STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
90 Church Street, 14th 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 #08-3624
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 previously issued Notice of Rate Changes has addressed overpayments through December 31, 2006. However, the November 1, 2002 through October 31, 2003 base period is also used to calculate the operating portion of the 2007 rates. Based on the enclosed audited rates calculated by the Bureau of Long Term Care Reimbursement, the Medicaid overpayment currently due is $101,365. 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 2007 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
Nursing Facility					
01/01/07-03/31/07	$268.72/267.79	$267.52/266.59	$1.20	20,311	$ 24,373
04/01/07-06/30/07	267.21/266.28	266.01/265.08	1.20	20,865	25,038

Rate Period	Issued Rates	Final Rates	Rate Decrease	Medicaid Days	Medicaid Impact
07/01/07-08/31/07	$268.95/268.02	$267.75/266.82	$1.20	14,267	$ 17,120
09/01/07-12/31/07	268.95/268.02	267.75/266.82	1.20	27,904	33,485
NF Medicaid Overpayment					$100,016
Ventilator Unit					
01/01/07-03/31/07	$602.21/596.65	$601.88/596.32	$0.33	1,060	$ 350
04/01/07-06/30/07	598.68/593.16	598.35/592.83	0.33	1,021	337
07/01/07-08/31/07	598.68/593.16	598.35/592.83	0.33	649	214
09/01/07-12/31/07	598.68/593.16	598.35/592.83	0.33	1,357	448
Vent Unit Medicaid Overpayment					$ 1,349
TOTAL MEDICAID OVERPAYMENT					**$101,365**

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:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2266
File #08-3624
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 at

Sincerely,

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

Attachment
Enclosure

CERTIFIED MAIL #
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: $101,365

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

AUDIT #08-3624

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 2266
File #08-3624
Albany, New York 12237-0048

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

CORRECT PROVIDER NUMBER