New York State Department of Health
Office of Health Insurance Programs
Capital Reimbursement Certification

Facility_____
Operating Certificate Number_____
Capital Reimbursement Rate Year - 2020
Declaration Control Number (DCN) of corresponding RHCF-2 or 4_____

Certification Statement

Misrepresentation or falsification of any information contained on this form may be punishable by fine and/or imprisonment under New York State Law and Federal Law.

Certification of Operator

☐ I hereby certify that the attached capital schedule **does** contain revisions to the Department's capital schedule provided to me. I am the signatory to the RHCF-2 or 4 for the attached capital reimbursement schedule and that I have the authority to bind the above listed facility. I certify that this revised schedule was completed, to the best of my knowledge and ability, in accordance with the New York State statutes, regulations and policies that govern Medicaid capital reimbursement for nursing facilities. I have attached a narrative explaining the revisions, along with supporting documentation.

☐ I hereby certify that the capital schedule provided by the Department, **does not** require revisions to the Department's capital schedule provided to me. I am the signatory to the RHCF-2 or 4 and that I have the authority to bind the above listed facility. I have read the above statements and I have examined the Department's capital reimbursement schedule, which serves as the basis for the capital per diem of the corresponding rates, based upon certified information contained in the DCN identified above, and that to the best of my knowledge and belief, it is true and complete and is in accordance with the New York State statutes, regulations and policies that govern Medicaid capital reimbursement for nursing facilities.

I will provide any supporting documentation as requested by the Department of Health, the Office of the Medicaid Inspector General and any other audit, enforcement or oversight agency and/or body.

I understand that this attestation is in lieu of an administrative appeal of the attested rate. Further, I understand that any challenge to the attested rate, through administrative action or otherwise, will result in forfeiture of the facility calculated attested rate and adoption of the Department's original reimbursement rate. I understand that this in no way limits the administrative appeal rights of the facility and that an administrative appeal may be pursued in accordance with applicable New York State statutes, regulations and policies, including any rights under 10 NYCRR 86-2.13 & 86-2.14.

I understand that the Department of Health's acceptance of the attached schedule, in no way precludes the Office of the Medicaid Inspector General from conducting audits and/or exercising its oversight capacity in any manner whatsoever, including, but not limited to, actions taken pursuant to 18 NYCRR Parts 517, 518 and 519.

I hereby certify that I have read the foregoing conditions and that I have the legal authority to bind the above listed facility to the terms herein.

Modifications of the terms contained herein shall render this attestation null and void.

_____ DATE

_____ SIGNATORY'S NAME (PRINTED)

_____ SIGNATURE

_____ SIGNATORY'S TITLE