FINAL REPORT OF
THE NEW JERSEY STATE COMMISSION OF INVESTIGATION
ON THE PROPERTY COST REIMBURSEMENT SYSTEM
FOR NURSING HOMES PARTICIPATING IN THE
NEW JERSEY MEDICAID PROGRAM

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INTRODUCTION

Since December of 1974 when Medicaid and Medicare payments to nursing homes began to undergo public scrutiny, several agencies and committees of New Jersey government became involved with one more aspect of the inquiry. In December of 1974 the Governor requested the State Commission of Investigation (hereinafter referred to as "S.C.I." or "Commission") to conduct an evaluation of New Jersey's system of Medicaid reimbursement. Also, in December of 1974, the New Jersey Attorney General's office announced that it was probing the alleged interests of Dr. Bernard Bergman in New Jersey nursing homes. Later, that office set up a special portion of its Enforcement Bureau to specifically deal with possible criminal activities and fraud in the area of reimbursement to nursing homes and other providers. This unit has already produced several indictments. In January of 1975, Governor Byrne announced the formation of a cabinet-level committee to study the problems of Medicaid reimbursement for nursing home care. That committee issued its report on November 13, 1975, and the recommendations relating to property costs reimbursement reiterated several of the suggestions initially made by the S.C.I. on April 3, 1975, in its first interim report on nursing home reimbursement. The New Jersey Legislature also created its own committee to examine nursing homes in January of 1975. That committee, chaired by Senator John Faye of Middlesex County, is examining the quality of care in New Jersey nursing homes receiving Medicaid reimbursement and other aspects of the program.

Because of the attention being given to other facets of the Medicaid system as it relates to nursing homes, because reimbursement of land and building costs presents one of the largest cost factors of Medicaid reimbursement and because investigators involved in the area have realized that it is this component of reimbursement which is most often abused and most in need of reform,[1] the S.C.I. has continued to direct its attention to this area.

In the first report issued by the Commission in April of 1975, the genesis of a certain schedule of ceilings for rentals and imputed rentals was examined along with other components of the property cost reimbursement system created by the Division of Medical Assistance and Health Services (hereinafter referred to as "DMAHS") of the Department of Institutions and Agencies. One of the primary conclusions of that report was that the schedule of maximum rentals and imputed rentals was inflated so as to permit unnecessary hypothetical profits. The purpose of this report is to examine the realities of the former hypothesis and to further comment upon some other undesirable features of the property cost reimbursement system. This will be accomplished via an in-depth study of a number of nursing homes now participating in the Medicaid Program. Additionally, the report will address some of the deficiencies of

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1. See, e.g., Reimbursement of Nursing Home Property Costs; Pruning the Money Tree, Report of the New York State Moreland Act Commission on Nursing Homes and Related Facilities, January, 1976; Report on Nursing and Related Facilities, Temporary State Commission on Living Costs and the Economy, April, 1975; Report of the Ad Hoc Committee on Capital Cost Reimbursement Rates, New York Public Health Council, October 25, 1975.

the Medicaid administration in DMAHS and the Department of Health as they relate to property cost reimbursement.

Some of the most noteworthy findings of the report are:

1. That there are profiteers and opportunists with investments in substantially Medicaid funded nursing homes in the state who recoup returns as high as 105% annually and have no connection with the operation of the facility.

2. That there has been and continues to be a large number of nursing homes participating in the Medicaid program which have never been audited.

3. That due to the lack of auditing, substantial over-payments have occurred to a number of homes examined by the Commission.

4. That there is no effective control by either the Department of Health or DMAHS on escalating property cost expenses.

5. That communication between the two agencies with the responsibility for administering the program is extremely poor.

6. That there exists a combine of loosely connected groups of New York-based entrepreneurs who control a substantial percentage of the Medicaid beds in New Jersey.

Finally, a summary of the recommendations appearing at the end of each section of this report is as follows:

1. That the entire present system of property cost reimbursement be completely overhauled along a pattern suggested initially by New York's Moreland Commission with modifications suggested by the S.C.I.

2. That while the foregoing system is being implemented certain controls on escalating property cost reimbursement should be adopted by the Department of Health.

3. That construction costs on new facilities and additions be strictly controlled since they will directly affect reimbursement.

4. That additional auditors be hired by DMAHS and that an educational program be provided for them to further increase their efficiency.

5. That Senate Bill 594, presently pending before the New Jersey Legislature, be substantially strengthened as to reporting requirements by individuals with interests in nursing homes and that that knowledge be utilized by the administering agencies.

6. That communication between DMAHS and the Department of Health be created by the institution of a standing committee on property cost reimbursement and ownership.

I. CASE STUDIES ON PROPERTY COSTS REIMBURSEMENT UNDER THE MEDICAID SYSTEM

INTRODUCTION

As was stated at the outset, one of the purposes of this report is to examine certain nursing homes participating in the Medicaid program around the state and to comment upon the reimbursement of their property costs. The Commission is of the opinion that the property cost reimbursement system existing presently is unwiedly and wasteful. From figures supplied by the Division of Medical Assistance and Health Services of the Department of Institutions and Agencies, approximately $22 million will be reported to that agency by nursing homes as property expense in fiscal 1976. Reimbursement of property costs represents a significant percentage of the total Medicaid payments to nursing homes of $130 million in fiscal 1976. Efforts to restructure the system with an eye towards cost savings are, therefore, necessary and valuable.

As was the case in the first report issued by the Commission, however, a rudimentary understanding of reimbursement is a necessary prerequisite to a full comprehension of the analyses in this report. That first report contained a complete explanation of the reimbursement formula and the relevant pages are appended hereto as Exhibit 1, for the reader's edification. The only facet of the reimbursement system which plays a critical role in this report, however, is the system relating to property cost reimburse-

ment. Simply stated, DMAHS recognizes[2] property costs as debt service (mortgage interest) plus insurance on building plus depreciation plus a percentage return on equity. Where the home is rented via an "arms-length lease", the yearly rental is used for the amount of reimbursable property costs up to the maximum amounts supplied by the aforementioned rental schedule which is appended as Exhibit I to Exhibit I.

The foregoing are the traditional types of land and building treatment in a commercial situation. The maximum rental schedule and DMAHS regulations, however, create other classifications of arrangements which are important to understand for present purposes.

First, where an operator leases the nursing home from a party who is related by family ties or by business relationships, the lease is considered a "non-arms-length" one and the operator then has two options: he may use the amount computed from the maximum rental schedule, column "B", or he may use the actual carrying charges of the lessor (debt service, depreciation, insurance and return on equity) whichever figure is higher. This option is not available to lessees operating nursing homes under leases which are the product of arms-length agreements between

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2. The term "recognizes" is a relative one. It is important to note that, although 100% of property related expenses are listed on the nursing home cost reports, the actual amount of reimbursement would be the listed figures times the percentage of Medicaid occupancy. Thus, for instance, if property costs are reported at $100,000 and the Medicaid occupancy level is 50%, $50,000 is the actual reimbursement.

unrelated parties.

Finally, DMAHS grants owner-operators "imputed rent"[3] where their carrying charges do not meet the appropriate amount computed by the utilization of column "B" of the rental schedule. Thus the owner-operator has the option of using actual carrying charges or the imputed rental amount, again, whichever is greater.

In summary, then, there are four essential classifications of property cost reimbursement: 1) actual carrying charges granted to owner-operators whose property related expenses are greater than the imputed rental computation; 2) imputed rental granted to owner-operators whose actual carrying charges are less than the imputed rental computation; 3) the amount of the lease up to the maximums set by the schedule to lessees operating under an arms-length agreement; and 4) the amount of actual carrying charges of the lessor or the computation from the schedule, column "B", (again, whichever is greater) to the lessee operating under a "non-arms-length" lease between related parties.

Some discussion of the operation of the schedule is appropriate. Reference to Exhibit 2 discloses columns of monetary figures according to the year of construction and geographic location of the nursing home. For a nursing home in Essex County built in 1973, operating under an arms-length lease, for instance, the

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3. This topic was commented upon in an in-depth fashion in the Interim Report issued by the S.C.I. on April 3, 1975. The recommendation which resulted from that examination was twofold: 1) that consideration be given to complete abrogation of the concept, and 2) that the option of taking the higher of the two computations be discontinued immediately.

figure is $1,618. $1,618 is then multiplied by the number of certified medicaid beds in the institution to arrive at the rental ceiling, thus, if the Essex County nursing home contained 100 beds, the ceiling would be $161,800 ($1,618 times 100). DMAHS would therefore reimburse any arms-length lease up to $161,800.

The basis for the monetary amounts was unknown to the officials of DMAHS responsible for its implementation as of February 1975, when their testimony was taken. The Commission established that New Jersey adopted (with modifications) the New York schedule on the topic and further that that schedule was based on an average of inflated carrying costs supplied by the Metropolitan Nursing Home Association of New York City. The amounts are supposed to reflect construction costs for the buildings, but the manner in which they were extrapolated from an average of carrying costs was never fully explained.

There are several observations and comments which can be made upon New Jersey's system of property costs reimbursement, some of which are based upon facts from the prior report, some of which are evidenced by the instant report and others which are apparent from the face of the regulations. The Commission believes that the following are some particularly salient comments:

1. <u>The reimbursement of carrying costs fails to take account of certain critical financing factors</u>.

The DMAHS approach to reimbursement of the carrying costs — debt service, depreciation, insurance and a return on equity — fails

to take account of cash flow, tax advantages and real estate/ building appreciation so that owners actually reap more profit from their financial posture than DMAHS presently recognizes.

2. The present system encourages trafficking in nursing homes.

Because the sale prices of nursing homes are not controlled by either the Department of Health through the certificate of need program or DMAHS through its auditing function, it is not uncommon for new homes to be quickly sold after construction at a price which far exceeds the construction costs. Nor is it uncommon, for these same reasons, for homes to be sold over and over again every two or three years with a constantly escalating sales price, the debt portion of which is, in effect, often substantially amortized by the State of New Jersey. This cost escalation, of course, bears no relationship whatsoever to the quality of care.

3. In addition to the "quick sale", refinancing is a common occurrence with a resultant monetary detriment to the State.

There is a natural inbred impetus for the owner of a nursing home to keep the interest portion of his mortgage payments at a high level. In the first place, mortgage interest is deductible for income tax purposes, and, in the second place, it is a reimbursable Medicaid cost. The portion of mortgage payments which is attributable to the principal, however, is neither deductible nor reimbursable. With traditional mortgage agreements, or course, the early amortization payments are heavily weighted in favor of

the interest portion which gradually declines over the period of amortization. Amortization merits the owner almost nothing, however (with the exception of the comparably minimal return on equity), and the owner, therefore, is impelled to resell and/or refinance on a rather regular basis. The State is the natural loser in this set of circumstances since it continues to reimburse for a continually elevated debt service.

4. The "double profit" syndrome.

There is no regulation upon the percentage of the value of the nursing home which may be financed and, where refinancing occurs, there is no regulation concerning the utilization of the proceeds of that refinancing. Furthermore, upon resale to a related party, the seller may take back a second mortgage beyond the institutional financing to make up the possibly inflated sales price. The risk on second and third mortgages, of course, is usually high, but in the case of a Medicaid nursing home with a high percentage occupancy, the payment of the mortgage interest is, in effect, guaranteed by the State.

5. With respect to leases, the fact of the existence of maximums set by the schedule causes no lease negotiations to be truly "arms-length".

Experienced nursing home owners are, of course, aware of the maximum rent for their home which can be costed for Medicaid

purposes and this factor substantially effects the negotiations between lessor and potential lessee. The lessee often finds himself in an extremely poor bargaining position because the State has, in effect, predetermined the rental for any given home. The Commission has found at least one occasion, for instance, where the actual lease documents call for rental equal to the maximum amount which Medicaid will reimburse.

6. The fact that the schedule is inflated, by being based upon existing inflated property costs, allows the amortization of inflated mortgages by lessors and a high profit margin to lessors and middlemen who assign or sublet at a profit.

The inflation of the maximum amounts listed in the schedule, of course, presents numerous possibilities for financial gain to astute lessors. Some of the possibilities which the Commission has established are listed above, and, again, where Medicaid occupancy is high, a substantial portion of the profits are derived from the State. It is also important to note that none of these profits bears any relationship whatsoever to the quality of care being provided in the particular nursing home and the lessor or sub-lessor is rewarded for nothing more than his business acumen.

7. The schedule amounts to be employed by each home are hinged to the year of construction of that home, and since misrepresentation of the year of construction would produce higher reimbursement, the utilization of the schedule becomes an invitation of fraud.

The above-described situation becomes particularly acute where the home operates from a refurbished building originally constructed for another purpose. Since the renovation is often costly and, in many cases, financed, and because DMAHS allows only the employment of the year of original construction, the temptation to misrepresent is great. To complicate matters, it appears that such misrepresentations have often gone unchallenged or at least unaudited by DMAHS, which situation is, again, costly to the State. The condition is probably fostered by the fact that DMAHS has no written guidelines for the treatment of renovated homes and the Commission will recommend that one be created.

8. The concept of "imputed rental", ostensibly created to attract older homes to the program, may be outmoded and, in certain cases, should definitely be abrogated.

Since operators who have relatively low carrying charges, and/or are almost fully depreciated, are given the option of employing imputed rental computed from column "B", there is a theoretical impetus for the home to become active in the program. Stripped to its essentials, however, the concept does nothing less than give owners something for nothing. New York officials testified sometime ago that imputed rental would probably be discontinued there and, again, the Commission suggested a similar action in New Jersey. The specifics of the S.C.I. recommendation are again contained in the appropriate sections.

As stated previously, the Commission has chosen several nursing homes for examination. The history of the financial transactions with respect to construction costs, financing, sales and leases makes up the bulk of the reported examination of these homes, but, because resale prices and leases are not indicative of value, the Commission has also undertaken herein to pinpoint other indicators of value. Additionally, various comments will be made upon profit realized through the property cost reimbursement and upon other faults of the property cost reimbursement system exhibited by that home.

Edison Nursing Home

The Edison Nursing Home is located at 465 Plainfield Avenue, Edison, New Jersey in Middlesex County. It contains 302 beds and is populated to a degree of 98% by Medicaid patients. The home is operated by a corporation called Edison Nursing Home, Inc., which is wholly owned by Mr. Herbert Kallen and his wife Lenore. Mr. Kallen and his wife sold the stock of the corporation which owns the land and building in October of 1970 and this transaction will be discussed hereinafter. Per its 1975 cost report, as desk audited by DMAHS, total adjusted property expenses are $266,068 per year. This amount, since it is higher than the imputed rental schedule is the one used for Medicaid reimbursement purposes. Pursuant to the same cost report, the home was constructed in 1966.

Edison Tower, Inc., was incorporated on June 4, 1963. On October 25, 1963, 13.49 acres of land for the site were sold to Edison Tower, Inc. The grantor of said parcel was the Second Construction Corp., Inc. (Leon Weiss and Rudolph Weiss) and the sale price listed on the deed was $1.00. On the same date, October 25, 1963, there was executed an F.H.A. Building Loan Agreement listing a construction mortgage amount of $2,225,300 (89.99% of assessed valuation by F.H.A.). The listed general contractor was the Weiss-Bern Corporation. The mortgagee on the mortgage of $2,225,300 was the Garden State National Bank. The listed total project cost for construction on the F.H.A. application was $1,744,338, listed non-construction costs

amounted to $176,849 for a total of $1,921,187.

On April 1, 1965, a certificate of occupancy was issued. On July 1, 1965, the original construction mortgage of $2,225,300 was modified and transformed into permanent financing with the same mortgagor and the same mortgagee (the bank had, in the interim, changed its trade name).

On October 13, 1970, Edison Tower, Inc., sold its outstanding stock to Mr. Kallen. The terms of the sale were as follows: 1) a $150,000 cash downpayment, 2) the assumption of the existing mortgage (amount outstanding at the time of sale - $1,943,665), and 3) a personal note whereby a corporation known as 465 Plainfield Inc. (another corporation wholly owned by Mr. Kallen) promised to pay W.B.W. Associates, a co-partnership having its principle place of business in Brooklyn, New York, and made up of Messrs. Weiss, Bernstein and Weiss (who were also the stockholders of Edison Tower, Inc.), the sum of $916,720.56. The terms of the note called for the payment of interest only from November 1970 through the first day of October 1973 and thereafter, with minor adjustments, a payment of principal and interest at the rate of 7½% per annum, amounting to payments of $7,916.67 per month, beginning the first day of November, 1973, through October 1980 at which time the unpaid balance is due and payable.

The June 30, 1971 cost report submitted to DMAHS lists the following items for property cost reimbursement purposes:

land - $159,000, improvements - $3,120,929, for a total of $3,279,929. In July of 1971, the nursing home was appraised for tax purposes at $2,293,788. In the interim the real estate tax assessment was increased to $2,950,350. On July 2, 1973, the nursing home requested that that real estate tax assessment be lowered to $2,500,000 on the theory that the assessment was, "in excess of fair market value." In support of this petition, another appraisal was submitted using three different methods of appraisal, reproduction ($2,462,500), comparable sales ($2,501,600) and income capitalization ($2,462,500). The assessment on improvements was reduced by $60,000, as a result of this petition, on November 8, 1973. On June 27, 1974, another petition was filed seeking a reduction to $2,500,000 for the same reasons as the 1973 petition. That petition was dismissed on August 27, 1974 and an appeal was filed with the State Division of Tax Appeals on October 31, 1974.

Comments and Observations

On October 13, 1970, the amount of financing on the nursing home was the amount of the outstanding mortgage ($1,943,665) plus the amount of the aforementioned note from 465 Plainfield Corp. to W.B.W. Associates ($916,720) for a total of $2,860,385. After the first year, the nursing home became a more than 90% Medicaid facility and remains so to this date. The result, of course, is that the State of New Jersey has paid the over-

whelming majority of the interest on this indebtedness since it was incurred.

The aforementioned figure, $2,860,385 is more than $360,000 in excess of any appraisal that has ever been done on the nursing home, including appraisals that were done some two years before this transaction. The figure is also over $1,000,000 in excess of the total construction cost listed on the initial F.H.A. application when the home was being built. Finally, the figure is also more than $360,000 in excess of the value placed on the home by the owners themselves in their various tax appeals. It is true that the sale included an amount of $300,000 for furnishings in the nursing home and another $150,000 for good will, but the cost reports filed by the institution indicate nowhere that the financing on the institution pertains to anything but the building.

In the view of the Commission, the October 13, 1970 sale would probably not have taken place but for the advent of the Medicaid system. This example points out that, since there is no limitation upon the amount of debt financing which the Medicaid program will allow, informed entrepeneurs will sell nursing homes at highly inflated values as long as the state continues to underwrite unlimited debt.

White House Nursing Home

The White House Nursing Home is located at 560 Berkeley Avenue, Orange, New Jersey, and contains 176 beds. White House Nursing Home, Inc., which, according to the license application, is wholly owned by Mr. Eliezer M. Grossman and his wife, operates the nursing home under a lease from the I & S Realty Corporation, 1354 46th Street, Brooklyn, New York. The yearly rental is $1,700 per bed ($299,200).

The land and building of the White House Nursing Home was purchased on October 11, 1972. The institution was formerly the Beard School. The purchasers were Messrs. Stephen Atkins, Jack Atkins and Harold Kent, trading as the Beard Nursing Home Association. The purchase price, according to the deed, was $450,000. The Beard School was constructed in 1909.

On October 13, 1972, a letter of construction mortgage commitment was granted by the Franklin Capital Corporation to Atkins Associates, Inc. (the same group which made up the Beard Nursing Home Association) in the amount of $1,725,000. The first disbursement on that construction mortgage was $450,000, and that amount, according to the mortgagee, was utilized for the purchase of the land and building. The mortgage was granted at 4-3/4% over the prime rate with a minimum of 9% and a maximum of 12%.

On February 23, 1973, I & S Realty Corp. (who ostensibly did not as yet own the facility) executed a lease with the

aforementioned White House Nursing Home, Inc. The lease is of the "net-net" variety and calls for a yearly rental of $1,700 per bed ($299,200 per annum) during the first 121 months of the term and $1,800 per bed ($316,000 per annum) for the remaining term of 21 years.

Thereafter, on May 24, 1973, the Beard Nursing Home Association, a partnership made up of the aforementioned Messrs. Atkins, Atkins and Kent, sold the facility to I & S Realty Corp., a New Jersey corporation which lists its sole officers and directors as Icek and Sara Cywiak. The purchase price, according to the deed, was $2,057,000. In addition to the assumption of the outstanding mortgage, the buyers executed on May 5, 1973, a second mortgage in the amount of $182,500 back to the Beard Nursing Home Association. This mortgage was granted at an annual interst rate of 7½% for a term of five years.

The institution, according to information obtained by the Commission, had some difficulty in obtaining permanent financing. The previously mentioned second mortgage was modified and extended on November 28, 1975 whereby the principal sum was reduced and the term was extended. Thereafter, on January 19, 1976, a new first mortgage was negotiated in the amount of the original construction mortgage ($1,725,000) in order to allow additional time to obtain permanent financing. The rate of interest on that mortgage is 10½%; payments are $20,125 per month for a term of three years with a required balloon

payment of approximately $1,500,000, at the end of the term. The promissory note filed by I & S Realty with the aforesaid mortgage bears the signatures of Messrs. Atkins, Atkins, Kent and their wives as individual and collective guarantors. This same group ostensibly sold the property some two and one half years prior to the date of this promissory note.

The real estate tax assessment on the land upon which the nursing home is situate is listed at $179,300; the assessment on the building is $616,000. The assessment rate in the City of Orange is 76.51% of true.

Comments and Observations

1. It is the stated policy of DMAHS that the original year of construction is employed when determining the maximum rental ceiling for renovated facilities. That policy was not followed with respect to the White House Nursing Home cost report.

An examination of the 1975 cost report for the facility discloses that DMAHS allowed a 1973 construction date which has the effect of allowing a rate of $1,618 per bed ($284,768) as ceiling in the case of an unrelated lease. Thus, DMAHS disallowed only $14,432 ($299,200 - $284,768) with respect to the amount claimed for rent. If the stated policy was followed, the year of construction would be 1909 and the maximum rental figure would be $256 per bed ($45,056). Thus the disallowance should have been $254,144.

2. Since, as in most cases with nursing homes, the lease in this case is of the "net-net" variety, the only actual expense to the owner is mortgage amortization. Thus, the yield on the original investment can be computed by subtracting the yearly mortgage expense from the amount received under the lease and then expressing that figure as a percentage of that original investment.

In the instant case, I & S Realty purchased the nursing home for $2,057,000. Toward that purchase price, however, two mortgages were undertaken. The principal sum on the first is $1,725,000 and the total amount on the second was originally $182,500. If it is presumed that the balance of the payment was in cash, the maximum initial investment of I & S Realty was $149,500.

The nursing home has not as yet obtained permanent financing, but assuming that it does in the near future and assuming that the terms are conventional ones (a principal amount of $1,725,000 (the construction cost) at 10½% interest for 21 years) the monthly first mortgage payments will be $16,985 ($203,820/yr). The proposed payment on the second mortgage is $2500 per month ($30,000/yr) for five years. When these amounts are subtracted from the income on the lease ($299,200) the return on the initial investment of $149,500 is 44% in the first five years and 64% for the balance of the term.

Emerson Convalescent Center

The Emerson Convalescent Center is located at 100 Kinderkamack Road, Emerson, New Jersey. The institution contains 148 beds and began operation in 1975. It is projected that this nursing home will be populated by 90% Medicaid patients. The institution is presently owner-operated by a corporation known as the Emerson Convalescent Center, Inc. That corporation was incorporated on April 1, 1975 and its stockholders, all of whom own less than 15% of the corporation are Messrs. Frank Chaimovits, Morris Schnitzer, Nathan Friedman, Ernest Hollander, Leo Rosenson, Mark Kamin, Jacob Bergstein, Herman Menche, Joseph Schwartz, and Zev Ajlman.

The first corporation involved with this institution was an entity known as Emerson Nursing Homes, Inc., which was incorporated on August 9, 1965. At that time, however, the corporation owned only the tract of land upon which the nursing home is now situate and no building was built until some time later. On September 13, 1968, the Manor of Emerson was incorporated and that entity purchased the aforementioned tract of land from Emerson Nursing Homes, Inc. on March 26, 1970 for an amount of $306,931. Thereafter, on February 11, 1971, the Manor of Emerson obtained a construction mortgage in the amount of $1,784,900 from the Carteret Savings & Loan Association, Newark, New Jersey. The term of this mortgage was 20 years

and the interest rate was 8½%. Only interest payments were required from March 1971 through November 1972, thereafter the principal and interest payments equaled $15,489 per month.

Before the structure was completed, however, bankruptcy proceedings were filed on February 17, 1973 by the Manor of Emerson. As a result of that filing, the receiver was authorized to execute a construction contract with the Glenwal Construction Company, Inc., who would be authorized to complete the work in the building which was at that time approximately one half completed. Also as a result of the bankruptcy proceedings, a new mortgage commitment was obtained from the Advance Mortgage Co., in the amount of $2,900,000. That mortgage was executed on March 28, 1973 and was to run at a rate of 7% per annum for a term of 30 years. Only interest payments were required from May 1973 through August 1974, but thereafter installments of interest and principal in the amount of $18,021 per month were required. Subsequently on October 16, 1975, a supplemental mortgage was granted by the Advance Mortgage Co. to the Manor of Emerson in the amount of $192,100 which required payments of $1,200 per month at an interest rate of 7% per annum for a term of 30 years. This supplemental mortgage was later consolidated with the original mortgage of $2,900,000 into one instrument with a required principal of $3,092,100 to be amortized in payments of $19,431 per month for 30 years. On the same day, October 16, 1975, the institution was sold by the Manor of Emerson to the Emerson Convalescent Center, Inc., a New Jersey corporation made up of the stock-

holders previously mentioned in this section of the report. The sales price was $3,342,100. The present tax assessment on the institution is $112,400 for land and $1,200,000 for improvements. The tax ratio in Emerson is 54% of true value. The original assessment on the land and improvements was $112,400 for land and $1,655,000 for improvements. On August 15, 1975, however, the Manor of Emerson, through its attorney, filed a petition for reduction in that assessment for the following reason: "The assessment is far in excess of either the market value or cost of construction and building certificate of occupancy has not been issued by local authorities so building cannot be occupied." The aforesaid petition requested a reduction in the assessment on the building to $800,000 for the foregoing reasons. As a result of that application, the tax assessor's office of Emerson Borough sought and received assistance from the Division of Taxation, Local Property and Public Utility Branch, concerning the actual value of the building. As a result of that request, an appraisal study was made by the Division of Taxation in order to assist the Tax Assessor's Office of the Borough of Emerson. The result of that evaluation was that the total value of the land and building as of October 1, 1974, was $2,169,244 ($2,056,844 - building; $112,400 - land). As a result of this appraisal, the tax assessment was reduced to its present figure.

Comments and Observations

The Commission is of the opinion that the Emerson Convalescent Center represents a classic example of over-mortgaging and a resultant unnecessary expense to the Medicaid program. A competent appraisal has set the value of the land and building at $2,169,244, as of October, 1974. As of October 1975, however, mortgages on the institution amounted to $3,092,100. Adjusting for an increase in value between October 1974 and October 1975, the Medicaid program, therefore, would be allowing the reporting for reimbursement purposes of mortgage expenses applicable to approximately $800,000 over the appraised value of the building.

It is interesting to note that the owning and operating corporation disclosed its awareness of the fact that the building and land was not worth in excess of $3,000,000 when it filed its appeal of the assessment on August 15, 1975. As was previously illustrated, that operating corporation stated that the assessment was "far in excess of either the market value or the cost of construction". It is the Commission's view, therefore, that the market value of $3,342,000 as denoted in the recent sale of the institution is a completely artificial one and that that sale could never have been consummated as financed, but for the existence of the favorable reimbursement formulas of the Medicaid program. As in other cases found by the Commission, mortgagees are granting loans based not upon the actual value

of the building but upon income producing potential. The excessive financing is based upon the income producing potential which, in turn, is predicated on state reimbursement. That reimbursement, however, is based on the initial excessive financing — the classic situation of a dog chasing its tail.

Heritage Hall Nursing Home

Heritage Hall Nursing Home is located at 524 Wardell Road, Neptune, New Jersey in Monmouth County and is operated by a corporation known as H.G.H. Nursing Home, Inc. The facility contains 115 beds and 99% of its occupancy is made up of Medicaid patients. Mr. Harry Ostreicher is the president of H.G.H. Nursing Homes, Inc. and owns 91% of the corporation. H.G.H. Nursing Homes, Inc. rents the facility from Mr. Herman Greenbaum of Flushing, New York. The present rental is in the amount of $150,000 per year. Mr. Greenbaum purchased the home in 1974.

The nursing home was originally built as a motel in 1962. Thereafter, on June 14, 1966, the National Theater Supply Company sold the home to Hamilton Hall Nursing Home, Inc., for a purchase price of $262,000. On September 22, 1966, Hamilton Hall Nursing Home, Inc., became Heritage Hall Nursing Home, Inc. The nursing home was opened on May 22, 1967. On September 7, 1967, Heritage Hall Nursing Home, Inc., obtained a mortgage in the amount of $525,000 at 6-3/4% for a term of 10 years from the Hudson City Savings Bank. On November 29, 1968, a second mortgage in the amount of $50,000 at 18% interest for a term of 5 years was granted with four individual investors as the mortgagees. On November 13, 1973, Heritage Hall Nursing Home, Inc. obtained a mortgage in the amount of $760,000 for a term of 10 years at 9% interest from the Knick Service Corporation. The initial mortgage of $525,000 was canceled and, previously, on October 11, 1973 the aforementioned $50,000 mortgage had been canceled.

On June 26, 1974, Heritage Hall Nursing Home, Inc. sold the nursing home for $1,175,000 to Mr. Herman Greenbaum. It should be noted that only 12 acres of a total of 54.7 acres in the plot were transferred pursuant to this sale. The terms of that sale, according to the attorney who handled the transaction, were as follows: Greenbaum assumed the outstanding amount of $760,000 existing mortgage which, at the time of the sale was $755,000, executed a mortgage back to Heritage Hall Nursing Home, Inc. in the amount of $125,000, and provided a cash investment of approximately $290,000. The $125,000 mortgage was given at an interest rate of 8½% per annum for ten years (monthly payments of $1550).

Prior to this sale, however, on March 30, 1974, Mr. Greenbaum leased the home, effective July 1, 1974, to a corporation known as H.G.H. Nursing Home, Inc., the present operator of the facility. The terms of the lease were as follows: 1) the annual rent for the first year was $140,000, to be paid in equal monthly installments of $11,666.66, commencing June 1, 1974; 2) for the second year and for 25 years thereafter the rental would be $150,000 per year payable in monthly installments of $12,500, commencing June 1, 1975; 3) the aforementioned amounts can be escalated based upon increases in the Consumer Price Index. The lease is a "net-net" one with the lessee undertaking all obligations for the property, other than the payment of the aforesaid mortgages.

This lease transaction and purchase by the aforementioned Mr. Greenbaum, according to a Department of Health Certificate of Need Financial Feasibility Analysis Group study, increase the per patient per day cost to the Medicaid system by $2.04.

Records existing in the tax assessor's office for New Shrewsbury disclose a $751,000 assessment on the building and $35,800 on the land. Replacement value according to the tax records lists an amount of $810,843.

Comments and Observations

1. During the first ten years of the lease, Mr. Greenbaum's rate of return will be minimal. From the second year of the lease forward, he will be receiving income of $150,000 per year in rental and paying out $115,524 on the first mortgage and $18,600 on the second mortgage. After the initial ten year period, however, both mortgages will be satisfied and the lease will run for an additional 15 years at at least $150,000 per year. Thus, it is more realistic to speak of income versus expenses over the terms of the lease and mortgages. Mr. Greenbaum's total income under the lease will be $3,740,000 (25 x $150,000 - $10,000), his total payout on the first mortgage will be $1,155,240 and his total payout on the second mortgage will be $186,000 for total expenses of $1,341,240. When expenses are subtracted from income, Mr. Greenbaum's net yield is $2,398,760 on an investment of $290,000. Although much of the yield is deferred, the net average rate of return

over the 25-year period os 33%. Furthermore, this yield is actually higher when one considers that principal portion of the mortgage payments, in effect, is returned to Mr. Greenbaum when the mortgages are satisfied at the end of the ten year terms and he owns the nursing home unencumbered.

2. Prior to the July 1, 1974 lease, the rental on the nursing home was $80,000 per year, but as a result of the July 1, 1974 lease, that rental increased to a total of $163,000 per year with no relation to increased patient care. The Department of Health analyzed this increased rental and calculated the result as an increase in the per patient per day costs to the State of $2.04. That report, however, addresses itself only to the issue of financial feasibility and not to the issue of whether so substantial an increase in the Medicaid rate should be justified albeit allowed in the first place. The increase in the rate takes place, furthermore, even though the rental is in excess of DMAHS maximum rental schedule.

Bay View Nursing and Convalescent Center

Bay View Nursing and Convalescent Center is located in Bayville, New Jersey, and contains 323 beds. This facility is presently operated by Bay View Convalescent Center Inc. under a sublease from Bay View Nursing & Convalescent Center Inc. According to information obtained by the Commission, the nursing home was originally constructed in 1927 and was renovated in 1970 and transformed into a nursing home.

On April 3, 1970, Seabrook Center Inc., a corporation composed of Mr. Charles Bick, of New York, New York, and Dr. Mattis Yellin, of Lakewood, New Jersey, purchased the nursing home from the original owners, Mrs. and Mrs. Abraham Kraig, who owned it via various corporations. The purchase price was $1 million, which included approximately $430,000 in cash, the assumption of a $100,000 first mortgage, and the supplying of an additional amount of approximately $430,000 in secondary and tertiary mortgages.

Thereafter, on October 15, 1973, Seabrook Center Associates (now listed as a partnership with its principal place of business as Bayville, New Jersey) entered into an agreement of lease with the Bay View Nursing and Convalescent Center, Inc. for a term of 25 years at an annual rental of $175,000 per year. The lease is of the "net-net" variety whereby the lessee is responsible for the payment of all operating costs of the facility. On January 24, 1974, the same Bay View Nursing and Convalescent Center, Inc., entered into an agreement with one Samuel Paneth,

whereby Mr. Paneth purchased the right to sublease from the Bay View Nursing and Convalescent Center, Inc. for an amount of $314,000. $250,000, according to the agreement was to be paid in cash, and an additional $64,000 was supplied via four personal notes of Mr. Paneth at an annual interest rate of 7%. That agreement came to fruition on July 1, 1974, whereby the Bay View Nursing and Convalescent Center, Inc. subleased the premises to the Bay View Convalescent Center, Inc. There is no mention of Mr. Paneth in that sublease, but it is assumed that the July 1 lease is a product of his negotiations with various other parties. The lease between Bay View Nursing and Convalescent Center,Inc. and Bay View Convalescent Center Inc. calls for an annual rental of $220,000 per year for a five-year term renewable for three successive five-year terms over the further period to end September 30, 1998.

The Bay View Convalescent Center, Inc., according to documents filed with the Department of Health, is made up of the following individuals - Anna Heller, 1459 56th Street, Brooklyn, New York (51.6%), Eva Blau, 1621 53rd Street, Brooklyn, New York (13.4%), and the following individuals with 10% or less, all residing in Brooklyn, New York, Elizabeth Friedman, Fred Herzka, Oscar Heller, Margaret Friedman and Herman Klein. The Bay View Convalescent Center, Inc. is the entity which presently operates the facility. According to records of DMAHS, the lease is considered an arms-length transaction.

Comments and Observations

1. There is a discrepancy between the date of construction supplied to the Commission by Mr. Oscar Heller, the present administrator (1927), and the date of construction filed on the cost report of the institution (1940). Due to the listed construction date of 1940, the institution is allowed as a ceiling on the rental $317 per bed or $102,391 per year. If the actual construction date of the institution is 1927, the facility would be allowed the minimum figure of $230 per bed or $74,290 per year. This discrepancy amounts to an overreporting of expenses of approximately $28,000 per year.

2. Perhaps the most interesting observation with respect to the Bay View Nursing and Convalescent Center, Inc., however, is the disparity between the amount being reimbursed by the Medicaid program for rental of buildings and the amount actually being charged. As has been stated, even with the aforementioned discrepancy, the nursing home has been receiving reimbursement for only $102,391 per year. The actual rental being paid by the operating corporation pursuant to the lease of July 1, 1974, is $220,000 per year. Thus, the nursing home is spending in excess of $117,000 per year on the rental of the building, which figure is not being reimbursed by the Medicaid program. Since the nursing home averages an approximate Medicaid population of 94%, it would be unwarranted to conclude that this excess rental figure is being provided by the private patients housed in the

institution. Two alternative conclusions, therefore, arise: either the patients at the Bay View Nursing and Convalescent Center are receiving substandard care because a large portion of the reimbursement of the nursing home is being diverted into the rental of the building, which factor does not relate to patient care, or there is enough surplusage in a large nursing home populated mainly by Medicaid patients to pay a rental which is in excess of double the amount being reimbursed for that purpose.

3. Finally, the Commission is of the opinion that it is valid to comment upon the return of Bayview Nursing and Convalescent Center Inc. as a participant in another lease-sublease arrangement. Bay View Convalescent Center Inc. purchased the right to sublease from Bay View Nursing and Convalescent Center, Inc. for a purchase price of $314,000. Bayview Nursing and Convalescent Center, Inc. will receive the difference between $175,000 and $220,000 over a period of 25 years, assuming renewal of the sublease. In total, it will receive a sum of $1,125,000, on an investment of $314,000, or a net return of $811,000. There is no evidence that this return in any way effects patient care.

Beachview Nursing Home

The Beachview Nursing Home is located at 401 Boardwalk, Atlantic City, New Jersey, and contains 100 beds. The facility is operated by the Beachview Nursing Home, Inc., under a lease from a firm known as Romar Realty.

The land upon which the nursing home is situated was sold in 1963 by an entity known as the Metrode Company, Inc. to the Metro Operating Company for an amount of $55,000. On November 15, 1963, a building contract between the Metro Operating Company and Joseph Montoro was executed. The final cost of construction of the nursing home was $491,052. On March 28, 1966 the Metro Operating Company leased the nursing home to a corporation known as B. J. Nursing Homes, Inc., for an amount of $120,000 per year. This lease was essentially of the "net-net" variety, except that the owners of the institution, Metro Operating Company, were required to pay the first $19,000 in taxes. The net amount of the lease is therefore $101,000 per year for a term of 21 years.

On July 28, 1967 the Metro Operating Company obtained its permanent financing in the form of a mortgage in the amount of $650,000 at an interest rate of 7½% per annum for a term of 18 years from the First Federal Savings and Loan Association of Philadelphia, Pennsylvania. On May 14, 1968, the Metro Operating Company sold the premises to a corporation known as Brimsco Inc., for a sum of $942,500. On the following day, May 15, 1968, Brimsco conveyed the property to an entity

known as Romar Realty Co. of New York, New York. Again, the purchase price was $942,500. The terms of this sale are a $5,000 initial downpayment plus the assumption of the first mortgage which possessed an outstanding amount of $638,000 at the time in addition to the assumption of various credit notes totaling $63,000 and various other credits. The sale was also made subject to the existing lease with B. J. Nursing Homes, Inc.

Thereafter, On June 10, 1973, B. J. Nursing Homes, Inc. assigned their position in the lease from the new owner, Romar Realty, to a corporation known as Beachview Nursing Home, Inc. The term of that assignment was a purchase price of $275,000, amortized at a rate of $1,667 per month for the remaining life of the lease which was at that time 13-2/3 years. The amortization of this lease purchase cost was, according to information received from the facility accountant, included in the cost report for Medicaid purposes, and amounts to $20,000 per year.

Comments and Observations

1. If the $20,000 per year amortization of the lease purchase cost, which was executed in 1973, becomes a reimbursable expense, there has been created, in the Commission's opinion, another method to circumvent the regulaticns of the maximum rental schedule. The nursing home under examination

presently receives the maximum rental allowable of $105,000 per year. If B.J. Nursing Homes, Inc., had subleased the premises, at an increased rental, the reimbursable rental expense would not change due to that maximum. Due to the fact of the assignment, however, and possible reimbursement of the leasehold purchase expense, there is an additional amount which will be reimbursed regardless of the strictures of either the maximum rental schedule or any other regulation of DMAHS. According to information received by the Commission, the Audit Section of DMAHS is presently considering whether or not to reimburse this expense.

Lincoln Park Intermediate Care Center

Lincoln Park Intermediate Care Center is located at 499 Pine Brook Road, Lincoln Park, New Jersey. The institution contains 526 beds and 294 are certified for Medicaid purposes. The home became certified for Medicaid in January of 1973.

Lincoln Park Intermediate Care Center is the registered trade name for a joint venture between two corporations which, cumulatively own and operate the nursing home. The trade name was filed on December 20, 1974, and the participating corporations are Lincoln Park Nursing and Convalescent Home, Inc., and Mimi Holding Co., Inc.

Lincoln Park Nursing and Convalescent Home, Inc., is the operating corporation and was incorporated on July 2, 1965. 100% of the corporation is owned by Mr. Jerry Turco. Mimi Holding Co., Inc. was incorporated on March 31, 1966, owns the land upon which the nursing home is situated, and in turn, owned by Mr. Jerry Turco (60%) and Mrs. Dolores Turco, his wife, (40%).

On April 15, 1966, Mimi Holding Co., Inc. purchased a 22.94 acre tract and the sale price was $28,340 (from sources other than the deed). On January 2, 1972, Mimi Holding Co., Inc. entered into a contract with J. Turco Paving Contractor, Inc., another corporation owned by Mr. Turco, for the construction of a nursing home. The consideration for the performance of that contract was $3,500,000. A building permit was issued

on May 18, 1972. On July 6, 1972, a construction mortgage was granted to Mimi Holding Co., Inc., by Sackman Gilliland Corporation as the mortgagee in the amount of $4,000,000. On November 27, 1973, the construction mortgage was transformed into permanent financing via an assignment of the original mortgage to the Rochester Savings Bank of Rochester, New York. The face amount of the mortgage is $4,000,000, the interest rate is 9½% and the term is 25 years.

On April 12, 1974, the building contract amount was amended from $3,500,000 to $3,750,000. Additionally, on June 19, 1974, another mortgage was obtained by the Mimi Holding Co., from a corporation known as Financial Resources Group as the mortgagee. The face amount of that instrument was $300,000 and the rate of interest is "5% above prime but in no case less than 15%." The term was one year.

A more noteworthy factor, however, for the purposes of this report is a more recent situation concerning the financial dealings surrounding a proposed sale and lease of the subject nursing home. The New Jersey State Department of Health has recently granted a certificate of need for a change of operator and there are plans to expand the nursing home for Medicaid purposes, via certifying an additional 226 beds for Medicaid. The Commission has explored the surrounding circumstances via the testimony of the proposed purchaser, David Schwartz, exhibits which refer to the sale, and interviews with several of the involved parties. In March of 1974 the facility was appraised by the office of Carl Krell, M.A.I., real estate appraisers of

East Orange, New Jersey. The amount of the appraisal at that time was $6 million. On May 28, 1974, there was completed an "updated appraisal" of the same facility and the amount of that appraisal was $9 million, computed according to a capitalization of income method. The May 28th appraisal also contains an evaluation of the property pursuant to cost analysis and the total figure under that method is $6,835,600.

Shortly thereafter, Mr. Turco, the owner of the facility, entered into negotiation with one David Schwartz, of 1262 45th Street, Brooklyn, New York, with respect to the sale of the facility. Mr. Schwartz testified before the Commission that the bulk of the negotiations centered around the appropriate sale price of the facility and that the final agreement was that Schwartz would buy the facility for an amount of $8 million. The agreement was formalized on November 21, 1974. The terms of that agreement are as follows:

1. The purchase price is the sum of $4 million in excess of the balance due on an existing first mortgage.
2. The terms of payment are as follows:
   a. The sum of $300,000 simultaneously with the execution of the contracted sale.
   b. The sum of $1,200,000 at the time of closing.
   c. A second mortgage in the amount of $2,500,000. with Mr. Schwartz as mortgagee and Mimi Holding as mortgagor.

The contract of sale contains many additional terms and conditions, but the most important variable was that the actual closing of title would not take place unless the Department of Health of the State of New Jersey issued a certificate of need previously mentioned, which would have the effect of certifying all the beds in the facility for Medicaid purposes. At the time of the contract, of course, only approximately half of the beds were certified for Medicaid purposes.

Thereafter, on January 29, 1975, several events took place effecting the proposed sale. First, the original agreement between Mimi Holding Co., Inc., and David Schwartz as purchaser was modified to take into account the second mortgage on the property held by Financial Resources Group. Schwartz agreed to assume the second mortgage and Mimi Holding Co., Inc. (Turco) agreed to reduce the downpayment of $1.5 million to $1.2 million, due to the assumption of the $300,000 mortgage. Secondly, Schwartz created a co-partnership with its principal office in Brooklyn, New York, called Lincoln Park Associates. His partner in this venture was an individual by the name of Allen Black and Mr. Schwartz testified that the consideration from Mr. Black was approximately $50,000. Schwartz then assigned all of his interests in the contract of sale to the partnership.

Finally, also on January 29, 1975, Schwartz (Lincoln Park Associates) entered into a memorandum of understanding with an entity known as Lincoln Park Intermediate Care Center, Inc., a corporation of the State of New Jersey made up of Mr. Abraham

Greenbaum and Mr. David Mandell. By the terms of that agreement, Lincoln Park Intermediate Care Center, Inc., agrees to provide Lincoln Park Associates with $500,000 toward the purchase price of the facility as reflected in Schwartz's initial agreement of November, 1974, as modified on January 25, 1975. Additionally, the agreement between Lincoln Park Associates and Lincoln Park Intermediate Care Center, Inc., proposes that a lease be entered into at the time of closing between Lincoln Park Associates and Lincoln Park Intermediate Care Center, Inc. That lease will run from Lincoln Park Associates as landlord to Lincoln Park Intermediate Care Center, Inc., as the tenant. The memorandum of understanding further provides that the terms of the lease with respect to payment will be as follows: The annual rent will be $585,000 per year for 294 intermediate care beds and for 20 shelter care beds. In the event that the other beds are transformed into Medicaid certified beds via the approval of the certificate of need application, the rental will be $1,910 per bed per year. The Commission was also provided with the actual lease which was a product of the aforementioned memorandum of understanding and was dated May 1975. In conformance with that memorandum of understanding, the lease calls for a rental of $1,004,660 per year for a term of 21 years (total rental of $21,097,860). It is also of note that one of the clauses in the memorandum of understanding provides that, although the maximum rental is $1,004,600, the lessor must accept whatever the Medicaid program provides to the lessee as

reimbursement of rent down to $861,000.

It is important to note that all of the aforementioned documents, including the sale of the Mimi Holding Co. to Lincoln Park Associates, the modification agreements, the memorandum of understanding, and the subsequent lease are dependent upon the granting of a certificate of need to transform the Lincoln Park Convalescent and Nursing Home from approximately a 50% Medicaid certified facility into a 100% Medicaid certified facility. The most recent available information with respect to the granting of that certificate of need is as follows: 1) Two certificates of need are actually necessary, one approving the transfer, the other certifying the additional beds for Medicaid purposes; 2) the certificate of need for the transfer has been approved but the second certificate of need application has not yet been filed.

Comments and Observations

It is the opinion of the Commission that the proposed sale and lease of the Lincoln Park Facility is illustrative of the many and varied problems of the present system of property cost reimbursement as it exists in the Medicaid system in New Jersey today. The schedule of maximum rental allowable is allegedly reflective of construction costs. The Lincoln Park facility was constructed for approximately $3.75 million and the "imputed rent" figure which would be employed

on Lincoln Park's cost report, assuming 100% Medicaid certification, is $811,618, yet the actual carrying charges for the facility (mortgage interest, insurance, depreciation and a return on equity) amounts to only $504,637. This is true, even though there is no equity on the part of the owner in the present facility as listed on the cost report. According to Mr. Schwartz's testimony, the beds which are not presently certified for Medicaid purposes are lying vacant. If the certification is approved, however, the owner, due to the deficiency of the present system, will be allowed to report a figure over $300,000 higher than his actual carrying charges. Moreover, the possibility of certifying the additional beds has surfaced an opportunity which is presently being taken advantage of by the proposed purchaser and lessee.

The final result is that a home that was built and finished in November of 1974 for $4 million, is sold one year later for $8 million. It is the belief of the Commission, as supported by the conditional nature of the documents involved, that such a transaction could not and would not take place if it were not for the existence of the presently property cost reimbursement system of Medicaid. The Commission is of the belief that the following observations are relevant:

1. Mr. Schwartz's return may be computed, of course, by comparing his initial investment with his income. After the aforementioned series of agreements and modifications, the bottom line investment for Mr. Schwartz as Lincoln Park

Associates is approximately $700,000. His annual costs may be computed by adding the amortization of the original mortgage of $4 million ($419,604 per year), the amortization of the $300,000 second mortgage for a term of three years ($124,795 per year), and the amortization of the $2.5 million third mortgage given back to Mimi Holding Company for a period of 15 years ($250,000 per year) for a total of $794,399 per year. Mr. Schwartz's income, of course, is the yearly amount to be paid under the lease which is $1,004,660 for a term of 21 years. Expressing the return (income less expenditures) as a percentage of the original investment over a 21-year period illustrates that Mr. Schwartz is receiving a return of approximately 30% per year. Mimi Holding Co., Mr. Turco and his wife, will be receiving $250,000 per year and a balloon payment of $550,470 under the terms of the $2.5 million mortgage. Since Mr. Turco obtained 100% financing for the facility, his initial investment is zero and his return is infinite.

2. The fact that the actual rental is actually dependent upon the reimbursement provided by the Medicaid program illustrates that astute investors do not actually negotiate at arms length but instead hinge their leases upon the maximum which the program will provide. It is alleged that those maximums are reflective of construction costs, but in the case of Lincoln Park, they will theoretically allow reimbursement of in excess of $1,000,000 per year for a home which cost approximately $4,000,000 to build.

3. The Commission was also interested in the affect upon the Medicaid rate. To understand the actual impact of this transaction on the Medicaid rate and the expense to the State of New Jersey, it would be relevant to reconstruct what the Medicaid rate would be but for this sale. Using the true year of construction of 1973, the per patient day cost of the lease is the maximum rent allowable of $851,068 , plus the equipment rental of $105,200, divided by the number of patient days. Assuming a 90% occupancy rate, the per patient day cost generated by the lease would be $5.53. If Mr. Turco retained ownership and converted the 232 sheltered care beds, his property cost would be $765,856 (the correct imputed rental amount) divided by the number of patient days. Again, assuming 90% occupancy, the per patient day real estate cost, exclusive of taxes, would be $4.43. This difference of $1.10 per patient day times a 90% occupancy rate of 172,800 patient days per year gives an additional cost to the state of $190,080 per year. If Mr. Turco were to retain the nursing home and apply for certification himself, this expense could be completely avoided.

The most disconcerting factor, however, is that no portion of this increased cost is being applied to patient care. Mimi Holding Co., Inc., in the person of Mr. Turco and his wife, will have nothing to do with the operation of the nursing home, but will be collecting $250,000 per year after having received $1.2 million in cash on an initial investment which was 100%

financed. Mr. Schwartz, likewise, will also have nothing to do with the operation of the nursing home and will be collecting a net return of $210,261 per year for three years and $385,056 per year for 18 additional years. Moreover, there is no present administrative regulation or statute existing either in the laws of New Jersey or the regulations of DMAHS or the Department of Health which would prevent this situation from occurring. The Department of Health, as has been stated, has already granted one of the certificates of need necessary to consummate the transaction. It is because of this fact that the Commission decided to examine in detail the present procedures existing in both of the aforementioned administrative agencies for dealing with such transactions. Portions of this report commenting on those procedures follow.

Recommendations

A) Introduction

Based upon its initial report filed on April 3, 1975, and information garnered since that time, including facts relating to the nursing homes examined herein, the Commission is of the opinion that the present system of property costs reimbursement under the Medicaid program as it relates to nursing homes in the State of New Jersey, is wasteful, imbalanced and inequitable. The Commission is also aware, however, that it must be mindful of the realities of the industry involved in making its legislative recommendations. Any legislative recommendations, therefore, must avoid the temptation to be punitive in character and must necessarily strike the proper balance between providing an efficient and cost-conscious property cost reimbursement to nursing home operators, while at the same time presenting the attractiveness of a return on investment so that an adequate number of investors are attracted into the program. Furthermore, the Commission is also aware of its statutory mandate to pinpoint present abuses so that they may be rectified. The Commission considers the legislative recommendations portion of this report to be crucial to the Medicaid system because of the imminent alterations in approach both at the state and federal level. Several states, including New Jersey, are presently involved in a search for a better system of property cost reimbursement and the Commission is, therefore, hopeful that the following suggestions will be of aid.

Several different approaches to the problem have been examined by the Commission, including the administrative regulations suggested and implemented by the State of New York and its Public Health Council. Those recommendations were examined and discarded as overly dependent upon the former system of reimbursement and insufficiently salutory for the purpose for which they were designed. Additionally, the Commission examined a plan of reimbursement which would employ the Instant Mortgage Equity Technique of property investment analysis. That system was also discarded because it was considered highly complex, unwieldy and totally inappropriate in certain instances. Several months ago, however, the Commission began to examine the suggestions of the New York State Moreland Act Commission on Nursing Homes and Residential Facilities concerning property cost reimbursement appearing in a report entitled Reimbursement of Nursing Home Property Costs: Pruning the Money Tree, January, 1976. That system has been scrutinized by the Commission's professional staff, along with outside consultants utilized by the Commission for that specific purpose for a number of weeks, in order to develop a suggestion for the State of New Jersey that would fit the aforementioned goals. The result of that effort follows hereinafter and essentially is a proposal based upon the recommendation of the Moreland Commission with certain modifications which will be discussed hereinafter. Initially, however, it is necessary to understand the basic recommendation of the Moreland Commission which is explained below.

B) The Moreland Commission Recommendation on Property Cost Reimbursement - A "Fair Rental" System

The underlying aim of the Moreland Commission recommendation is to provide a reimbursement which would be based on the cost of efficiently providing debt and equity financing for nursing home real property costs. Furthermore, this goal should be realized while taking into account broad inflationary trends and an increase in the value of the nursing home property, while not allowing for increased cost to the state via inflationary sales, leasebacks, rentals, or other non-arms-length schemes. The S.C.I. is in basic agreement with those aims. The method employed by the Moreland Commission was to arrive at a value for the nursing home property and to then apply a certain percentage return to the value which would be realized by the owner in the form of a "rental amount" to be provided over a specified period of time. That "rental amount" would not change over this period of time nor vary as a result of future sales, future leases, or future changes in financing relationships.

In order to implement the aforesaid aims, the Moreland Commission suggested a return on the nursing home building, based on the project cost thereof over a 40-year amortization period. Another rate of return was suggested for the land upon which the nursing home building was situated. To those two values would be applied the "Medicare rate of return" which is the standard currently used by the Medicare system for a return on real property

investment and is equal to 1½ times the average interest rates on the Federal Hospital Insurance Trust Fund obligations. The result of the aforesaid calculations would be provided to the operator as "rental" for the 40-year useful life of the building with appropriate adjustments at 10-year intervals for contingencies.

To sufficiently understand the Moreland Commission recommendation, an example is appropriate. The following example is, in fact, one proffered by the Moreland Act Commission report, pages 88-89:

Assume a nursing home is built for a total project cost of $1.0 million, of which $50,000 represents land costs (5% of total costs) and $950,000 is the remaining project cost. Assume as well that the Medicare rate of return at the time is 10%. The "mortgage constant" (obtained from standard financial tables) used to calculate the annual "building rental" based on a 40-year amortization period would be .10226 (or 10.226%). Applying this percentage to non-land costs gives a building rental of $97,147. This amount would be the building rental component of the payments for the real property costs to be made in each of the following 10 years. The land rental in the first year is simply 3.33% (one-third the Medicare rate of return) of the $50,000 land cost of $1,665. Thus, in the first year, the total fair rental payment for real property costs would by $97,147 + $1,665 = $98,812.

In the second year, the building rental would remain at $97,147; however, assuming a 6% rate of inflation, land value would be adjusted to $53,000. Assuming, too, the Medicare rate

of return remained at 10% in the second year, as in the first, one-third of this rate would be applied to the $53,000 adjusted land value in the second year and would be $97,147 + $1,765 = $98,912.

Continuing the example, at year ten, assuming the five-year average Medicare rate of return to be used at this interval still remains at 10%, no adjustment would be made in the building rental.

However, should the applicable Medicare rate of return average fall to 8%, the building rental would be calculated with a "mortgage constant" for the remaining 30-year useful life based on an interest rate of 8%. This is .08882 or 8.882% per year. This percentage is applied to the unamortized portion of original non-land project cost, at the end of the first 10 years of operation of the project. Under the 10% return, 40-year amortization schedule used for the first 10 years in this example, 3.6% of the original non-land costs would have been amortized in the first ten years. Consequently, 96.4% of $950,000 or $915,800 would remain to be amortized. A building rental calculated at 8.882% of $915,800 would amortize this amount over 30 years while providing in each year (up to and including the 30th year) an 8% return on the then unamortized balance.

C) S.C.I. Observations and Modifications

1) The Proposed Rate of Return

The Commission's initial concern was whether the suggested rate of return, that is, one which would equal the Medicare rate

of return, was adequate. From the S.C.I.'s point of view, this rate of return should follow the mortgage market in the industry, while being slightly above that interest requirement in order to provide for whatever type of financing the owner obtained and perhaps to provide an incentive for efficient financing. In order to determine whether in fact the Medicare rate of return met the aforementioned requirements, the Commission compared it to several other interest rates for a period of 10 years. The result of that examination appears in the chart which is included at the following page. As can be observed from reference to that chart, the Medicare rate of return apparently does fluctuate with interest rates charged by lending institutions on residential and non-residential mortgages. At the same time, it is slightly above all of the rates appearing on the chart, and, therefore, satisfies the previously mentioned considerations. The S.C.I. is therefore convinced that the Medicare rate of return, that initially suggested by the Moreland Act Commission, is a fair and equitable one for the Medicaid reimbursement system for New Jersey.

2) The Useful Life of the Facility

As has been recognized by the examination of the Moreland Commission recommendations, there is employed in that formula a 40-year amortization period for the computation of the fair rental. This 40-year amortization period is most probably adapted from traditional concepts of useful life as extrapolated from traditional accounting principles relating to depreciation.

MISC. INTEREST RATE TRENDS

Category	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975
Prime	4.50	4.19	5.13	5.81	6.00	4.78	4.90	7.96	9.87	7.15
AAA Bonds (Moody's)	5.07	5.37	6.16	6.90	7.77	7.22	7.24	7.39	8.54	8.80
A Bonds (Moody's)	5.29	5.72	6.47	7.31	8.24	8.15	7.67	7.78	9.11	9.60
New Conventional Home Mortgages (U.S. Average by FHLBB)	-	-	7.31	8.01	8.51	7.63	7.62	7.98	8.91	9.08
Life Insurance Industry Average Non-Residential Committed Mortgage Rate	6.42	6.97	7.66	8.69	9.93	9.07	8.57	8.76	9.47	10.22
A Major N.Y.C. Lending Institution's Average Committed Mortgage Rate	-	-	-	8.84	9.92	9.17	8.51	8.89	9.44	9.93
Medicare Rate (1-1/2 times Average Rate on Federal Hospital Insurance Trust Fund Obligations)	-	-	8.234	9.891	10.891	8.969	8.891	9.969	11.234	11.094

The Commission is of the opinion, however, that a 40-year life for a nursing home in today's market is somewhat ambitious. Additionally, and perhaps more importantly, the mortgage obtained by a nursing home owner will almost never span a 40-year period. Instead, he will be required to pay off a mortgage which typically runs between an 18 and 23 year term. To provide him with a level payment of a particular dollar amount for a 40-year period, therefore, would be to grant him perhaps insufficient funds in the initial 20-year period while the mortgage is actually being amortized and then later provide a continuing payment for the balance of the period when, in fact, the mortgage has been satisfied.

The Commission is of the opinion, then, that it is perhaps more realistic to provide a payment for 25 years, as opposed to 40 years. Such a time period would more nearly parallel existing market conditions and grant larger payments to the nursing home operator when he, in fact, really requires them. In practice, the Commission suggests merely employing the same Medicare rate of return as previously discussed but utilizing, rather than a 40-year amortization schedule, a 25-year amortization schedule. The effect of this practicability would be to increase the yearly payments to the operator since the "mortgage constant" for 25 years is larger than that for 40-years. For instance, the mortgage constant for a 10% rate of return over a 40-year amortization period would be .10226, while the mortgage constant for a rate of return of 10% over a 25-year amortization period would be .11017.

The Commission is, therefore, of the opinion, and does recommend, that a 25-year amortization period be employed rather than a 40-year amortization period, as suggested by the Moreland Act Commission. The effect of this change will be examined hereinafter.

3) Treatment of Land Costs

Reference to the aforementioned example with respect to the Moreland Act Commission recommendation discloses that the rate of return on land is treated differently than that of improvements thereupon. The Moreland recommendation grants a return of the initial land costs times 1/3 the Medicare rate of return. (For instance, in the example of a 10% Medicare rate, a 3.33% return is granted on the land per year.) Additionally, the Moreland Commission recommendation would increase the basis of the land for inflationary trends in each 1-year period. Again referring to the example, assuming a 6% rate of inflation, the land value would be adjusted to $53,000 in the second year and thereafter be multiplied by 1/3 the Medicare rate. The Moreland Commission explains this treatment as a recognition of the fact that land values are being continuously adjusted to account for general inflationary trends and, since the full Medicare rate of return already includes a component which compensates for the effects of inflation, the fraction is applied in order to avoid duplicitous inflationary adjustments.

The Commission is of the opinion that a more efficient way to adjust for inflationary trends would be to employ the full Medicare rate of return while not adjusting the basis. The Commission is of the further opinion that the application of a full Medicare rate of return to land costs would be a more realistic rate of return in view of current market trends in the land acquisition area. Of course, in view of this recommendation, sufficient controls would have to be applied through the Department of Health so that the initial land costs would not be exorbitant.

D) Summary and Comparison - New Facilities

Based on the foregoing analysis, the S.C.I. recommendation is different from the Moreland Commission recommendation in two significant respects: a) the amortization period would be reduced from 40 to 25 years and b) the full Medicare rate of return would be applied to the land costs, the base figure remaining the same throughout the period. The chart below depicts the Moreland Commission recommendation compared with the S.C.I. proposed recommendation and illustrates the aforementioned distinctions.

MORELAND COMMISSION RECOMMENDATION
(New Facility)

Assumptions

Land	50,000
Building & Other	950,000
	$1,000,000

Medicare Rate = 10%

Calculations

1) $950,000 (non-land costs) x .10226 (Mortgage Constant 10% - 40 yrs.) = 97,147

2) $50,000 (land costs) x .0333 (1/3 of the Medicare rate) = 1,665

TOTAL PROPERTY COST REIMBURSEMENT = $98,812

S.C.I. PROPOSED RECOMMENDATION
(New Facility)

Assumptions

Land	50,000
Building & Other	950,000
	$1,000,000

Medicare Rate = 10%

Calculations

1) $950,000 (non-land costs) x .11017 (Mortgage Constant 10% - 25 yrs.) = 104,662

2) 50,000 (land costs) x .10 (full Medicare rate) = 5,000

TOTAL PROPERTY COST REIMBURSEMENT = $109,662

E) The S.C.I. Recommendation with Respect to Existing Facilities

1) The Moreland Commission Recommendation

The aforementioned S.C.I. recommendation with respect to new facilities is reasonably simplistic as is the Moreland Commission recommendation for the same type of facility. Several other problems and adjustments present themselves, however, when any fair rental system is applied to an existing facility. Rate of return, of course, would not have to be adjusted, but the most difficult problem is in arriving at a fair present value

of the land and improvements to be used as a basis to which the rate of return is applied.

The Moreland Commission suggests the use of "book values" as the basis for the rate of return on improvements. Book value is defined as the initial cost of the improvements less depreciation accumulated over the number of years the home has been in existence. This cost factor would be extracted from the books of the owner of the facility. For example, if the home initially cost $1 million and had been in existence for one year, the cost basis would be $975,000 ($1 million minus $25,000 (depreciation of 2½% x $1 million)). For land values, the Moreland Commission suggests again the use of the book value of the land when the facility is less than 20 years and the application of an inflationary index to land when the facility is more than 20 years old. The amortization period would reflect the remaining useful life of a facility. In other words, if a facility was 20 years old, the book value would be established and the facility would receive fair rental payments for the remaining 20 years of the 40-year useful life. The rate of return used in determining building rental would be the average of the immediately preceeding 5-year period for Medicare rates of return. The chart below depicts the application of the Moreland Commission recommendation to an existing facility in New Jersey - Lincoln Park Intermediate Care Center.

MORELAND COMMISSION RECOMMENDATION
(Existing Facility - Lincoln Park)

Assumptions

Land (Actual Cost)	28,430
Improvements (Actual Reported Cost)	3,991,746
Medicare Rate	11%

Calculations

1) $28,430 (land cost) x .0367 (1/3 Medicare Rate) = 1,043

2) 3,991,746 x .975 (Depreciation 40 yr. life = 2½%) x .11172 (Mortgage Constant 11% at 40 years) = 434,809

TOTAL = 435,852

(Remaining life = 39 years)

The Moreland Commission also suggests that where the New York Health Department has made adjustments for prior arms-length sales, that is, determined a book-value for the facility, that determination would be employed in computing the fair rental. Finally, where a home is, for instance 50% depreciated, the remaining value would be amortized over the balance of the holding period - in this case twenty years (50% x 40 years).

2) S.C.I. Observations and Proposed Modifications

Two previously mentioned modifications would also be applied to existing facilities under the S.C.I. recommendations, that is, the full Medicare rate of return would be applied to the land value (as opposed to 1/3 the Medicare rate of return under the Moreland Act Commission), and a 25-year amortization period would be employed as opposed to a 40-year amortization period employed under the Moreland Act Commission.

The subject of existing facilities also raises a topic which represents perhaps the most significant departure by the S.C.I. from the recommendations of the Moreland Commission. This departure deals with the issue of the Moreland Commission suggestion that "book values", a concept which has been previously explained, be employed as the basis for the return building value. The S.C.I. is of the opinion that a return on book value represents an overly conservative approach to the problem. Specifically, in subtracting accumulated depreciation from the initial building costs to arrive at a value which forms the basis for the return, the Moreland Commission ignores the present value (sometimes referred to as replacement cost) of the structure in place. The Commission believes this component of the Moreland Commission recommendation to be somewhat inequitable since it ignores traditional concepts of using building costs and appreciation in value. Some recognition should be given to these factors and one method which the Commission initially examined was a trending approach via the "Dodge Index" or some other indicator of construction costs.

After some experimentation with this method, however, the S.C.I, considers actual appraisals on existing facilities to be the more intelligent avenue. The Commission questioned its experts in this area and has found that the task of appraising all existing facilities would be formidable but by no means impossible. There are national firms, some with New Jersey offices, who specialize in large scale appraisals. The approximate cost has been estimated at between $1,000 and $1,500 per facility (an overall expenditure of between $185,000 and $250,000). That cost, in the Commission's view, pales to insignificance when it is realized that the savings on the Lincoln Park facility alone could finance it. The S.C.I., therefore, suggests that, as a component of the fair rental recommendation, such a project be undertaken.

Finally, rather than employing the Medicare rate for an average of the last five years, the S.C.I, recommends employing the Medicare rate at the year of construction. This would alleviate granting a disparity of rates and penalizing some operators while granting higher rates to others based simply on the chance of the fluctuating Medicare rate.

The chart below depicts the result of the Commission's recommendation with respect to existing facilities. In step 2 of the calculations an approximation has been made for total depreciated replacement value for exemplification purposes only. In actuality the figure for total depreciated replacement costs would be provided by the appraisals suggested heretofore.

S.C.I. RECOMMENDATION

(Existing Facility - Lincoln Park)

Assumptions

Land (Actual Cost)	28,430
Improvements (Actual Reported Cost)	3,991,746
Medicare Rate	11%

Calculations

1) 28,430 (land cost) x .11 (full Medicare Rate) = 3,127

2)a. 3,991,746 (initial costs) x 1.075 (1 yr. trend forward for building costs) = 4,291,127 (replacement cost)

b. 4,291,127 (replacement cost) x .975 (2½% depreciation 1yr. - 40yr. life) = 4,183,848 (total depreciated replacement cost)

3) 4,183,848 (total depreciated replacement cost) x .11938 (mortgage constant 11% at 24.3 yrs.) = 499,468

TOTAL 502,595

(Remaining Life = 24.3 years)

3) Summary and Comparison - Existing Facilities

Again, using the Lincoln Park facility, the Commission undertook to compare its recommendation proffered herein with three other approaches: the actual present carrying charges of Lincoln

Park, the imputed rental figure that DMAHS would grant based on full certification of all 526 beds and, the Moreland Commission recommendation:

COMPARISONS

(Existing Facility - Lincoln Park)

Assumptions

Land (Actual)	28,430
Improvements (Actual Reported Cost)	3,991,746
Medicare Rate	11%
Bed Capacity	526
Year of Construction	1974

Calculations

S.C.I.	vs.	Moreland	vs.	Actual	vs.	Imputed
Land (Actual) x Full Medicare Rate plus Improvements (Full Depreciated Replacement Cost) x Mortgage Constant =		Land (Actual) x 1/3 Medicare Rate plus Improvements ($\frac{\text{Initial}}{\text{cost}}$) - Depreciation x Mortgage Constant =		Mortgage Interest (380,096) plus Depreciation (96,669) + Return on Equity (0)		526 beds at $1,543 per bed
$502,595*		$435,852*		$476,765*		$811,618

*Plus Insurance ($27,872)

These carrying charges, of course, will be substantially increased if the proposed sale to Mr. Schwartz is consummated but, as has been stated earlier, the Commission is of the opinion that, although that increase would be valid under existing regulations, it is completely unwarranted. See pp. 38-47 , infra.

As is illustrated by the foregoing chart, the Moreland Commission recommendation supplies an amount which is insufficient to satisfy the actual debt service plus depreciation while the S.C.I. recommendation would grant an amount slightly in excess of the actual charges. The imputed rental schedule, on the other hand, which would be employed assuming certification of all 526 beds, reimburses an amount (excluding insurance) $334,853 in excess of the actual carrying costs and $307,350 (again, excluding insurance) in excess of the S.C.I. recommendation. The chart clearly depicts, in the Commission's view, the three crucial points of this section of the report; 1) present reimbursement procedure is anamolous, 2) the Moreland Commission recommendation is overly conservative and has the effect of under-compensation, and 3) the S.C.I. recommendation provides efficient financing with perhaps a small profit.

F) The S.C.I. Recommendation with Respect to Existing Renovated Facilities

Many of the facilities presently participating in the program have employed buildings which were built in the first instance for a different purpose (hotels, motels and the like). As has been discussed, the present DMAHS approach to those facilities has been to grant only the original year of construction of the building when choosing a multiplier from the maximum rental and imputed rental schedule. The Commission is of the belief that this approach often works to the detriment of the operator and that that hardship may

be the cause of the relatively frequent miscalculation of the year of construction.

In the Commission's opinion, there is no effective difference between a nursing home built originally for that purpose and one which was initially constructed for some other purpose as long as life-health safety standards are satisfied.

The S.C.I., therefore, recommends that existing renovated facilities be treated the same as other existing facilities, that is, that they be included in the facilities to be appraised. The appraiser's function would, however, be altered in two respects. First, since the land was initially purchased for another purpose, the appraiser should take this factor into account and valuate comparatively as if the land had been purchased for nursing home use. Secondly, in arriving at the depreciated replacement cost, the appraiser would necessarily be mindful of the fact that the shell of the building, for instance, is much older than the remainder of the project and will have a shorter useful life. The appraiser will, therefore, adjust and employ a "composite life" approach to depreciated replacement cost.

G) Major Capital Improvements During the Twenty-Five Year Life

A question arises as to the treatment of additions to the facility which increase bed capacity. The Commission recommendation with respect to these additions is twofold: 1) Where those additions presently exist, they will be appraised separately from the remainder

of the facility and given their own useful life. The calculation of fair rental will be bifurcated and the total of the two calculations will be the total reimbursement; 2) Where the addition is completed subsequent to the institution of the recommendations desceibed herein, the addition will receive reimbursement based on the construction cost, as audited by the Department of Health, and will be assigned a 25-year life and the current Medicare rate. Major capital improvements which do not increase bed capacity should be treated by DMAHS or the Department of Health according to relevant federal guidelines.

H) Activity in Other Jurisdictions and Conclusion

As a final step in its examination of the recommendations of the Moreland Act Commission, the S.C.I. undertook to determine the relative validity of those recommendations, by contacting the Moreland Act Commission in an attempt to decipher the present status of the implementation of those recommendations and any spinoff implementation in other jurisdictions. Via an interview with Mr. Morris Abrahms, Chairman of the Moreland Act Commission, the S.C.I. determined that through various meetings with the New York Public Health Council, the Moreland Act Commission recommendations for property cost reimbursement with minor modifications will soon be enacted via official Health Department regulation into the actual administrative treatment for Medicaid purposes in New York. Additionally, it was learned in this same interview that the State of Connecticut has examined the proposal of the Moreland Act

Commission and has also enacted that recommendation into administrative regulations in the Connecticut Department of Health.

Perhaps more importantly, the paramount concern of the Medicaid industry and of the state programs administering the plan over the past few months has been the effect of Public Law 92-603 upon that system. As of July 1, 1976, this law will require Medicaid systems in participating states to provide for reimbursement to nursing home facilities "on a reasonable cost-related basis" to be determined in accordance with methods and standards to be developed by the states. Any new recommendation which proposes a new treatment of any cost center of the reimbursement system, therefore, would necessarily be evaluated in view of these aforementioned guidelines. Specifically with reference to property cost reimbursement, it is important to note that in a recent notice of proposed rule making by the Department of Health, Education and Welfare, 45 CFR Part 250, relating to the medical assistance program and an explanation of regulations which would be implemented to effectuate the underlying principles set forth in the previously mentioned P.L. 92-603, HEW specifically commented upon the Moreland Act Commission's treatment of property cost reimbursement and approved same as a reasonably cost-related method of treating property cost reimbursement. The objection, therefore, that the S.C.I. proposed recommendations would run afoul of the aforementioned P.L. 92-603 would seem to be obviated by the statements of the enactor.

Finally, towards the end of the instant investigation, the Commission took the testimony of Mr. Gerald J. Reilly, Director of the Division of Medical Assistance and Health Services, concerning the present system of property cost reimbursement and the S.C.I. proposed recommendation relating thereto. Mr. Reilly commented that he was aware that there were problems of profiteering existing in the system and felt that any proposed change which would have the effect of reducing those profits would be a welcome one. Mr. Reilly also commented that there has been no change in the present system of property cost reimbursement since the S.C.I.'s initial recommendation in April, 1975, because the Department of Health is soon to become involved in rate setting and, therefore, property cost reimbursement. Mr. Reilly reported that as a function of that new involvement, the Department of Health is presently working on a new system of property cost reimbursement and the S.C.I. is, therefore, of the opinion that the recommendations herein could be helpful to that Division of state government.

Finally, the Commission wishes to point out that the recommendations proposed herein are not offered as any panacea. On the other hand, they do represent the S.C.I.'s extended effort, aided by recognized experts in the field, to fulfill the statutory mandate of suggested salutory alterations of a system which sorely needs them. The Commission is of the opinion that the best solution to the problem would be legislative or administrative enactment of these recommendations and that the worst solution would be to do nothing at all.

THE AUDIT FUNCTION OF THE DEPARTMENT OF INSTITUTIONS & AGENCIES

Introduction

The Division of Medical Assistance and Health Services of the Department of Institutions and Agencies has the overall responsibility for administering the Medicaid program payments to approximately 230 nursing homes in the State of New Jersey. Approximately 72% of these nursing homes fall into the proprietory specification, 19% into the non-profit classification, while the remainder, approximately 9%, are governmental homes. In fiscal 1976, the State of New Jersey will spend approximately $65 million for nursing home reimbursement and the figure will increase to approximately $85 million in fiscal 1977. The federal government matches these expenditures in equal amount. Until recently, the audit section of the Division of Medical Assistance and Health Services has the responsibility of setting the individual rates for each nursing home and validating that the payments to each specific nursing home were correct through auditing procedures. The audit section presently employs 25 people, including its chief, of which 20 are classified as field auditors. The bulk of the work of this section is processed by these 20 field auditors.

Audit Section Methodology

In order to better understand the functioning of the audit section, the Commission, on two occasions, took the testimony of

Mr. Nicholas J. Perroni, Chief Auditor and Administrative Head of the Audit Section. In order to be completely conversant with the work of this section, it is necessary to understand the three basic functions of a field auditor. During the course of a particular year, the nursing home files a "cost report" for its last year of operation. In that cost report is included all of the operating expenses of the facility for the past year. A check of that cost report is made by one of the auditors at the "desk review" for the accuracy of the mathematical computations and the proper reporting of the amounts involved. Subsequent to the computing of the total overall operating expenses of the home, that amount is divided by the total number of patient days (number of beds occupied in the facility for the past year) and the rate for the coming year is computed. It is important to note that other than the aforementioned checks for proper reporting and proper mathematical computations, the desk review is in no way a functional audit. This fact was confirmed by Mr. Perroni in his testimony before the Commission.

The remaining two functions are, in fact, actual audit procedures. The first form of audit conducted by the section is called a per diem field audit. This validation is a complete check of the books and records of a nursing home and results in the verification of the figures supplied to the Division of Medical Assistance and Health Services via the aforementioned cost report. Where deficiencies are established by the per diem audit, resulting in an overpayment to the facility for a particular year involved, a monetary recovery is recommended as a result of

the per diem audit.

The last function of the auditor is another field audit called an income audit. As opposed to the per diem audit, the income audit validates only other sources of income which the nursing home receives for the patient housed in the facility. Examples of such other income would include S.S.I. benefits and the like. These amounts, of course, should be deducted from the overall operating expenses so that there is a direct effect upon the Medicaid reimbursement received by the home for the year involved. Again, where deficiencies are evidenced, a monetary recovery is recommended by the auditor for the particular year involved.

Through Mr. Perroni, the Commission obtained the figures for the number of audits completed and the recommended recoveries for the years 1972 through 1975. The chart below depicts these figures and also computes an average recovery figure suggested per audit completed.

Year	Income Audits	Suggested Recovery	Per Diem Audits	Suggested Recovery
1972	28	$ 78,907	13	$ 710,607
1973	73	301,250	38	349,665
1974	63	552,641	25	18,621
1975	29	544,017	17	177,711
Totals	193	$1,476,815	93	$1,256,604
Avg. Recovery Per Audit		7,652		13,512

As is depicted in the chart above, a total of 93 per diem audits have been completed since the year 1972 up to December of 1975. Since this is the only complete audit performed on the facilities, and since Mr. Perroni testified that a number of homes have been audited two or three times, the Commission feels that it is important to point to this figure as a matter of concern. What the figure means, in a practical sense, is that only approximately 40% of the total number of nursing homes participating in the program have ever been audited since its inception. The obvious reason for this, and the only one proffered by Mr. Perroni in his testimony, is that there are not a sufficient number of auditor positions available to the Audit Section of the Division of Medical Assistance and Health Services. Mr. Perroni further testified that, in the early years of the functioning of his section, the return on the suggested recovery amounts was approximately 6:1, that is, the amount suggested for recovery was approximately six times the amount appropriated by the State of New Jersey for the functioning of the Audit Section. In recent years, that figure has been reduced to somewhere in the neighborhood of 3:1, but the Commission is of the belief that, even discounting for the lower suggested recoveries where more homes are audited, there is absolutely no reason why more audit positions should not be implemented in the Section. This problem will be further commented upon in the recommendations section of this portion of the report.

State Commission of Investigation Observations

Although the overriding problem is a shortage of staff, as previously mentioned, the Commission is also of the view that the practices and procedures of the Audit Section are deficient in certain respects. The Commission also adds, however, that some of these deficiencies will be corrected if the Commission's suggested fair rental system is implemented. What follows is an outline of some of the areas that have been pinpointed by the Commission as being possible areas of deficiencies.

A) Relationship of Auditor with Nursing Home Personnel

It came to the Commission's attention during the investigation that there have been cases where auditors from the Audit Section of the Division of Medical Assistance and Health Services have adopted the position of advisor rather than auditor with respect to nursing home administrators in facilities around the state. This topic was commented upon in verbal discussions between Mr. Reilly, the Director of the Division and representatives of the Attorney General's Office. Mr. Reilly stated that he felt the problem was one of educating the auditors to their proper professional role and the Commission agrees. The Commission is also of the opinion that the auditors should be educated as to possible criminal violations in matters uncovered via their audit. Those matters should be reported to the already existing Legal Action Committee which is made up of representatives of the Division and the Attorney General's Office.

B) The Equipment Rental Ploy

One area of possible chicanery which came to this Commission's attention was the ploy of listing an item for equipment rental on the cost report. The Commission's interest was first drawn to this matter via the executive session testimony of a nursing home operator who was questioned on the negotiations which were the basis of a lease agreement. When the operator was questioned as to maximum rental allowable in an unrelated lease for the facility involved, he reported a figure which was $200 higher than the actual maximum rental allowable according to the schedule promulgated by DMAHS. He also reported that he determined this figure by a call to the Division of Medical Assistance and Health Services but an examination of the lease shows that he took only the scheduled maximum amount for rental but then added a $200 per bed figure for "equipment rental". Mr. Perroni testified before the Commission that there are no published figures on maximum amounts for equipment rental but said that the arbitrary figure set in the minds of most auditors was between $100 and $200 per bed. Mr. Perroni also admitted that the nursing home operator involved could have been advised of this fact over the telephone. The effect of that advice, if given, was to substantially increase the amount of rent reimbursed by the State of New Jersey for that nursing home for the fiscal year.

The Commission also noted instances where the actual rental amount per the lease was in excess of the schedule amount for a nursing home of the size and year of construction involved. The

cost reports examined, however, showed that the overage (the difference between the maximum schedule amount and the lease) was simply transferred to a column called "equipment rental" on the cost report. Mr. Perroni was questioned as to whether this could be a method whereby nursing home operators received a higher rent than the schedule called for merely by calling the monies "equipment rental" rather than building rental. Again, Perroni admitted that such a situation could occur and the Commission is of the belief, through its examination, that it, in fact, did in certain instances. Again, the effect was to substantially increase the reimbursement to the nursing home from the State of New Jersey. The equipment rental ploy is a good example of the result of the Audit Section functioning as an advisor rather than an auditor to the nursing home operator.

C) Miscalculation of Year of Construction

The Commission established through testimony that where a nursing home begins to function as such via the renovation of an old building built for a purpose other than a nursing home, the maximum rental schedule should be employed by using the date of construction of the original building, rather than the date of renovation. Column A of the maximum rental schedule begins in 1934 with an amount of $256 per bed and ranges up to $1,818 per bed in 1975. It is obvious, therefore, that a miscalculation as to the date of construction can have monumental effects on the property cost reimbursement of a nursing home. If the nursing

home was renovated in 1968, for instance, and built in 1948, it should receive $480 per bed as a maximum allowable rental. If the year of renovation is used, however, the nursing home will receive $1,040 per bed as a maximum rental allowable. The Commission has examined only a small number of nursing homes but has found a miscalculation of the year of construction in at least 3 instances. Mr. Perroni was of the opinion that this matter could only be sufficiently validated on a field audit, but the Commission is of the opinion that if greater attention had been given to the year of construction on the desk review, for instance, by a certification by the nursing home operator or administrator, that the problem area could have been substantially alleviated.

D) Non-communication with the New Jersey Department of Health

It became apparent to the Commission during its investigation that because of the somewhat unusual arrangement existing in New Jersey with respect to the Medicaid program, that is, the dual responsibility for administration lodged in DMAHS and the Department of Health, a high degree of communication and cooperation is necessitated. The conclusion that the Commission has reached, on the contrary, is that very little communication between these two administrative branches exists. The problem came to the fore with respect to the granting of a certificate of need by the Department of Health where that grant will significantly increase

the amount of reimbursement to the particular nursing home. Sister Cathleen Maloney testified that she receives very little cooperation from DMAHS with respect to obtaining cost reports and the like in order to examine the effect on the Medicaid rate. On the other hand, she also testified that the effect on the Medicaid rate was not one of her paramount concerns. Additionally, representatives of DMAHS testified that although they have the power to consider unwarranted an escalation in reimbursement solely as a result of property costs, they rarely get involved in such a situation because the certificate of need has already been granted by the Department of Health. The Commission will comment on an attempted mode of alleviation of this problem in the recommendations portion of the report.

E) Allowance of Escalating Property Costs Reimbursement

Mr. Perroni was specifically questioned on whether the Division of Medical Assistance and Health Services took an aggressive posture with respect to escalating property costs and the reimbursement therefor where, for instance, a new lease comes into being at a higher amount, or the mortgage of the institution is recast at a higher principal amount or rate, or the facility is sub-leased to another operator at a higher amount, or an individual operator obtains financing which is in excess of apparent 100% construction costs. In all of the aforementioned cases, Mr. Perroni was of the opinion that he had the power to deny proposed reimbursement of figures which would be in excess of the desk reviewers opinion as to

propriety. He admitted, however, that where the increase was within Division regulations (that is, within the amount proposed by the maximum rental schedule or the actual debt service on the mortgage involved) that there was very little the auditor or desk reviewer could do. Additionally, he recalled not one single situation where an exorbitant lease or debt service was nullified on the aforementioned theory.

The Commission is led, therefore, to the conclusion that there is no effective control in DMAHS on rising property cost reimbursement figures, as long as they are within the aforesaid regulations set by that Division. Perhaps more importantly, when coupled with the fact that there is no control existent within the Department of Health over the same area of rising costs, the conclusion is that the area of property cost reimbursement is pregnant with the possibility for manipulation by unscrupulous operators and unfettered by aggressive administrative regulations to the contrary.

Recommendations of the Commission of Investigation

Before addressing the specific recommendations of the Commission, it should be noted that some of the aforementioned areas of concern would be obviated by the Commission's recommendation for a fair rental system of property cost reimbursement. One such area is the recently reviewed problem of rising property cost reimbursement in an uncontrolled atmosphere. Other areas would be the equipment rental ploy and the miscalculation of the year of construction.

All of these areas of abuse would be avoided since the fair rental system would provide an amount of money which would not change for at least a ten-year holding period.

A) Additional Auditors

The most obvious recommendation for the foregoing examination of the function of the audit section is that there seems to be a dire need for additional personnel. The established fact that more than half of the nursing homes involved in the program as of the end of 1975 have never received an audit is astounding. One method of curing this deficiency is to add a sufficient additional number of auditors.

Mr. Reilly, Director of DMAHS, testified before the Commission that in his fiscal 1977 budget, he requested an additional 12 positions for the Audit Section and had received none. The Commission strongly recommends that the decision not to allow these new positions be seriously reconsidered.

The problem of additional staff admits not only of practical illustration, but will soon be mandated by federal law. The recently enacted Section 250.30(b), Part 250, Chapter II of Title 45 of the Code of Federal Regulations includes the following statement:

(a) State Plan Requirements

(9) . . .

(iii) A description of the state's system for validating the accuracy and reasonableness of cost information reported by facilities

> (is required). The state agency must submit a report of the number and results of field audits conducted during the preceding twelve month period by September 1 of each year. States must provide adequate procedures for annual on-site audits of the financial records of all participating facilities over an initial three-year period beginning July 1, 1976, in which no less than one third of the facilities are audited each year. In each year beginning July 1, 1979, field audits must be performed in at least 10% of participating facilities selected on a randam basis as representatives of all facilities.

The Commission is of the belief that the task prescribed by the aforementioned federal regulation would be an impossible one with the present number of auditors, even though a portion of their responsibilities will be transferred to the Department of Health in 1977.

The Governor's Cabinet Committee suggested the employing of an outside auditing firm to either aid the Audit Section in its function or take over the audit function in toto. The Commission's experience with the employment of outside auditing firms is that the undertaking often becomes a highly costly one. Additionally, start-up time due to necessary education is often substantial. The S.C.I. would, therefore, suggest the addition of the new positions as aforesaid, rather than employing the outside auditor approach.

B) Communication Between the Department of Health and the Division of Medical Assistance and Health Services

Through the interviews and testimony taken by the Commission,

it is established that the communication between the Department of Health and DMAHS is minimal with respect to property cost reimbursement. Any input that the Audit Section might have on escalating the Medicaid reimbursement for property costs has either not been sufficiently requested by the Department of Health or not been gratutiously offered by DMAHS. That situation has produced an atmosphere whereby the two administrative branches are, in the Commission's opinion, working at cross purposes through a neglect of theoretically available modes of communication.

It is obvious that input by the Audit Section could have a substantial and beneficial effect upon the certificate of need program and this requirement of input will only increase as the Department of Health takes on added responsibilities for rate setting in 1977.

The only reported communication from witnesses examined and interviewed by the Commission was of a high-level nature. The results of that interchange rarely, if ever, filtered down to the individuals with the everyday responsibilities for the auditing of the nursing homes and the granting of a certificate of need. The Commission therefore recommends that an inter-agency committee be created with the appropriate members of the Department of Health (which would necessarily include an individual from the certificate of need program, a representative of the construction and architectural cost control section of the Department of Health, and an individual with specific responsibilities in financial feasibility

studies) and representatives of DMAHS (especially a designated member of the Audit Section and a designated member of the Surveillance Review Section). This committee should meet, in the Commission's opinion, at least on a monthly basis to review work being done by the Department of Health in connection with either new construction or the granting of a certificate of need in some other area and should receive input from DMAHS on the effect on the Medicaid reimbursement rate for the facility involved. This recommendation could be carried out most likely by administrative fiat.

C) Auditor Education

The present method of educating new auditors in the Audit Section of DMAHS is to have them train on the job with an experienced auditor. No formal education is granted to auditors in the Division. This circumstance most likely gives rise to the new auditors having the same predilections and accounting practices of the more experienced auditors, whether those predilections and tendencies are beneficial or detrimental. The Commission recommends that the Division set up for the Audit Section a formal method of education which would be sufficiently objective and would grant the auditors specific training to develop a professional approach to the relationship with the operator, an awareness of possible areas of criminal fraud, and a sufficient working knowledge of the particular industry in which they are involved. As a practical matter, the Commission is aware that the Audit Section has, for several years, requested such a program but has never

recieved funding for same. It is the Commission's opinion, like other suggested investments in the Audit Section, that funding of a training program would only reap benefits in the long run for the State of New Jersey.

THE DEPARTMENT OF HEALTH CERTIFICATE OF NEED PROGRAM

Pursuant to N.J.S.A. 26:2H-1, et seq., the Department of Health has the responsibility for granting a "Certificate of Need" before certain health-related facilities in the state may be constructed, change ownership or operators, expand, or engage in several other types of activity which are listed in the statute. With respect to nursing homes, approvals are necessary for changes in ownership, lessees, stock purchases, new construction and the like. The S.C.I.'s interest was attracted to the program because it presents the potential for controlling the monetary amounts of purchases and leases by not granting a certificate of need unless it is first determined that the planned alteration will not create an unwarranted increase in the Medicaid reimbursement rate. The S.C.I.'s inquiry, however, disclosed that the potential has never been realized.

The certificate of need program itself, as administered in the Department of Health, excluding examinations made by assisting agencies, purports to inquire into each application with respect to three different criteria: does the planned modification comport with the Master Health Plan for New Jersey (is there a need in the particular area); does the planned modification in any way effect the license provisions of the facility; finally, is the project economically feasible. The inquiry is completed via a review by specific sections of the Department of Health. These units make their recommendations to the Review Committee

of the Health Care Planning Council which makes its recommendation to the Commissioner of Health, who makes the final determination, except that denials must be approved by the Health Care Administration Board, N.J.S.A. 26:2H-9. Local Health Planning Agencies also submit their recommendations to the Health Care Planning Council.

The interest of the Commission was initially attracted to the financial feasibility portion of the certificate of need program by its examination of the sale of the Lincoln Park facility. That transaction, which depends technically on the granting of two certificates of need before it can come to fruition, would place a value of $8 million on a nursing home which was constructed some nine months prior to the contract of sale for $3.8 million. Because the S.C.I. was of the opinion that the state should scrutinize such a sale for possible manipulation, an inquiry was made into the workings of the financial feasibility aspect and other portions of the certificate of need program. The testimony of Sister Cathleen Maloney, Chief of the Bureau of Health Statistics and Economics, was taken to this end.

N.J.S.A. 26:2H-8 provides in pertinent part:

> In making such determinations there shall be taken into consideration
> (a) the availability of services which may serve as alternatives or substitutes,
> (b) the need for special equipment and services in the area,
> (c) the possible economies and improvements in services to be anticipated from the operation of joint central services,
> (d) the adequacy of financial resources and sources of present and future revenues,

(e) the availability of sufficient manpower in the several professional disciplines and
(f) such other factors as may be established by regulations.

Sister Maloney testified before the Commission that it was one of her functions as Chief of the Bureau of Health Statistics and Economics to satisfy, for the certificate of need program, (d) above, that is, that the financial resources and sources of present and future revenues are adequate for a viable institution. In order to carry out this function, she testified further, she assigns one of her staff personnel to collect available financial data that was submitted with the application and to require further data where necessary to answer the question of whether the institution will be an on-going venture and be able to satisfy its outstanding financing. One of the key documents which is considered via this portion of the certificate of need inquiry, is a certified accountant's statement on the assets and liabilities of the institution. Sister Maloney was also questioned as to whether, perhaps as an adjunct to her statutory responsibility, she examined, where the home is substantially financed with Medicaid funds, whether there would be a substantial effect on the Medicaid rate via the proposed addition or change in ownership. Her final answer was that this was not considered a part of her function for several reasons, including the very obvious one that it is not called for by the statute or by any administrative regulation. Sister Maloney did testify however that, with respect to the Lincoln Park application, a comment

was made on her report that there would be a substantial increase in the Medicaid rate and that the proposed sale would, therefore, not be economically feasible. The first certificate of need was, however, granted over this recommendation. With respect to existing facilities, then, it is the opinion of the Commission that there is no effective control via the certificate of need program presently existing in the Department of Health for increased Medicaid reimbursement via escalating property cost reimbursement caused by successive transfers, sales and leases. The Commission will comment further upon this problem in the recommendations portion of this section of the report.

Sister Maloney further commented that, when she does have an interest on the effect of the Medicaid rate and has made inquiry into DMAHS with respect to pertinent information concerning that rate, she has often received poor cooperation as to the obtaining of the most current cost report. The communication between the Department of Health and DMAHS has already been commented upon in the section of this report dealing with the auditing function of DMAHS and the same recommendation would apply to this section of the report and will also be commented upon later.

Control of New Construction

By virtue of N.J.S.A. 26:2H-21, certain powers of the Department of Institutions and Agencies and its Bureau of Medical Facilities Construction and Planning were transferred to the

Department of Health in 1971. The presently existing administrative branch of the Department of Health is called the Health Facilities Construction and Monitoring Unit. Because it came to the attention of the Commission that is was the responsibility of this group to monitor construction costs as they relate to nursing homes, the Commission took the testimony of Mr. Joseph A. DiCara, Acting Chief of the Unit. The purpose of this inquiry was to attempt to determine from Mr. DiCara whether the construction of new nursing homes is controlled as to cost because an inflated cost figure obviously inflates the Medicaid reimbursement for property cost through inflated debt service reimbursement. Secondarily, the previously discussed recommendations of the Commission based on the proposed fair rental system would have as one of its critical underpinnings, an aggressive program of construction monitoring so that initial costs which would form the basis for reimbursement would not be inflated.

Mr. DiCara testified that his unit has been in existence only since July 1, 1975, in its present posture. He also testified that the unit has some key positions which were unfilled as of December 1975. These positions include one of an architect and another of a cost estimator for construction. He further testified that he does have some input into the certificate of need program but that, as yet, that input has been minimal due to the fact that the unit is a comparatively new one. He testified that his plans are to develop an expertise in the unit for evaluating construction costs of new facilities through the cost estimator.

The plans for the unit are to set up approximately 40 pocket areas of construction around the state so that planned construction may be estimated with respect to hypothetical figures set up for each area. The Commission was impressed with the potential presented by such a unit, especially in conjunction with the Commission's proposal of a fair rental system. The fact remains, however, that this unit has not had, as of December 1975, a significant impact on either the granting or denial of a certificate of need for a new nursing home facility based on the position that the construction costs listed were either overstated or understated. The Commission's recommendations with regard to the health facility construction and monitoring unit are discussed hereinafter.

Recommendations

Again, as with the comments relevant to DMAHS, several of the recommendations which would be made by the Commission with respect to the function of the Department of Health are obviated by the enactment of a proposed fair rental system. For instance, an obvious recommendation would be a transformation of the financial feasibility study into a complete inquiry into the economic effect of the proposed grant of a certificate of need, including the impact upon the Medicaid program. That recommendation, of course, will not be necessary once the proposed fair rental system is put into effect since sales, refinancing and new leases would be disregarded for the purpose of property cost reimbursement.

The recommendations which follow assume the eventual adoption of such a fair rental system.

A) Interim Recommendation with Respect to Escalating Sales Prices

The Commission realizes that no system of property cost reimbursement will be a panacea. The S.C.I. is also mindful that whatever system is eventually employed, some time may pass before its ultimate enactment. It is important, however, to note that applications such as the one made by the Lincoln Park facility may be continued and possibly approved by the Department of Health. An interim recommendation to prevent what the Commission believes is a monumental waste of pecuniary resources by the state is therefore appropriate.

In the State of New York, an interim procedure was employed by the New York Department of Health. The actual sales price in a proposed sale is ignored for reimbursement purposes. Instead, the original construction cost of the building and equipment is inflated upward using the Dodge Index and then "depreciated back" using the number of depreciable years between the date of construction and the date of sale. The Dodge Index is a common indicator of rising construction costs and is used extensively in the appraisal industry to arrive at a present replacement cost for older construction. The concept of "depreciating back" is a simple subtraction from the new trended figure of the depreciation already granted. In the case of Lincoln Park, the original construction cost was

$3,991,746. If the overall figure obtained from the Dodge Index was, for instance, 1.075, the trended construction costs one year after completion would be $4,291,127. Depreciation (1/40 times $4,291,127) would then be subtracted from the overall figure to give a total recognizable value for Medicaid property costs reimbursements of $4,183,849. As has been stated, Medicaid property cost reimbursement would be based only on that figure and the sale price would be disregarded. Thus, the owner would receive a return on the replacement cost of the facility with a modification for depreciation and the State would be protected against sales which are consummated only as a result of the present regulations of DMAHS concerning property cost reimbursement.

The Commission recommends this procedure until another method of reimbursing property costs is adopted by the Department of Health.

B) Construction Cost Control

The previously proposed fair rental system is based on the initial construction costs and, therefore, for new facilities, those construction costs are critical in the determination of the basis for that fair rental return. An obvious loophole in that proposed fair rental system would be the inflation of construction costs at the initial stages to raise the basis. It is, therefore, critical that the Department of Health develop a unit with the expertise to monitor construction costs around the state for new facilities. This task, in the Commission's

opinion, should not be an extremely difficult one if the Department of Health follows the Commission's recommendations of an overall valuation of all nursing homes in the state. Those figures divided by the number of beds, perhaps with some application of a trend forward, could give reasonable construction costs for all areas of the state. The S.C.I. believes that the Health Facility Construction and Monitoring Unit presently existing in the Department of Health would provide the administrative branch which could be augmented by sufficient personnel to carry out this task. Unmistakably, however, the present staff of this unit is not sufficient to carry out this function. A sufficient number of cost estimators and architects who would be responsible for field inspections would be indispensable. The Commission therefore recommends the creation of such a unit in the Department of Health in order to carry out the monitoring of the construction of new facilities.

C) Communication with DMAHS

As has been mentioned in a previous section of this report, the Commission has established that communication between the Department of Health and DMAHS is a necessary prerequisite to the successful functioning of the Medicaid system as it is now set up. This communication will remain important and perhaps become even more desirable when the Department of Health takes over the rate setting function in 1977. As we suggested earlier, therefore, the Department of Health should contemporaneously consider

becoming a member of an inter-departmental committee which would meet on a monthly basis and include the previously mentioned representatives to monitor and discuss the effect on the Medicaid rate of any planned additions or certification of need applications.

PYRAMIDING AND TRAFFICKING IN NURSING HOMES

Several of the investigating agencies involved in the general topic of the nursing home industry over the past year have discovered, in their respective jurisdictions, that several nursing homes may be owned by one individual or cartels. Interlocking directorates of corporations have also been established sometimes controlling a substantial percentage of the nursing home beds in that particular jurisdiction. Early on in the investigation, the S.C.I. was confronted with a rumor that a substantial percentage of nursing home beds in the State of New Jersey is controlled by a large group of people from a "twenty block square area in Brooklyn." The Commission has investigated that allegation and the general proposition that a small number of people may control a large percentage of the nursing home beds and found it to be partially true. The Commission is of the belief that it is relevant to comment upon that factor and the general area of trafficking and pyramiding for the following reasons:

1) If the responsible administrative branches of New Jersey state government are alerted to the expansive holdings of particular individuals, they will begin to notice patterns and methods of operation with respect to nursing homes and, perhaps more importantly, can develop a "track record" for particular operators which will have bearing upon not only the audit function of DMAHS, but also

upon the certificate of need application procedure of the Department of Health;

2) The fact that one nursing home operator may begin with a small home or one initial home and then quickly branch out into several homes in this State is at least circumstantially evidential of the fact that there is a profit to be made in the nursing home business which can be reinvested in that business rather quickly with substantial gains;

3) It is also important to examine possible trafficking and pyramiding from the point of view of the prima facie undesirability of allowing a substantial percentage of nursing home beds to be controlled by a small portion of people who at least would possess a potential to exert a coercive influence on the administrative branches reponsible for the functioning of the system and the creation of new regulations.

The Commission has developed an interrelationship chart which depicts the connection between various nursing homes and various corporations and individuals operating in New Jersey and New York. Chart 1 depicts the holdings of Dr. Bernard Bergman of New York, New York, and his relationship with several New Jersey nursing homes through those holdings. Chart 2 exemplifies the same subject matter with respect to Mr. David Schwartz, 1262 45th St., Brooklyn, New York, the owner of the Shore Manor Nursing Home, formerly the Senator Convalescent Center in Atlantic City. Chart

3 illustrates the same subject matter with respect to Mr. Samuel Paneth, 1459 56th Street, Brooklyn, New York, owner of the Newark Extended Care Facility in Newark, New Jersey. Chart 4 demonstrates the holdings and interrelationships of Mr. Frank Chaimovits, 1543 56th Street, Brooklyn, New York, owner of the Beachivew Nursing Home.

The Commission is of the opinion that Charts 1, 2, 3 and 4 illustrate good examples of ownership, control or association with several nursing homes in New Jersey. The investigation involving Dr. Bernard Bergman in New York, of course, is well known to the public as a whole. Equally interesting, however, for New Jersey purposes, are Charts 2, 3 and 4. Mr. Schwartz, for instance, if the Lincoln Park sale is consummated, will control or have a direct influence upon 1,252 beds in New Jersey. Additionally, if the conclusion can be drawn that, through the connection of the Perlstein family, Mr. Schwartz also has some influence over the holdings of Mr. Paneth and Mr. Chaimovits, an additional 1,453 beds can be added so that the three groups, among them, control 2,705 beds representing approximately 11 % of the Medicaid beds in New Jersey. It is relevant to note here that there are two indictments which have been returned through the investigative efforts of the S.C.I. and a later referral and further investigation by the Attorney General's Office presently pending against the former owners and some of the present administrators of the Shore Manor Nursing Home.

CHART II

FRANK CHAIMOVITS
1543 56TH STREET BROOKLYN, N.Y.

LINCOLN PARK N.H. — EDWARD EINHORN PRES. ADMIN.

GOLDEN CREST N.H. — SHELDON FARBER LESSOR
MARTIN FRIEDMAN & JACK LICHT-OFFICERS & STOCKHOLDERS

MANOR AT EMERSON N.H. — MORRIS SCHNITZER, JACOB BERGSTEIN, ZEF AJLMAN & LEO ROSENSON STOCKHOLDERS

JOSEPH SCHWARTZ & ERNEST HOLLANDER STOCKHOLDERS

EDITH CHAIMOVITS WIFE OF FRANK, ISRAEL KLEIN, MORRIS & ESTHER ISACC, LEOPOLD FREUD

&

IZO PERLSTEIN, ALL STOCKHOLDERS — BEACHVIEW N.H.

TOBIAS PERLSTEIN, FATHER OF IZO, V.P. & STOCKHOLDER OF

EVA PERLSTEIN, WIFE OF TOBIAS, PRES. & STOCKHOLDER OF

MEYER J. PERLSTEIN, BROTHER OF TOBIAS, V.P. & STOCKHOLDER — PINECREST, N.H.

ARNOLD PERLSTEIN, SON-IN-LAW OF MEYER, SEC., STOCKHOLDER & ADMIN. OF

PINE ACRES N.H.

DAVID PERLSTEIN, BROTHER OF MEYER, SEC. & STOCKHOLDER OF

EMPLOYED BY — SHORE MANOR

FORMERLY T/A SENATOR CONV. CTR.
INDICTED 3-3-76 BY A N.J. STATE GRAND JURY
INVESTIGATION MEDICAID FRAUD

SEE CHART IV

N.H. NURSING HOME
PRES. PRESIDENT
V.P. VICE PRESIDENT
ADMIN. ADMINISTRATOR
CTR. CENTER
T/A TRADING AS
SEC. SECRETARY

CHART III

ADMIN. PRES., STOCKHOLDER & REG. AGENT

SAMUEL PANETH
1459 56TH STREET BROOKLYN, N.Y.

BUSINESS ASSC. WITH N.J. NURSING HOME INTEREST

SEE CHART #11

THOMAS PANETH BROTHER OF SAMUEL TRES. & STOCKHOLDER

PRES. & STOCKHOLDER

ARNOLD J. PERLSTEIN PRESENT ADMIN. & A FORMER OFFICER & STOCKHOLDER SON-IN-LAW TO

MEYER J. PERLSTEIN FORMER V.P. & STOCKHOLDER

PINE ACRES N.H.

ALEXANDER BLAU T/A MADISON REALTY ASSC.
TREAS. & STOCKHOLDER
PROPERTY OWNER VIA MADISON REALTY ASSC. OF
PINE ACRES N.H.

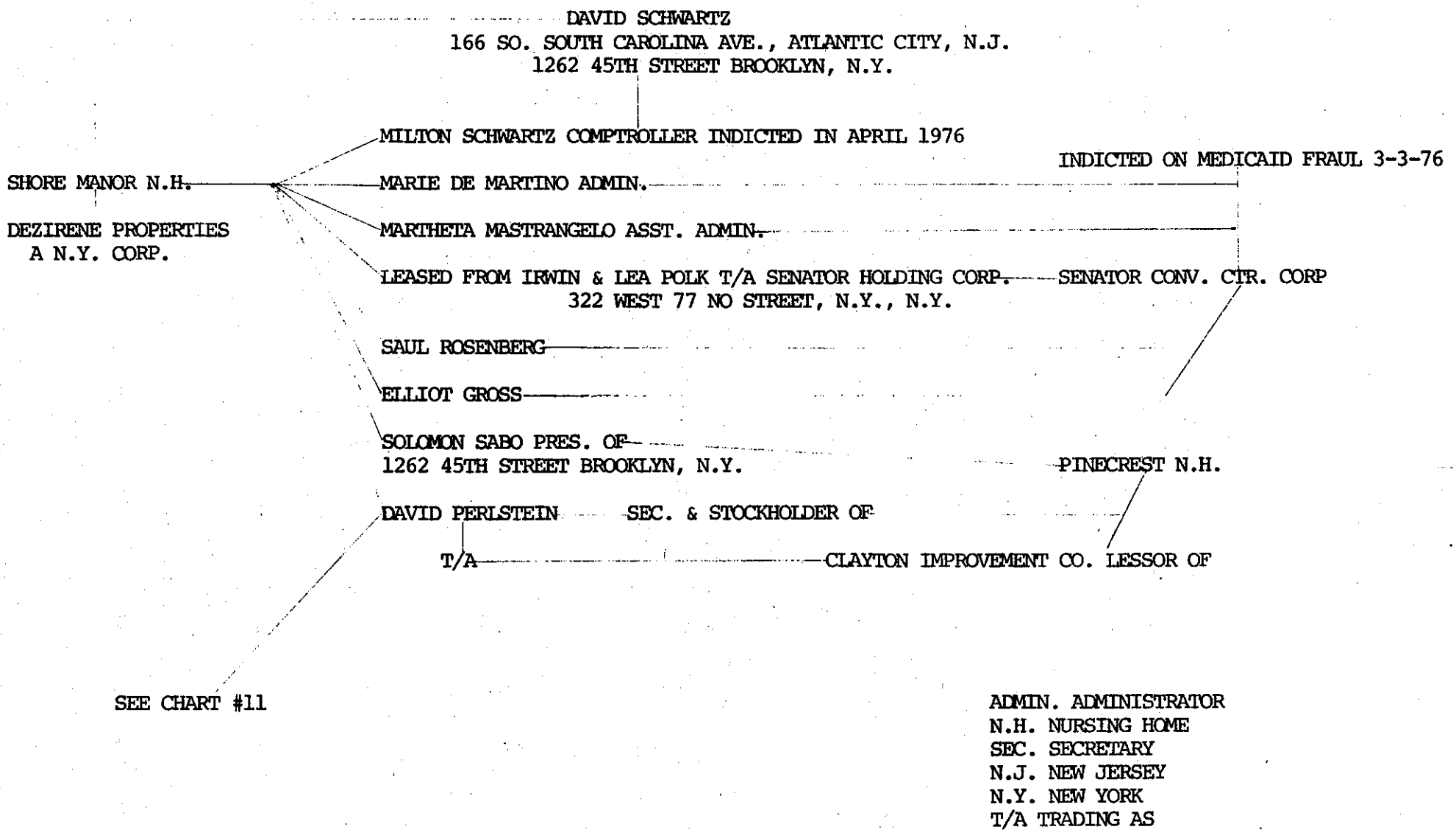
NEWARK E.C.F.

OSCAR HELLER STOCKHOLDER——V.P. STOCKHOLDER & ADMIN OF——BAYVIEW N. & CONV. CTR.

ANNA HELLER——————— PRES. & STOCKHOLDER

T/A TRADING AS
PRES. PRESIDENT
TREAS. TREASURER
CONV. CONVALESCENT
E.C.F. EXTENDED CARE FACILITY
N.Y. NEW YORK
N.H. NURSING HOME
V.P. VICE PRESIDENT
CTR. CENTER
N.J. NEW JERSEY
ADMIN. ADMINISTRATOR

CHART IV


DAVID SCHWARTZ
166 SO. SOUTH CAROLINA AVE., ATLANTIC CITY, N.J.
1262 45TH STREET BROOKLYN, N.Y.
MILTON SCHWARTZ COMPTROLLER INDICTED IN APRIL 1976
INDICTED ON MEDICAID FRAUL 3-3-76
SHORE MANOR N.H.
MARIE DE MARTINO ADMIN.
DEZIRENE PROPERTIES
A N.Y. CORP.
MARTHETA MASTRANGELO ASST. ADMIN.
LEASED FROM IRWIN & LEA POLK T/A SENATOR HOLDING CORP.
SENATOR CONV. CTR. CORP
322 WEST 77 NO STREET, N.Y., N.Y.
SAUL ROSENBERG
ELLIOT GROSS
SOLOMON SABO PRES. OF
1262 45TH STREET BROOKLYN, N.Y.
PINECREST N.H.
DAVID PERLSTEIN
SEC. & STOCKHOLDER OF
T/A
CLAYTON IMPROVEMENT CO. LESSOR OF
SEE CHART #11
ADMIN. ADMINISTRATOR
N.H. NURSING HOME
SEC. SECRETARY
N.J. NEW JERSEY
N.Y. NEW YORK
T/A TRADING AS

The Concept of "Selling Beds"

The Commission began the investigation with the assumption that nursing home corporations are set up much like traditional corporate organizations. To its surprise, the S.C.I. determined through the investigation that this was not necessarily true. Specifically, through the testimony of Mr. Joseph Cohen, principal stockholder and administrator of the East Orange Nursing Home and 23% owner of Perth Amboy Nursing Home, as corroborated by the testimony of Mr. Edward Einhorn, administrator of the Golden Crest Convalescent Center, Inc., Atlantic City, the S.C.I. discovered that there is in the industry a practice known as "selling beds".

Mr. Cohen explained that, with respect to the Perth Amboy Nursing Home, the initial cash necessity was $525,000, and that he garnered this capital by selling beds for $3,000 each through what he termed "social contacts". Simply put, for an investment of $3,000 in cash, a person is guaranteed one bed in the Perth Amboy Nursing Home and is also assured a profit of $400 annually (13.3%) over and above the profit of the entrepreneurs. Mr. Cohen testified that an individual may purchase as many beds as he desires from one to a controlling interest and receives his return on an annual basis. The Commission's investigation established that this situation exists in several nursing homes in New Jersey and it is the opinion of the Commission that the purchasing of a nursing home bed as one would purchase a used car is an undesirable practice from the point of view of the lack of contact between the bed owner and the actual operation of the nursing home.

More importantly, however, the practice has at least the potential of being a device to withhold from the administrative agencies which oversee the program, the actual identity of the people involved in the ownership. In the Commission's view, this situation will not be cured by the legislation pending before the New Jersey House at this time on disclosure. This problem will be discussed more fully in the recommendations section of this report.

Recommendations

A) Senate Bill No. 594

Senate Bill No. 594, which is pending at this time, addresses the problem of disclosure of nursing home interests and requires the name and address of the following natural persons or entities:

1) The operator of the nursing home;
2) Any person who, directly or indirectly, beneficially owns a 10% or greater interest in the land on which the nursing home is located;
3) Any person who, directly or indirectly, beneficially owns a 10% or greater interest in the building in which the nursing home is located;
4) Any person who, directly or indirectly, beneficially owns a 10% or greater interest in any mortgage, note, deed of trust or other obligation secured in whole or in part by the land on which or building in which the nursing home is located;

5) Any person who, directly or indirectly, has any interest as lessor or lessee in any lease or sub-lease of the land on which or the building in which the nursing home is located.

The S.C.I. is of the opinion that the classifications of persons in Bill No. 594 is probably sufficient, but is of the further opinion that a 10% ownership cutoff is too high. The Commission is cognizant of the fact that the reason for the cutoff is that full disclosure of all persons with interests might be unwieldy. The Commission, based on its experience, disagrees and suggests that sub-sections 2) and 3) be amended to include all persons having an interest in the nursing home land and building. This would prevent, for instance, the owner of 24 beds in the 250 bed Perth Amboy Nursing Home (an investment of $72,000, according to Mr. Cohen's testimony) from going undisclosed.

Subsection 4) of the Bill presents somewhat different problems. On the one hand, the 10% cutoff is reasonable because the answer to the question posed by subsection 4) may often name the owners of shares in banks and large institutions. On the other hand, the S.C.I. developed evidence of small groups receiving substantial payments out of the nursing home capital under various manners of unusual instruments. Some of those instruments might technically be considered <u>unsecured</u>. To augment the deficiency, therefore, the Commission suggests the addition of the following subsection.

6) Any person who, directly or indirectly, beneficially owns a 10% or greater interest in any mortgage, note,

deed of trust or other obligation which, although not secured by the land or building upon which the nursing home is located, is considered an outstanding liability on the books of the nursing home and was executed to finance directly or indirectly the purchase of the nursing home, land, building, lease or sub-lease pertaining thereto.

B) Certificate of Need Program Ramifications

The overall awareness of patterns of ownership and control possessed of by the administering agencies will, of course, be enhanced by Senate Bill No. 594. The Commission suggests, however, that the knowledge be utilized especially in the Certificate of Need program. An evaluation of the applicant with pertinent details such as other nursing home interests and performance record should be added to the certificate of need commenting procedure.

C) DMAHS Audit Section Ramifications

Knowledge of patterns of ownership and methods of operations of nursing homes is also relevant to the task of the DMAHS auditor. The report of ownership and relationship should also be filed with the audit section and should be perused and discussed by that section prior to field audit. Problem areas in other nursing homes owned by or related to the owner of the home under examination should be noted and examined as priority items.

EXHIBIT I

NEW JERSEY'S REIMBURSEMENT FORMULA

The most publicized aspect of New Jersey's Medicaid reimbursement formula is that, unlike some of its sister states, this state places an administrative ceiling on the amount which a nursing home may receive per patient per day of care. Those administrative ceilings are set out in Chart I below:

CHART I

Level of Care	Maximum Per Diem Reimbursement Rate Per Patient
Skilled Nursing Care (Level III)	$27.60
Intermediate Care (Level IV A)	$26.29
Intermediate Care (Level IV B)	$23.66

It should be remembered, however, that the foregoing amounts are maximums which a nursing home may receive. The Division of Medical Assistance and Health Services (DMAHS), however, may award particular nursing homes a reimbursement rate less than the maximum. Simply stated, the Division computes the total operating expenses claimed by the institution in question and then divides by the total number of patient days recorded by the nursing home in the previous year. (Patient days are defined as the total number of beds occupied in the institution over the course of a year.) The product of this calculation is the rate reimbursed for Level IV A patients provided the maximum is not exceeded. To arrive at the reimbursement rate for Level III patients, the Division adds 5% of Level IV A; to establish the Level IV B rate, 10% is deducted from

Level IV A. Again, however, the maximum amounts for the aforesaid levels may not be exceeded.

Example:

> Nursing home X has an operating expense for fiscal 1974 of $2 million. Nursing home X has a constant census of 274 patients per day for that entire fiscal year. Multiplying 274 x 365 gives a total patient days of 100,000 (approx.). Dividing $2 million (the operating expense) by 100,000 (the total patient days) gives a mid-level rate of reimbursement of $20 per patient per day. Adding 5% of $20 to the mid level produces the high level of $21 per day. Subtracting 10% of $20 from $20 produces the low level of $18 per patient per day. Thus, for fiscal 1975, nursing home X will be reimbursed at these rates for each patient at each level per day.

The SCI is of the opinion, however, that the critical consideration relating to the reimbursement formula is that New Jersey reimburses operating expenses on a dollar for dollar basis up to the maximum amount. Therefore, if any of the component figures of operating expenses are inflated or excessive, there exists the same inherent potential for abuse as in other states. The only function of the administrative ceiling is to quantitatively reduce the magnitude of abuse.

One of the major components of nursing home operating expenses reimbursed by the state is the carrying costs or rental payments of nursing home enterprises. The SCI decided at the outset of the instant investigation that it would be erroneous to probe for abuses within the system without first critically examining the rent and operating cost reimbursement system itself.

If the system itself allows or invites excessive reimbursement payments for such costs then it is self-evident that total reimbursement payments to nursing homes will also be excessive. Thus, this interim report will examine the facts surrounding the genesis of the rent and carrying cost regulations, the practical effect of those regulations, the weaknesses of which they admit, the abuses which they foster and possible alternatives which could possibly reduce abuses and monetary outlay by the State as a result of those weaknesses.

The Maximum Rental and Imputed Rental Schedule

Because carrying costs and rent are a major component of operating expenses, DMAHS determined to place some control over and limit upon the amounts which any particular nursing home could include in its cost report as a reimbursable expense. What follows is an explanation of the regulations and formulas utilized by New Jersey in reimbursing claimed carrying costs and rents. It will be illustrated that there are essentially three categories of operators of nursing homes for the purposes of reimbursement by the state: 1) The operator may be operating under a lease from an unrelated third party; 2) The operator may be operating under a lease from a lessor to whom he is related by a business tie; 3) The operator may himself be the owner of the home. Because of the difference in treatment between 1) and 2) above, it becomes material to discuss the procedures and guidelines employed in determining whether a lease is the product of an arms-length agreement between unrelated parties or a non-arms-length agreement between related parties. This problem of definition will be

discussed later in this report.

1. "Arms-Length" Leases

The underlying basis of the maximum rents appearing in Column "a" of exhibit 1 is that the market value of a lease on a particular nursing home building increases with the newness of the structure. For example, referring to exhibit 1, a nursing home constructed in 1971 may receive a maximum of $1,440 per bed under a lease arrived at between arms-length parties. Thus if this nursing home contained 100 beds, the maximum reimbursable rental in the arms-length situation would be $144,000 (100 x $1440). On the other hand, a nursing home built in 1934 containing the same number of beds would be subject to a cutoff at $25,600 for rental costs (100 x $256).

2. "Non-Arms-Length" Leases

Column "b" of exhibit 1 supplies similar allowances for rental in "non-arms-length" leases and sets amounts for "imputed rentals." As is apparent, however, the lessee under the non-arms-length or related lease is reimbursed 10% less per bed per year than his counterpart. Thus, for an institution constructed in 1971, the lessee in a related lease operating a 100 bed home would receive $129,600 (100 x $1296). The probable reason for the reduction in the rental ceilings in Column "b" of exhibit 1 is that related parties may arrive at agreements on rental which, due to the relationship, may not be reflective of the true market

value of a lease on the premises in question. The related lessee is also given the additional option of employing actual carrying charges. This will be discussed at length later in this report.

3. Imputed Rents

The second function of Column "b" in exhibit 1 is that it prescribes amounts for imputed rents. This concept attempts to compensate owner-operators for their decision not to lease the home by granting or "imputing" a prescribed schedule amount for rent. Where a nursing home is owned by the operator there is, of course, no rent involved. In such a situation, the owner-operator is allowed his carrying costs (mortgage interest plus depreciation plus insurance costs plus a 10.5% return on equity). There are situations, however, wherein owners' carrying charges are insubstantial. This occurs most often with older homes which are almost fully depreciated. In these situations, there was a concern that these kinds of owner-operators would sell to an entity which they controlled and then lease back to themselves. Thus, even though they would be governed by the lower non-arms-length figures, they would realize a substantial increase in reimbursements for building costs. To prevent this "sale and leaseback" situation the imputed rental vehicle was conceived. The basic underlying concept is that the owner-operator is treated in the same manner as the related lessee thereby removing impetus to become involved in the "sale and leaseback" subtrefuge. The validity of this approach will be examined later on in this report.

4. The Schedule in Operation

The operator-lessee, pursuant to an arms-length lease, may not claim reimbursement for any rental payments in excess of the maximum rates dictated by the schedule. Any rental payments in excess of the schedule amount may not be reimbursed.

Example

Mr. X operates nursing home Y which he leases from Mr. Z for $145,000. The lease is an unrelated one. Nursing home Y is located in Essex County, was constructed in 1970 and contains 100 beds. Referring to exhibit 1, the maximum rental allowable would be $128,000 ($1280 from column A on exhibit 1 times 100 beds). Thus, Mr. X could include only $128,000 in his cost report and would have to absorb the difference between $128,000 and $145,000.

Owner-operators and lessees under related leases are controlled by a somewhat more complex system. They have the option of choosing either their actual carrying charges or an amount from the schedule, whichever is more.

Example

Mr. W owns nursing home V which is located in Bergen County. Nursing home V was built in 1960 and contains 100 beds. Nursing home V's mortgage interest equals $21,000, its insurance premiums total $14,000, its total depreciation is $35,000 and it is credited with a $10,000 return on equity. Thus the total carrying charges are $80,000. The appropriate amount from the schedule (column b of exhibit 1) would be $63,400 ($634 x 100). In this case, however, Mr. W, on owner-operator, has the option of costing the higher figure and will thus employ $80,000, his actual carrying charges, even though he will exceed the schedule figure.

The related lessee, on the other hand, is treated in the same manner as the owner-operator on the theory that the lease agreement between related parties is a fiction. That is, the related lessee has the option of employing actual carrying charges or the schedule amount. Thus, DMAHS completely disregards the actual rental pursuant to the lease and compels the related lessee to claim either the appropriate figure from exhibit 1, column "b" or the actual carrying charges of the related lessor (owner), whichever is greater.

Example

Mr. R rents nursing home S from corporation T in which he has a 40% interest. Nursing home S was built in 1950 and contains 100 beds. Since the lease is disregarded, DMAHS looks to the carrying charges of corporation T. The mortgage interest amounts to $9,000 per year, depreciation totals $16,000, insurance premiums are $4,000 and a return on equity of $11,000 is credited. Total actual carrying charges, therefore, equal $40,000. The appropriate amount from exhibit 1, column b, however, totals $46,000 ($461 x 100) and Mr. R will therefore use that figure on his cost report.

EXHIBIT I

to

EXHIBIT I

DATE OF CONST.	URBAN - GROUP I AREAS		RURAL - GROUP II AREAS	
	MAXIMUM RENTAL ALLOWABLE UNRELATED LEASES (a)	IMPUTED RENTAL ALLOWABLE and MAXIMUM RENTAL ALLOW. RELATED LEASES (b)	MAXIMUM RENTAL ALLOWABLE UNRELATED LEASES (c)	IMPUTED RENTAL ALLOWABLE and MAXIMUM RENTAL ALLOW. RELATED LEASES (d)
1974	1715	1543	1543	1389
1973	1618	1456	1456	1310
1972	1526	1374	1374	1236
1971	1440	1296	1296	1166
1970	1280	1152	1152	1037
1969	1120	1008	1008	907
1968	1040	936	936	842
1967	960	864	864	778
1966	920	828	828	745
1965	880	792	792	713
1964	840	756	756	680
1963	800	720	720	648
1962	768	691	691	622
1961	736	662	662	596
1960	704	634	634	571
1959	672	605	605	545
1958	640	576	576	518
1957	624	562	562	506
1956	608	547	547	492
1955	592	533	533	480
1954	576	518	518	466
1953	560	504	504	454
1952	544	490	490	441
1951	528	475	475	428
1950	512	461	461	415
1949	496	446	446	401
1948	480	432	432	389
1947	464	418	418	376
1946	448	403	403	363
1945	432	389	389	350
1944	416	374	374	337
1943	400	360	360	324
1942	384	346	346	311
1941	368	331	331	298
1940	352	317	317	285
1939	336	302	302	272
1938	320	288	288	259
1937	304	274	274	247
1936	288	259	259	233
1935	272	245	245	221
1934	256	230	230	207

URBAN - GROUP I AREAS				RURAL - GROUP II AREAS			
1	Atlantic City	11	Mercer	1	Atlantic	15	Ocean
2	Bergen	12	Middlesex	5	Cape May	17	Salem
3	Burlington	13	Monmouth	6	Cumberland	18	Somerset
4	Camden	14	Morris	8	Gloucester	19	Sussex
7	Essex	16	Passaic	10	Hunterdon	21	Warren
9	Hudson	20	Union				