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

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

November 7, 2014

[redacted]
New Surfside Nursing Home, LLC
22-41 New Haven Avenue
Far Rockaway, New York 11691

Re: Notice of Rate Changes #14-5985
NPI Number: [redacted]
Provider Number: [redacted]

Dear [redacted]

The Office of the Medicaid Inspector General (the "OMIG") conducted an audit of New Surfside Nursing Home, LLC.'s (the "Facility") Medicaid rates for the rate period January 1, 2006 through December 31, 2008 (audit #11-3732). This audit included adjustments to base year May 1, 1988 through October 31, 1988 sales tax expense and resulted in downward adjustments of the Facility's January 1, 2006 through December 31, 2008 rates.

The May 1, 1988 through October 31, 1988 base year is also used to calculate the operating portion of the January 1, 2009 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 $3,585. This overpayment is subject to Department of Health ("DOH") and Division of Budget ("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 January 1, 2009 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 Overpayment
01/01/09 – 03/31/09	$215.48/$215.47	$215.25/$215.24	$.23	15,586	$3,585
TOTAL MEDICAID OVERPAYMENT					**$3,585**

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 2739
File #14-5985
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 50% withhold after 20 days until an agreement is established. 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. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

Should you have any questions regarding the above, please contact at or through email at Please refer to audit number 14-5985 in all correspondence.

Sincerely,

Bureau of Rate Audit
Division of Medicaid Audit
Office of the Medicaid Inspector General

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

NEW SURFSIDE NH, LLC.
22-41 NEW HAVEN AVENUE
FAR ROCKAWAY, NEW YORK 11691

AMOUNT DUE: $3,585

NPI [redacted]
PROVIDER [redacted]

AUDIT #14-5985

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 2739
File #14-5985
Albany, New York 12237-0048

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

CORRECT PROVIDER NUMBER