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

May 12, 2011

[redacted]
Sullivan County Adult Care Center
P.O. Box 671
Liberty, New York 12754

Re: Notice of Rate Changes #10-4882
NPI Number: [redacted]
Provider Number: [redacted]

Dear [redacted]

The Department of Social Services conducted an audit of your costs for base period September 1, 1991 through February 29, 1992 (audit #95-W04-3017). This audit resulted in downward adjustments of your September 1, 1991 through December 31, 1994 rates.

Previously issued Notice(s) of Rate Changes have addressed overpayments through December 31, 2007. However, the September 1, 1991 through February 29, 1992 base period 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 $30,655. 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 Collections Management Group.

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.

Rate Period	Issued Rates	Final Rates	Rate Decrease	Medicaid Days	Medicaid Impact
01/01/08-03/31/08	$174.86	$174.30	$0.56	11,018	$6,170
04/01/08-12/31/08	173.55	173.03	0.52	33,518	17,429
01/01/09-03/31/09	170.22	169.57	0.65	10,856	7,056
TOTAL MEDICAID OVERPAYMENT					**$30,655**

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:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
File #10-4882
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

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

Sincerely,

Division of Medicaid Audit, White Plains
Audit Management and Development
Office of the Medicaid Inspector General

Enclosure
CERTIFIED MAIL #
RETURN RECEIPT REQUESTED
Ver-10.0

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

SULLIVAN COUNTY ADULT CARE CENTER
P.O. BOX 671
LIBERTY, NEW YORK 12754

AMOUNT DUE: $30,655

NPI #: [redacted]
PROVIDER #: [redacted]

AUDIT #10-4882

AUDIT TYPE
[ ] PROVIDER
[X] 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:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
File #10-4882
Albany, New York 12237-0048

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

CORRECT PROVIDER NUMBER