



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 G. SHEEHAN  
MEDICAID INSPECTOR GENERAL

January 5, 2011

Mr. Howard Wolf, Administrator  
Grand Manor Nursing and Rehabilitation Center  
700 White Plains Road  
Bronx, New York 10473

Re: Notice of Rate Changes #10-4269  
NPI Number: [REDACTED]  
Provider Number: [REDACTED]

Dear Mr. Wolf:

The Department of Social Services conducted an audit of Grand Manor Nursing and Rehabilitation Center's (the "Facility") costs for base year 1983 (audit #91-W04-2674). This audit resulted in downward adjustments to your 1986 through 1991 rates. In addition, a "Stipulation in Settlement of Audit", was signed in March of 2010 to resolve audit #05-2164 which resulted in downward adjustments to the operating portion of your 2001 through 2004 rates.

Previously issued Notice(s) of Rate Changes and Revised Notice(s) of Rate Changes have addressed overpayments through 2007. However, the 1983 base year is also used to calculate the operating portion of the January 1, 2008 through March 31, 2009 rates. Further, the Stipulation included an adjustment for the duplication of sales tax which 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 \$41,415. This overpayment is subject to Department of Health (the "DOH") and Division of Budget (the "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 Impact</u>
01/01/08-03/31/08	\$187.99/186.37	\$187.58/185.96	\$0.41	20,377	\$8,355
04/01/08-06/30/08	184.75/183.15	184.34/182.74	0.41	20,299	8,323
07/01/08-12/31/08	188.08/186.48	187.67/186.07	0.41	40,095	16,439
01/01/09-03/31/09	185.96/184.33	185.54/183.91	0.42	19,756	<u>8,298</u>
<b>REVISED MEDICAID OVERPAYMENT</b>					<b><u>\$41,415</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 report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

Mr. Donald Collins  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 1237  
File #10-4269  
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 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 report, the OMIG will impose a 15% withhold after 20 days until the agreement is established. The OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. 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. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Bureau of Collections Management  
New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, New York 12204  
Phone #: (518) 474-5878  
Fax#: (518) 408-0593

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If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to secure payment and liquidate the overpayment amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds.

In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

If you have any questions regarding the above, please call me at (914) 397-1754.

Sincerely,



George D. Vislocky  
Rate Audit Manager  
Division of Medicaid Audit  
Audit Management and Development  
Office of the Medicaid Inspector General

Attachment  
Enclosure

CERTIFIED MAIL # 7001 0320 0004 5737 8805  
RETURN RECEIPT REQUESTED

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

**NAME AND ADDRESS OF AUDITEE**

**GRAND MANOR NURSING AND  
REHABILITATION CENTER  
700 WHITE PLAINS ROAD  
BRONX, NEW YORK 10473**

**NPI #:** [REDACTED]

**PROVIDER #:** [REDACTED]

**AUDIT #10-4269**

**AMOUNT DUE: \$41,415**

**AUDIT  
TYPE**

**PROVIDER**  
 **RATE**  
 **PART B**  
 **OTHER:**

**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:

**Mr. Donald Collins  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 1237  
File #10-4269  
Albany, New York 12237-0048**

5. If the provider number shown above is incorrect, please enter the correct number below.

[REDACTED]

**CORRECT PROVIDER NUMBER**