resident's monthly maintenance amount being billed. The Billing Recap Report is reviewed and verified by the Supervisor of Residents Accounts who is charged with resolving discrepancies before the end of the month when billing is completed.

A Cash Receipts Report details the disbursements of the receipts received during the month. The report identifies all monies received and segregates the monies as those owed to the Treasury of the State of New Jersey minus the monies to be deposited into the resident's personal fund account.

The Supervisor of Residents Accounts and the Business Manager will review the Aged Receivable Report monthly for delinquent accounts. Actions will be taken to resolve the issues such as forwarding an account to a collection agency.

The Assistant Business Manager will reconcile all banking accounts on a monthly basis. All supporting documentation is attached to the bank statement and maintained on file in the Business office.

Purchasing

Internal controls and compliance to applicable guidelines for purchasing need to be strengthened.

In compliance with the Department of Treasury and the DMAVA standard operating procedure, an interoffice communication letter was issued to all Department Heads effective June 28, 2011 directing that purchase order form 720 be completed prior to purchase. The purchase order form is forwarded to the Business Office Manager or the Assistant Business Office Manager for approval. Non contract vendor purchase orders over $1000 require three price quotes, or one price quote in event of a sole supplier, be submitted to the Business Office Manager/Assistant Business Office Manager for review prior to approval, per circular letter policy 11-10-DPP. Any purchase orders that are processed and not approved by the Business Manager or the Assistant Business Manager will be submitted to Administration for appropriate action.

Purchased items are received, verified and inventoried via the Receiving Department and reconciled against the approved purchase order. Documentation is forwarded to the Business Office for processing and final evaluation by the Business Manager. Administration will be notified of items received without an approved purchase order and administrative action taken as warranted.

During the OLS Audit, it was identified that the Home was using a disproportionate amount of Triple X-large briefs. The unit price for the Triple x-briefs was $1.78 more expensive than X-large brief from the same manufacturer or supplier. As of December 2011 all residents utilizing incontinence products were transitioned to a new product line provided by Gulf South.

Gulf South, a state contracted vendor, was consulted in the Home's effort to execute its incontinence program, a program utilized by long term care providers to efficiently and effectively manage incontinence. All of the residents in our facility utilizing disposable briefs were evaluated by a registered nurse consultant from Gulf South. This nursing professional measured and weighed our residents and applied this information to a sizing chart identifying which size brief the resident should be wearing. The briefs are color coded by size making the selection of the appropriate size briefs on the nursing units easy to identify. All nurses and nurses aides were in-serviced about the changes in brief vendor, sizing chart and color code chart.

The Facility's continuation of this incontinence system was based on the evaluation by the Gulf South Representative and in collaboration with our Nursing Professionals on our units which was successful in realizing a decrease in triple X-large brief usage with 73 residents being reclassified to sizes other than triple X- large.

It should be noted that regulatory standards of care dictate that residents are checked at least every (2) two hours to assess their incontinence and changed if needed. A soiled brief noted prior to the two-hour assessment period is always changed. Our facility provides the highest quality of care concerning incontinence and continues to enforce strict adherence to the required standards of care. Improper care of incontinence can lead to incontinence dermatitis, and ultimately pressure sores. We are very proud that our facility has a 1% incidence of pressure sores facility wide, a quality care standard that is measured and monitored closely by our regulatory agencies.

In May of 2006, in conjunction with the Vineland Veterans Home obtaining Medicare Certification, the Facility became responsible for the purchase of all Durable Medical Equipment identified as a medical need for residing residents. One of the more costly purchases involves the purchase of wheelchairs for residents in need. Other State expenses for which monies are not appropriated involve among others dentures, oral surgery, hearing aids, and eyeglasses. The State Veterans Homes do not have monies appropriated to address these cost items and thus in accordance with Administrative Code, Chapter 5, specifically as defined under extraordinary medical expenses, the Facility permitted needy residents a care and maintenance fee deduction, with the proviso that the DME become the property of the State. Durable medical equipment is inventoried, recycled and utilized for residents in need.

A typical example for a care and maintenance fee allowance by the facility would be as follows…

A resident is admitted to the facility with a "jazzy" electric wheelchair which was being paid for by Medicare. Medicare would normally pay for the wheelchair over a period of thirteen months at which time the chair would have been paid in full and become the property of the resident. However, in this case, the resident was admitted to the Facility well short of the thirteen month payment schedule and Medicare stopped payment on admission. The resident must then buy out the remaining balance on the wheelchair, which in this situation was $1,600, in order to keep it, but sadly he has no assets/funds. Given the aforementioned situation, the Vineland Veterans Home would have taken the remaining balance of $1,600 and divided the amount into a 12 or 18 month payment schedule to avoid having the resident lose his means of mobility. The wheelchair is inventoried as State property for resident uses throughout his/her stay at the home and upon discharge/death the wheelchair is recycled for other needy residents.

If a care/maintenance fee deduction to address such extraordinary medical expenses is not permitted, then Treasury will need to consider appropriating funds to cover these needed items.

Payroll

Controls over payroll processing need to be strengthened.

Disable the Timekeepers' Own Time Editing Function and Their Time and Attendance be independently Reviewed:

The timekeeper's own time and attendance editing function has been disabled. Human Resources Management will audit for compliance quarterly for the first two quarters. Thereafter, provided there are no violations, the audit will be completed bi-annually.

A Supervisor to Approve All Overtime Hours Worked:

The payroll department was directed not to pay any overtime that has not been approved by a supervisor's authorizing signature. Supervisors who had not previously performed this function are being trained in KRONOS. Non-supervisory staff members who have a need to access this information have been granted view capabilities only, thereby, enforcing the requisite of a supervisor's approval with authorizing signature on the actual timesheets for payment to occur.

Pay Check Distribution Be Separate From the Payroll Unit:

Payroll is no longer involved in receiving or distributing paychecks. This practice was stopped immediately during the audit. The Human Resource Department handles this function independently and separately from the Payroll Office.

Nurse Scheduling

Nursing overtime and utilization of temporary nursing agencies could be reduced if improved scheduling were developed.

The New Jersey State Department of Health's Standards for Licensure of Long Term Care Facilities N.J.A.C. 8:39... Subchapter 25 defines the bare minimum nurse staffing amounts and availability that a LTC Facility must provide based upon the total number of residents and their individual acuity requirements. LTC Facilities are held accountable to ensure minimum mandated staffing requirements are maintained at all times and in accordance with licensing standards. LTC Facilities are subject to annual and impromptu surveys that include a random three week review and assessment of nurse staffing schedules to ensure compliance with licensing staffing mandates. The Facility is also

required to post, in full public view, each day the actual number of staff on duty, by title assigned to the Nursing Department. Substandard performance results in a citation against staffing standards and can involve monetary penalties.

The State Department of Health staffing requirements, as defined in Administrative Code, focuses primarily on the direct care needs of residents, without regard to the vast ancillary administrative tasks required of our nurses, e.g., addressing staffing needs, directing staff performance, conducting resident assessments, handling family inquiries, pursuing injury and complaint investigations, etc... It should also be noted that many of our recent admissions have dual diagnoses which involve psychiatric disorders, requiring specific staffing adjustments not considered in N.J.A.C. 8:39. Sufficient staffing as referenced to in the report is subjective and only considers the bare direct care staffing minimums, as defined by the Department of Health and does not account for the day to day operational demands placed upon the facility's Nursing Department via State and VA Regulatory requirements.

In an effort to address the efficient use of staffing and reduce costs associated with agency use in the Nursing Department, the Facility implemented a revised reassignment/overtime authorization matrix effective July of 2011. As acknowledged by the OLS survey report, agency expenditures have been considerably reduced and this effort will continue. The Facility has also assigned a staffing coordinator to handle the day to day task of assuring minimum shift staffing coverage requirements and to enforce the recently implemented reassignment/overtime authorization matrix.

Daily Nursing schedules are attended to by the assigned Staffing Coordinator and Shift Supervisor of Nurses who ensure sufficient staff coverage via reassignment of staff when available, overtime assignments, Per Diem Pool staffing and lastly Agency. The following consistent protocol of application is used to facilitate needed coverage...

1. Use available facility staff via reassignment of those who are already at the facility for needed minimum nursing staff coverage.

2. When reassignments are not feasible, on and off duty employees are offered overtime, in accordance with the respective collective bargaining unit contract to achieve coverage minimums in accord with the overtime authorization matrix.

3. When efforts to reassign staff on duty or obtain overtime coverage have been unsuccessful, the Staffing Coordinator/Shift Supervisor of Nurses will turn to the Facility's pool of Per Diem employees, who receive a flat hourly rate and represent our most cost effective staff replacement initiative, to achieve coverage minimums in accord with the reassignment/overtime authorization matrix.

4. As a last resort and only when the efforts of the previous three steps have been exhausted and have failed to achieve coverage minimums will the Staffing Coordinator or the assigned Shift Supervisor of Nurses turn to Contract Agency to achieve coverage minimums, which for agency use was reduced to a minimum that is one staff person below the established Facility minimum.

Monthly computations of nursing staffing hours, in terms of per diem and agency use, is completed by the Human Resource Department and Business Office respectively and forwarded to Nursing Administration for tracking against actual assignments. Nursing Administration conducts daily reviews of shift staffing strength sheets, (reports that illustrate actual employees worked on a given day/shift), to ensure those responsible for staffing are staffing in accordance with the reassignment/overtime authorization matrix, which is designed to control costs while assuring DOH minimums are being met.

The Director and the Assistant Director of Nurses are directly accountable to monitor the performance of the Staffing Coordinator and the Shift Supervisor of Nurses to ensure the reassignment/overtime authorization matrix is enforced. When applicable, adjustments to staff and re-education are completed to make certain that staffing is maintained in the most cost effective manner.

Facility Administration will continue to monitor staff performance to assure protocols implemented to control and reduce costs associated with staffing the nursing department remain in effect and are enforced. Nursing Administration will monitor staffing assignment schedules to ensure registered nurses, licensed practical nurses and certified nurses' aides are utilized properly and in the most cost efficient manner. Violations involving staffing protocols will be addressed and administrative action taken as warranted.

Fixed Assets

Proper fixed asset records need to be established and maintained.

The Assistant Business Office Manager is responsible for the fixed asset accounting process for the Facility. In accordance with the DMAVA's policy and the Treasury Department's fixed asset circulars 11-18-OMB and 11-19 OMB, a fixed asset inventory record will be maintained for each fiscal year verified with accounts payable capital accounts. The record will indicate each capital purchase for the fiscal year, tag number assigned to the purchase, the location of the purchased item within the facility along with the Department Head's signature for verification and accountability. Documentation is maintained and kept on file in the Business Office for verification and review. The final Fixed Asset Accounting/Inventory Report file is submitted to the Business Manager for review and will account for all purchases. Administration will be notified for warranted corrective actions.