



STATE OF NEW YORK  
 OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 259 Monroe Avenue, Room 312  
 Rochester, New York 14607  
 (585) 238-8166  
 Fax: (585) 238-8169

DAVID A. PATERSON  
 GOVERNOR

JAMES G. SHEEHAN  
 MEDICAID INSPECTOR GENERAL

November 9, 2010

[REDACTED]  
 Elcor Nursing Home  
 48 Colonial Drive  
 Horseheads, New York 14845

Re: Notice of Rate Changes #10-3812  
 NPI Number: [REDACTED]  
 Provider Number: [REDACTED]

Dear [REDACTED]

The Department of Social Services conducted an audit of your costs for the October 1, 1989, through March 31, 1990 base period (audit #92-M04-1028). This audit resulted in downward adjustments of your 1989 through 1992 rates.

Previously issued Notice(s) of Rate Changes have addressed overpayments through December 31, 2007. However, the October 1, 1989 through March 31, 1990 base period is also used to calculate the operating portion of the 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 \$566,904. 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 2008 through March 31, 2009 rates may be subject to future audit. The revised rates and Medicaid impact are as follows.

<u>Nursing Facility</u>			<u>Rate</u>	<u>Medicaid</u>	<u>Medicaid</u>
<u>Rate Period</u>	<u>Issued Rates</u>	<u>Final Rates</u>	<u>Decrease</u>	<u>Days</u>	<u>Impact</u>
01/01/08-03/31/08	\$156.87/153.93	\$152.96/150.02	\$3.91	21,766	\$ 85,105
04/01/08-06/30/08	155.48/152.57	151.54/148.63	3.94	21,354	84,135
07/01/08-09/30/08	158.44/155.53	154.50/151.59	3.94	22,500	88,650
10/01/08-12/31/08	159.15/156.24	155.21/152.30	3.94	21,739	85,652
01/01/09-03/31/09	155.34/152.37	151.20/148.23	4.14	20,145	83,400
Nursing Facility Medicaid Overpayment					<u>\$426,942</u>

<u>Adult Day Care</u>			<u>Rate</u>	<u>Medicaid</u>	<u>Medicaid</u>
<u>Rate Period</u>	<u>Issued Rates</u>	<u>Final Rates</u>	<u>Decrease</u>	<u>Days</u>	<u>Impact</u>
01/01/08-03/31/08	\$93.92	\$77.22	\$16.70	1,431	\$ 23,898
04/01/08-06/30/08	93.10	76.58	16.52	5,330	88,052
01/01/09-03/31/09	88.13	71.06	17.07	1,641	28,012
ADC Medicaid Overpayment					<u>\$139,962</u>
<b>TOTAL MEDICAID OVERPAYMENT</b>					<b><u>\$566,904</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:

[Redacted]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 1237  
File #10-3812  
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

[Redacted]

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 [REDACTED]

Sincerely,

[REDACTED]

Director, Audit Resources Management  
Division of Medicaid Audit  
Audit Management and Development  
Office of the Medicaid Inspector General

Attachment  
Enclosure

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

**NAME AND ADDRESS OF AUDITEE**

Elcor Nursing Home  
48 Colonial Drive  
Horseheads, New York 14845

NPI #: [REDACTED]

PROVIDER #

NF: [REDACTED]

ADC: [REDACTED]

**AUDIT #10-3812**

AMOUNT DUE: NF	\$426,942
ADC	<u>139,962</u>
TOTAL	\$566,904

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 #10-3812  
Albany, New York 12237-0048

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

**CORRECT PROVIDER NUMBER**