STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

November 19, 2010

[redacted]
St Joseph's Hospital Nursing Home of Yonkers NY, Inc.
127 S Broadway
Yonkers, New York 10701

Re: Notice of Agency Action and
Final Audit Report #10-2046
NPI Number: [redacted]
Provider Number: [redacted]

Dear [redacted]

This is the notice of agency action and final audit report covering the Office of the Medicaid Inspector General's (the "OMIG") audit of St Joseph's Hospital Nursing Home of Yonkers' (the "Facility") ancillary services for the rate period January 1, 2007 through March 31, 2009. In accordance with 18 NYCRR 515.6 and 517.6, this report represents the OMIG final determination on issues raised in the notice of proposed agency action and draft audit report.

In response to the OMIG draft report dated April 13, 2010, you requested that the Medicaid overpayment be reduced by the Medicare Part B "carve-out" appeal dated May 11, 2010 for the period January 1, 2007 through March 31, 2009. This is in accordance with terms and conditions of the Stipulation of Settlement relating to Audit #03-T04-3022. Based on the enclosed audited rates calculated by the Bureau of Long Term Care Reimbursement (BLTCR), the Medicaid overpayment currently due is $757,225, as shown on Exhibit I. OMIG agrees that the Medicaid withholding of $757,225 will be limited to $199,797 pending the processing of the "carve-out" appeal by the BLTCR. 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.

The audit findings are detailed in the attached exhibits. The exhibits list base year ancillary services that are no longer performed by the facility yet are reimbursed in your Medicaid nursing home rate. Changes of this nature must be reported in accordance with 10 NYCRR 86-2.27. The failure to make such a report violates 18 NYCRR 515.2(a)(1); (b)(1)(i)(a); (b)(2)(i); (b)(3) and 540.7(a)(8).

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 #10-2046
Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the OMIG. 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.

You have the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. You may not request a hearing to raise issues related to rate setting or rate setting methodology. In addition, you may not raise any issue that was raised or could have been raised at a rate appeal with your rate setting agency. You may only request a hearing to challenge specific audit adjustments which you challenged in a response to the notice of proposed agency action and draft audit report.
If you wish to request a hearing, the request must be submitted in writing to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to of the Office of Counsel at

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply a signed authorization permitting that person to represent you along with your hearing request. At the hearing you may call witnesses and present documentary evidence on your behalf. If you have any questions regarding the above, please contact at

Sincerely

Coordinator Medical Facilities Audit
Division of Medicaid Audit
Audit Management and Development
Office of the Medicaid Inspector General

Attachments

EXHIBIT I - Summary of Per Diem Impact and Medicaid Overpayment
EXHIBIT II - Summary of Terminated Services Disallowances

CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

St Joseph's Hospital Nursing Home of
Yonkers NY, Inc.
127 S Broadway
Yonkers, New York 10701

NPI # [redacted]
PROVIDER # [redacted]

AUDIT #10-2046

AUDIT TYPE

[ ] PROVIDER
[ ] RATE
[ ] PART B
[X] ANCILLARY

AMOUNT DUE: $757,225*
*Withholding will be limited to $199,797

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 #10-2046
Albany, New York 12237-0048

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

CORRECT PROVIDER NUMBER

EXHIBIT I

ST JOSEPH'S HOSPITAL NURSING HOME OF YONKERS NY INC.

RATE PERIODS JANUARY 1, 2007 THROUGH MARCH 31, 2009

SUMMARY OF PER DIEM IMPACT AND MEDICAID OVERPAYMENT

	ISSUED RATES		FINAL RATES		RATE		
	Medicare Part B		Medicare Part B		DECREASE	MEDICAID	MEDICAID
RATE PERIOD	Non-Elig.	Eligible	Non-Elig.	Eligible	(INCREASE)	DAYS	OVERPAYMENT
01/01/07-03/31/07	$ 270.05	$ 265.03	$ 263.32	$ 258.30	$ 6.73	12,470	$ 83,923
04/01/07-06/30/07	268.51	263.52	261.81	256.82	6.70	11,886	79,636
07/01/07-08/31/07	262.41	257.42	255.71	250.72	6.70	8,341	55,885
09/01/07-12/31/07	262.41	257.42	255.71	250.72	6.70	16,057	107,582
01/01/08-03/31/08	266.85	261.75	260.02	254.92	6.83	12,131	82,855
04/01/08-06/30/08	260.14	255.08	253.36	248.30	6.78	12,859	87,184
07/01/08-12/31/08	268.54	263.48	261.76	256.70	6.78	25,437	172,463
01/01/09-03/31/09	268.06	262.89	261.08	255.91	6.98	12,564	87,697
TOTAL MEDICAID OVERPAYMENT							**$ 757,225**

EXHIBIT II

ST JOSEPH'S HOSPITAL NURSING HOME OF YONKERS N Y INC.

RATE PERIODS JANUARY 1, 2007 THROUGH MARCH 31, 2009

SUMMARY OF TERMINATED SERVICES DISALLOWANCES

	EEG CC #033	Inhalation CC #035	Psychiatric CC #038	Medical Staff CC #044
1983 Reported Costs	$ 21	$ 4,561	$ 6,804	$ 201,635
Less: Adjustment per Schedule I of HE-12B		31		
Expense per HE-12B	$ 21	$ 4,530	$ 6,804	$ 201,635
Traceback %	100.00%	100.00%	100.00%	100.00%
Total Expense Eliminated from Rate	$ 21	$ 4,530	$ 6,804	$ 201,635