



STATE OF NEW YORK  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
445 Hamilton Avenue, Suite 506  
White Plains, New York 10601

ANDREW M. CUOMO  
GOVERNOR

JAMES C. COX  
MEDICAID INSPECTOR GENERAL

August 19, 2014

[REDACTED]  
Schervier Pavilion  
22 Van Duzer Place  
Warwick, New York 10990

Re: Notice of Rate Changes #14-2893  
NPI Number: [REDACTED]  
Provider Number: [REDACTED]

Dear [REDACTED]

The Office of the Medicaid Inspector General conducted an audit of Schervier Pavilion's costs for base year January 1, 1996 through December 31, 1996 (audit #01-W04-3126). This audit resulted in adjustments of your May 17, 1996 through December 31, 2001 rates.

Previously issued Notice(s) of Rate Changes have addressed over or underpayments through December 31, 2007. However, the January 1, 1996 through December 31, 1996 base year is also used to calculate the operating portion of the January 1, 2008 through March 31, 2009 rates. Based on the enclosed audited rates calculated by the Bureau of Long Term Care Reimbursement, the Medicaid overpayment currently due is \$190,636. This overpayment is subject to Department of Health ("DOH") and Division of Budget ("DOB") final approval. While not anticipated, any difference between the calculated overpayment and the final DOH and DOB approved amount will be resolved with the Facility by the OMIG Bureau of Collections Management.

Enclosed are the appropriate rate sheets to support the amount due. The rate sheets reflect only the carry forward of the base period operating expense adjustments. All other components of the January 1, 2008 through March 31, 2009 rates may be subject to future audit. The revised rates and Medicaid impact are as follows.

<u>Rate Period</u>	<u>Issued Rates</u>	<u>Final Rates</u>	<u>Rate Decrease</u>	<u>Medicaid Days</u>	<u>Medicaid Overpayment</u>
01/01/08-03/31/08	\$218.71	\$212.83	\$5.88	6,083	\$35,768
04/01/08-06/30/08	213.62	207.78	5.84	5,963	34,824
07/01/08-12/31/08	219.38	213.54	5.84	13,147	76,778
01/01/09-03/31/09	215.87	209.86	6.01	7,199	43,266
<b>TOTAL MEDICAID OVERPAYMENT</b>					<b><u>\$190,636</u></b>

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below.

**OPTION #1:** Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #14-2893  
Albany, New York 12237-0048

**OPTION #2:** Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until an agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management  
New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, New York 12204  
[REDACTED]

[REDACTED]  
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Should you have any questions, please contact me at [REDACTED] or through email at [REDACTED]. Please refer to audit number 14-2893 in all correspondence.

Sincerely,

[REDACTED]  
Bureau of Rate Audit  
Division of Medicaid Audit  
Office of the Medicaid Inspector General

CERTIFIED MAIL [REDACTED]  
RETURN RECEIPT REQUESTED

Ver-13.0

**NEW YORK STATE  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
REMITTANCE ADVICE**

**NAME AND ADDRESS OF AUDITEE**

Schervier Pavilion  
22 Van Duzer Place  
Warwick, NY 10990

**NPI #:** [REDACTED]  
**PROVIDER** [REDACTED]

**AUDIT #14-2893**

**AMOUNT DUE: \$190,636**

<b>AUDIT</b>	<input type="checkbox"/>	<b>PROVIDER</b>
<b>TYPE</b>	<input checked="" type="checkbox"/>	<b>RATE</b>
	<input type="checkbox"/>	<b>PART B</b>
	<input type="checkbox"/>	<b>OTHER:</b>

**CHECKLIST**

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:  
[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #14-2893  
Albany, New York 12237-0048
5. If the provider number shown above is incorrect, please enter the correct number below.

[REDACTED]  
**CORRECT PROVIDER NUMBER**