



STATE OF NEW YORK  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
90 Church Street, 14<sup>th</sup> Floor  
New York, New York 10007

ANDREW M. CUOMO  
GOVERNOR

JAMES C. COX  
MEDICAID INSPECTOR GENERAL

May 17, 2012

[REDACTED]  
New Franklin Rehabilitation and Health Care Facility  
142-27 Franklin Avenue  
Flushing, New York 11355

Re: Notice of Rate Changes #08-1895  
NPI Number: [REDACTED]  
Provider Number: [REDACTED]

Dear [REDACTED]:

The Office of the Medicaid Inspector General (the "OMIG") conducted an audit of your costs for base period November 1, 2002 through October 31, 2003 (audit #04-C04-1018). This audit resulted in downward adjustments of your November 1, 2002 through December 31, 2005 rates.

The November 1, 2002 through October 31, 2003 base period is also used to calculate the operating portion of the 2006 rates. Based on the enclosed audited rates calculated by the Bureau of Long Term Care Reimbursement, the Medicaid overpayment currently due is \$94,294. 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 2006 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>
<b>NF</b>					
01/01/06-02/28/06	\$258.76/257.85	\$257.58/256.67	\$1.18	12,723	\$15,013
03/01/06-03/31/06	258.58/257.67	257.40/256.49	1.18	6,396	7,547
04/01/06-05/31/06	257.99/257.08	256.81/255.90	1.18	13,143	15,509

<u>Rate Period</u>	<u>Issued Rates</u>	<u>Final Rates</u>	<u>Rate Decrease</u>	<u>Medicaid Days</u>	<u>Medicaid Impact</u>
06/01/06-08/31/06	\$259.18/258.27	\$258.01/257.10	\$1.17	20,115	\$23,535
09/01/06-11/30/06	258.50/257.59	257.33/256.42	1.17	20,195	23,628
12/01/06-12/31/06	260.44/259.53	259.27/258.36	1.17	6,638	<u>7,766</u>
<b>NF Medicaid Overpayment</b>					<u>92,998</u>
<b>Vent</b>					
01/01/06-02/28/06	\$593.64/588.21	\$593.32/587.89	\$0.32	577	\$ 185
03/01/06-03/31/06	588.35/582.92	588.05/582.62	0.30	341	102
04/01/06-05/31/06	586.98/581.56	586.68/581.26	0.30	730	219
06/01/06-08/31/06	588.14/582.72	587.82/582.40	0.32	1,095	350
09/01/06-11/30/06	585.62/580.20	585.32/579.90	0.30	1,058	317
12/01/06-12/31/06	587.50/582.08	587.17/581.75	0.33	372	<u>123</u>
<b>Vent Medicaid Overpayment</b>					<u>1,296</u>
<b>TOTAL MEDICAID OVERPAYMENT</b>					<b><u>\$94,294</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 2266  
File #08-1895  
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 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 [REDACTED] at [REDACTED]

Sincerely,

[REDACTED]

Audit Manager  
Division of Medicaid Audit  
Audit Management and Development  
Office of the Medicaid Inspector General

Attachment  
Enclosure

CERTIFIED MAIL # [REDACTED]  
RETURN RECEIPT REQUESTED

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

**NAME AND ADDRESS OF AUDITEE**

New Franklin Rehabilitation  
and Health Care Facility  
142-27 Franklin Avenue  
Flushing, New York 11355

**AMOUNT DUE: \$94,294**

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

**AUDIT #08-1895**

<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 2266  
File #08-1895  
Albany, New York 12237-0048

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

**CORRECT PROVIDER NUMBER**