Center for Medicare Advocacy
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Special Report

Hidden Profits that Detract from Nursing Facility Care Are Unregulated and Ignored

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Medicare cost reports submitted by nursing facilities are not audited to determine compliance with related party requirements.

Nursing home owners and operators hide their profits by making inflated payments to companies they own and control, which are called related parties. The diversion of millions of dollars of public reimbursement to private personal profit through payments to related parties limits the money available for resident care and results in residents' poor care, suffering, and death. At present, facilities pay 40% of their revenues to related parties. The Centers for Medicare & Medicaid Services (CMS) does not review or audit the Medicare cost reports that skilled nursing facilities (SNFs) submit annually to determine whether SNFs comply with long-standing federal disclosure and other requirements for related parties. In an audit, the HHS Office of Inspector General reports that seven of 14 facilities in its sample "did not properly adjust some of their related-party costs to Medicare-allowable costs as required, which resulted in $1,703,734 in overstated costs." HHS Office of Inspector General, *Some Selected Skilled Nursing Facilities Did Not Comply With Medicare Requirements for Reporting Related-Party Costs*, A-07-21-02836, p. 7 (Dec. 2024). The lack of any federal oversight of related party issues in Medicare cost reports is a shocking dereliction of duty that must be corrected.

Medicare Payments to SNFs

In Fiscal Years 2015-2020, the Medicare program paid SNFs $160.4 billion, including $65.4 billion to related parties Federal regulations define related parties at 42 C.F.R. §413.17(b) as businesses with common ownership or control. Federal regulations also provide that if SNFs do business with related parties, the costs of services or supplies provided by the related parties must not exceed the price of comparable services or supplies purchased elsewhere in the open market (42 C.F.R. §§413.17(c)(2), 413.17(d)(1)(iv)). The exact language of this federal rule has not changed since the rule was promulgated in 1986, 51 Fed. Reg. 34793, 34797 (Sep. 30, 1986). Facilities spend more than 40% of Medicare payments on businesses that they own or control.

OIG Audit

The HHS Office of Inspector General (OIG) selected a non-statistical sample of 14 SNFs representing "a variety of geographic locations, sizes, ownership characteristics (i.e., recent ownership changes, type of ownership, chain organizations, affiliations with private equity companies), and CMS quality ratings." *Id.* 5-6. It chose one cost report for each of the 14 facilities, based on factors including:

- "the recency of changes in ownership,"
- "significant variances in reported related-party costs compared to other cost reporting periods for the same SNF, and
- "related-party costs that constituted a higher percentage of total expenses for the SNF for that cost reporting period as compared to other cost reporting periods within our audit period for the same SNF."

Id. 6.

OIG found that seven of the 14 SNFs "did not properly adjust some of their related-party costs to Medicare-allowable costs as required, which resulted in $1,703,734 in overstated costs" – an average of $243,390 for each facility. HHS Office of Inspector General, *Some Selected Skilled Nursing Facilities Did Not Comply With Medicare Requirements for Reporting Related-Party Costs*, A-07-21-02836, p. 7 (Dec. 2024). Specifically, OIG found that the seven SNFs' overstatements totaling $1,703,734 consisted of:

- "a total of $857,169 in overstated costs from **undisclosed related parties** for which profits were not removed at all,
- "a total of $763,835 in overstated costs from **disclosed related parties** for which profits were not removed at all, and
- "a total of $82,730 in overstated costs for which **profits were not correctly adjusted**."

Id. 14.

OIG observes "These overstated costs could affect future SNF prospective payments if they are used when updating prospective payment rates." *Id*.

Cost reports are not reviewed or audited to determine nursing facilities' compliance with related party requirements

SNFs submit annual cost reports showing how they spend their reimbursement to Medicare Administrative Contractors (MACs), which are private health care insurers that process medical claims. SNF must attest to the accuracy of the cost reports. MACs conduct desk reviews of cost reports and may audit Medicare cost reports. *Id*. 2-3. However, MACs did not identify or correct any of the errors identified by OIG because, as a matter of policy, MACs do not review "as part of their oversight activities, the disclosure of related parties or the reporting of related-party costs when the MACs performed desk reviews or audits of the selected SNFs' cost reports during our audit period." *Id*. 7. *See also id*., 14.

Although CMS has not directly paid SNFs based on cost reports since it implemented a prospective payment system for Medicare SNFs 20 years ago, it uses the cost reports submitted by SNFs to update Medicare Part A rates for SNFs. Consequently, facilities' cost reports have a direct impact on Part A payments and result in inflated payments to SNFs.

Despite the significance of cost reports, neither MACs nor any other part of the federal government determines SNFs' compliance with related party requirements set out in regulations nearly 40 years ago.

OIG Recommendations

OIG recommends that CMS

- "require the MACs to include, as part of the normal desk review or audit process, a review of reporting and disclosure of related-party costs;
- "develop and implement guidance for SNFs on the appropriate methods for providers to determine their allowable related-party costs; and
- "provide guidance to reeducate MACs on the need to review, grant, and document requests from SNFs for exceptions to cost reporting requirements in compliance with 42 CFR § 413.17(d)."

Id. 15.

CMS concurs with the second and third recommendations, but rejects OIG's first recommendation to "require the MACs to include, as part of the normal desk review or audit process, a review of reporting and disclosure of related-party costs." *Id*. 15. While recognizing OIG's concern about SNFs' overstating their costs, CMS writes,

> However, the inclusion of additional costs, including non-allowable related party costs, does not have a direct impact on Medicare payment to SNFs. As explained above, CMS considers the information provided when updating payment rates, but the cost report is not the only basis for calculating payments under the SNF Prospective Payment System.

Id. 23 (Appendix C).

CMS writes that requiring MACs to audit SNF cost reports would require analysis of outside resources and the use of "significant resources and funding without a commensurate impact on Medicare payment." *Id.*

CMS limits its analysis to what it views as the direct impact of cost reports on Medicare payments to SNFs. CMS's tunnel vision misses the bigger picture – that SNF's inflated payments to businesses they own and control divert public payments from resident care to private profit. Moreover, CMS completely ignores its "duty and responsibility" under the 1987 Nursing Home Reform Act "to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys," 42 U.S.C. §1395i-3(f)(1). As shown below, violation of federal related party requirements identified by OIG affects both parts of CMS's "duty and responsibility" – ensuring that residents receive good care and that nursing facilities effectively and efficiently use the public reimbursement they receive.

Why Related Party Transactions Matter

Related party transactions matter because nursing home owners and operators hide their profits by making inflated payments to companies they own and control. Nursing facilities' diversion of millions of dollars of public reimbursement to private personal profit results in

poor care, suffering, and death of residents. Multiple reports and litigation by the New York State Attorney General identify problems that result from related party transactions.

Six years ago, *The New York* Times, in collaboration with *Kaiser Health News*, published an early article on the phenomenon of related parties and their impact on private profits and resident care. In "Care Suffers as More Nursing Homes Feed Money Into Corporate Webs," (Jan. 2, 2018), Jordan Rau described Allenbrooke Nursing and Rehabilitation Center, a Tennessee nursing facility that was sued by the family of a resident whose leg was amputated as a result of poor care. Although the facility reported a $2 million deficit and appeared to be severely underfunded in 2009, Rau reported:

> That same year, $2.8 million of the facility's $12 million in operating expenses went to a constellation of corporations controlled by two Long Island accountants who, court records show, owned Allenbrooke and 32 other nursing homes. The homes paid the men's other companies to provide physical therapy, management, drugs and other services, from which the owners reaped profits.

Over an eight-year period, the Long Island accountants' family trusts collected $40 million from their nursing home chain's $145 million in revenue.

Rau reported that nearly three-quarters of the country's nursing facilities "outsource a wide variety of goods and services to companies in which they have a financial interest or that they control" in a practice known as related party transactions. Financial disclosure information submitted to Medicare at the time showed that facilities contracted with related companies for a tenth of their costs. The OIG's 2024 report shows that related party transactions now account for 40% of facilities' spending.

Kaiser Health News' analysis found that facilities using related parties "have [8 percent] fewer nurses and aides per patient, they have higher patient injuries and unsafe practices, and they are the subject of complaints almost twice as often as independent homes." Facilities using related parties have higher fines and more fines for serious health violations.

Recognition of the impact of facilities' use of related parties on resident care has increased over the years. In Where Do the Billions of Dollars Go? A Look at Nursing Home Related Party Transactions, p. 2 (2023), the National Consumer Voice for Quality Long-Term Care ("Consumer Voice") expresses concern that CMS violates its obligation under the 1987 Nursing Home Reform Act, 42 U.S.C. §1395i-3(f)(1), to ensure that public reimbursement is focused on care when it allows nursing homes to "funnel Medicare and Medicaid dollars meant for nursing home resident care through companies they own with little to no scrutiny on how this money is used."

In the report, Consumer Voice analyzes Medicare cost reports for three nursing home chains – Life Care Centers, Pruitt Health, and Brius. Pruitt health, for example, owns nearly 90 nursing facilities in Florida, Georgia, North Carolina, and South Carolina, among other states. For the three-year period 2018-2020, Pruitt Health's Medicare cost reports showed that the company paid its related parties nearly $88.5 million more than the actual costs reported by the related parties, 18.36%.

Pruitt Health Care All Related Party Payments				
Year	**Related Party Reported Costs**	**Reported Payments to Related Parties**	**Amount by Which Payment Exceeds Reported Cost**	**% Payment Exceeds Costs**
2018	$162,395,326.81	$189,795,459.73	$27,400,132.92	16.87%
2019	$163,710,556.24	$188,439,854.28	$24,729,298.04	15.11%
2020	$155,756,110.14	$192,088,484.63	$36,332,374.49	23.33%
Total	$481,861,933.19	$570,323,798.64	$88,461,805.45	18.36%

Id. 9.

Pruitt Health's lease payments of $121,345,764.16 to related parties over the three-year period exceeded the actual costs of $83,099,902.88 by $38,245,861.28, or 46.02%. *Id*.

In the same three-year period 2018-2020, Pruitt's federal star ratings for health inspections, staffing, and overall were low, reflecting poor care for residents. In 2019 and 2020, Pruitt's star ratings on a five-point scale were "below average" in all three categories.

Pruitt Health Average 5-Star Ratings			
	Overall	**Health Inspection**	**Staffing**
2018	3.04	2.82	3.04
2019	2.6	2.57	2.29
2020	2.82	2.51	2.52
Average	2.82	2.63	2.62

Id. 10.

In "Tunneling and Hidden Profits in Health Care" (July 13, 2024), economists Ashvin Gandhi and Andrew Olenski analyzed 24 years of Medicaid cost report data in Illinois and found that nursing facilities hid 62.9% of their profits by paying inflated prices to related parties, largely in real estate and management fees. They calculated that if nursing facilities spent their hidden profits on staffing, mean staffing ratios would significantly increase – by nearly 0.23 hours per resident day (HPRD) of registered nurse (RN) time, a 28.9% increase, or by 0.47 HPRD of certified nurse aide (CNA) time, a 21.0% increase. Report 3.

A similar analysis by the Empire Center, *Following the Money: An Analysis of "Related Company" Transactions in New York's Nursing Home Industry* (Jul. 5, 2022), found that New York State nursing facilities in 2020 spent more than one billion dollars, or 16% of their operating expenses, on payments to related parties**. Nursing home owners made more of their profit from related-party transactions than from their nursing homes operations. Facilities that diverted money to related parties spent less of their reimbursement on staff and had lower ratings for the quality of care they provided.**

The New Jersey State Comptroller investigated South Jersey Extended Care (SJEC), New Jersey's lowest rated nursing facility, and exposed "a pattern of waste and abuse of public funds, financial mismanagement, disregard of federal and state oversight requirements, and substandard care" in the five-year review period April 1, 2018 to March 17, 2023. New Jersey State Comptroller, "Investigation Uncovers Multimillion Dollars of Fraud, Waste, and Abuse at New Jersey's Worst

Nursing Home; Report by the Office of the State Comptroller exposes years of hidden profiteering by the owner/operators of South Jersey Extended Care, the State's worst-rated nursing home" (Press Release, Dec. 12, 2024); the 52-page report is *An Investigation of Fraud, Waste, and Abuse in New Jersey's Lowest-Rated Nursing Home* (Dec. 12, 2024).

In the review period,

> The [owners] entered into multimillion-dollar, inflated-cost contracts with businesses they owned and controlled for goods and services their companies substantially failed to provide. Over the review period, SJEC received $35.6 million in Medicaid funds but spent $38.9 million on contracts with entities owned or controlled by Krausman and Konig. They failed to report any of these related-party transactions to the state and federal governments, as required. They concealed their roles in order to avoid scrutiny and hide their conflicts of interest.
>
> They funneled tens of millions in profits, funded by a steady stream of taxpayer funds, into their network of for-profit and not-for-profit entities – to the detriment of SJEC's residents. Funds that could have been used to hire additional staff, improve facilities, or enhance resident programs were instead used for owner distributions, "consulting" fees, and charitable donations to organizations they controlled.

During the five-year period, SJEC "was the worst-rated facility in New Jersey by CMS standards." Since at least 2013, it has received a one-star rating in almost every rating period. In a 75-day period reviewed by the Office of the State Comptroller (OSC), the facility "failed to provide sufficient, qualified staff on every single day." The executive summary reports:

> SJEC employed unqualified and unlicensed direct care staff and failed to consistently fill critical roles, such as a licensed Director of Nursing and a licensed social worker. Not surprisingly considering these glaring failures, SJEC's medical records were disorganized and missing crucial documents, including residents' care plans, medication administration records, and documentation of whether residents had received any assistance with activities of daily living like eating, walking, or going to the bathroom. Health inspection surveys also documented numerous deficiencies—more than double the state average in the last three inspection cycles—including serious issues such as neglect, abuse, unsanitary conditions, and inadequate medical care.

SJEC understaffed by 49.6%. For example:

> On July 4, 2021, SJEC had 106 residents, requiring 13 CNAs to staff the day shift and 8 direct care staff for the night shift. Instead, SJEC had only three CNAs from 7:00 am to 9:00 am, four CNAs from 9:00 am to 3:00 pm, zero direct care staff from 11:00 pm to 12:00 am, and two direct care staff from 12:00 am to 7:00 am. This means that SJEC only had 4 of 13 required CNAs for the day shift and 2 of 8 direct care staff for the night shift.

SJEC showed increasing debt and declining assets over the five-year period. At the same time and during the pandemic, when the facility was showing that its expenses exceeded its revenues,

the straw owner took $1.3 million in distributions and the actual owners' businesses charged the facility inflated prices for goods and services and "collectively allocated $45.5 million in profits to themselves."

Finally, New York State Attorney General Letitia James has filed a number of lawsuits against individual nursing facilities, alleging that the facilities committed financial fraud by diverting reimbursement to excessive private profit through related parties, while at the same time providing negligent and inhumane care to residents.

In November 2022, Attorney General James filed a lawsuit against The Villages of Orleans Health and Rehabilitation Center ("The Villages"), alleging that the owners "wove a complicated web of fraud, using their ownership stakes in multiple companies to turn The Villages into a profit machine." "Attorney General James Sues Orleans County Nursing Home for Years of Fraud and Resident Neglect" (Press Release, Nov. 29, 2022); Verified Petition. From 2015 through 2021, The Villages received $86.4 million in funding and made transfers to the owners of $18.6 million (more than 20%). When the facility was owned by Orleans County, it had a three-star rating from CMS. The owners bought the Villages in 2015 and the rating declined in four months to one star.

While profits were diverted to The Villages' owners, residents suffered. The Attorney General's Press Release reports:

> The Villages' reprehensible history of insufficient staffing and low quality of care is directly traceable to the owners' financial scheme. Residents were subject to repeated abuse and neglect as the most basic functions of care were abandoned. Residents were forced to sit in their own urine and feces for hours; suffered malnourishment and dehydration; developed sepsis, gangrene, and other infections due to gaping bed sores and inadequate wound care; endured medical toxicity and unexplained doping; and sustained falls and other physical injuries. Some of these abuses, including other unmonitored or undocumented circumstances, resulted in hospitalization and even death.

The Verified Petition describes the suffering of individual residents. For example, at ¶6:

> Delayed Wound Treatment, Unexplained Doping and Death: Resident 42 was admitted to The Villages on January 6, 2021, with a Stage II pressure sore near the base of her spine, but it was not treated for the first time until 18 days later. By June 24, Resident 42 suffered from two Stage III pressure sores. A specialty wound care consultant recommended a treatment regime, yet The Villages did not order this new treatment until nearly a week later, and did not provide a new dressing until July 1. When the consultant re-assessed Resident 42's wounds on July 7, both wounds had deteriorated to "unstageable." Additionally, The Villages gave Resident 42 psychotropic medication, purportedly for "severe anxiety," a diagnosis which cannot be found in Resident 42's medical records. Resident 42 was also frequently given medications for nausea, cough, and pain, without documented clinical need. Resident 42 was found unresponsive on July 13, and her records are silent as to what care, if any, she was provided before being sent to the hospital, where she died on July 13, 2021, from acute cardiopulmonary arrest

secondary to respiratory failure. Staff at The Villages failed to notify Resident 42's healthcare proxy that she was sent to the hospital.

See also similar cases, *Fulton Commons*, petition, Memorandum of Law in Support of the Verified Petition, and Attorney General's press release; and Cold Spring Hills, petition, Memorandum of Law in Support of Verified Petition, and Attorney General's press release. In *People of the State of New York v. Abraham Operations Associates LLC d/b/a Beth Abraham Center for Rehabilitation and Nursing, et al.,* Index No. ____/23 (NY Supreme Court, New York Co., filed Jun. 28, 2023), the New York Attorney General made similar allegations against four facilities owned by Centers Health Care, *People of the State of New York, by Letitia James, Attorney General of the State of New York v. Abraham Operations Association LLC, et al*, Index No. 451549/2023 (N.Y. Supreme Court, New York County, Jun. 28, 2023). In the Verified Petition and Press Release (Jun. 28, 2023), the Attorney General describes a similar diversion of reimbursement from resident care to private profit of the owners and the resulting lack of care for residents. Judge Melissa A. Crane denied the motions to dismiss on all counts (Aug. 29, 2024).

Recommendations

Nursing facilities' diversion of public reimbursement to inflated private profit and failure to provide residents with the care and services they need are key issues that CMS must address. The Center for Medicare Advocacy supports OIG's three recommendations to CMS to

- "require MACs to include, as part of the normal desk review or audit process, a review of reporting and disclosure of related-party costs;
- "develop and implement guidance for SNFs on the appropriate methods for providers to determine their allowable related-party costs; and
- "provide guidance to reeducate MACs on the need to review, grant, and document requests from SNFs for expectations to cost reporting requirements in compliance with 42 C.F.R. §413.17(d)."

OIG Report 15.

In addition to implementing OIG's recommendations, the Center for Medicare Advocacy urges CMS to seek statutory authority to enact and enforce legislation mandating **direct care ratios** – requirements that facilities spend specific and designated percentages of their reimbursement on resident care and limiting profits. Such legislation would implement the Secretary's general "duty and responsibility" under the 1987 Nursing Home Reform Law "to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys," 42 U.S.C. §1395i-3(f)(1).

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